

Eliminating Health Disparities

Conversations

WITH

Latinos



HELEN RODRIGUEZ-TRIAS

AMERICA BRACHO

ROSA MARIA GIL

ISABEL M. MARTINEZ

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ETR
Associates

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ETR ASSOCIATES

SANTA CRUZ, CALIFORNIA

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ELIMINATING HEALTH DISPARITIES MONOGRAPH SERIES

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*Dedicated to
Helen Rodriguez-Trias
1929–2001*

DR. HELEN RODRIGUEZ-TRIAS graciously agreed to serve as this monograph's editor and was interviewed shortly before her death in December 2001. Her words and those of her friends and colleagues were not initially sought as a memorial to her, but have become one. We dedicate this issue of the *Eliminating Health Disparities* series to her memory with the hope of contributing to her vision of a world without the injustices against which she fought with such grit and grace.

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Health Disparities Among Latinos

THE 31 MILLION LATINOS LIVING IN THE UNITED STATES TODAY represent a growing, diverse population. From just 6% of the U.S. population in 1960, Latinos now comprise 12.5% of the U.S. population—a result of both accelerated immigration since the mid-1960s and higher fertility rates than other population groups. According to the U.S. Census Bureau, within a decade Latinos are likely to become the second largest racial/ethnic group in the United States, after whites.¹

Traditionally concentrated in California, Texas, Florida and New York, Latino populations have settled in many other parts of the country, including the Midwest and Northwest. Chicago, with 750,000 Latino people, now has the third-largest Latino population in the country.

The term *Hispanic* is an artifact of reporting requirements, created by the federal government in the early 1970s in an attempt to link several groups within the United States by their ties—hereditary, colonial or linguistic—to Spain over the past several centuries. This link, while useful in some ways, masks significant differences among the populations included in the term: Mexican Americans (currently 60% of the Latino population in the United States), Puerto Ricans (about 15%), Cuban Americans (about 10%), and immigrants from Central America and the Caribbean. (A tenth of the population of El Salvador—approximately 500,000 people—is believed to have settled in the United States since the 1970s, escaping civil war in that country.)²

¹U.S. Census Bureau. Population projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995-2005. *Current Population Reports*, 1996.

²*Hispanics in the United States: An Insight into Group Characteristics*. Essay posted on the website of the Department of Health and Human Services, Office of Minority Health, Hispanic Agenda for Action (HAA). <http://www.omhrc.gov/haa/HAA2pg/AboutHAA1a.htm>. Accessed 6/13/02.

Even within these groups, further distinctions exist that have implications for health. These could include difference in region and/or nation of origin, length of time in the United States (some Latinos in the Southwest trace their roots to the 17th century), income levels, family size, educational attainment, and the degree to which group members speak English, Spanish or both.

The Health Status of Latinos

Forty-four million Americans lack health insurance coverage—a national crisis. This crisis falls disproportionately on America’s Latino population, who represent a quarter—or 11 million—of the uninsured, the highest rate of any racial or ethnic group. The Commonwealth Fund’s 2001 Health Care Quality Survey reported that nearly half of Latinos under the age of 65 (46%) said they had been uninsured for some period of time during the past year—a rate more than double that reported by whites. This was highest for Latinos of Central American descent (55%) and Mexican descent (49%).³

As noted in another recent Commonwealth Fund survey, “a key reason why so many Hispanics lack health insurance is not that they do not work, but rather that their employers do not offer them coverage.”⁴ In fact, the report notes, of the 11 million uninsured Latinos, 9 million are in families in which at least one person works. However, because many Latinos work in low-wage jobs and/or small firms—two categories least likely to offer health insurance—their coverage rates lag behind those of any other group.

³Doty, J. J., and B. L. Ives. *Quality of Health Care for Hispanic Populations: Findings from the Commonwealth Fund 2001 Health Care Quality Survey*. New York: The Commonwealth Fund, March 2002.

⁴Quinn, D. *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans*. New York: The Commonwealth Fund, February 2000.

Holes in the Safety Net

Despite low income levels that would make 6 million working-age Latino adults and 3 million children eligible for publicly funded insurance programs, half of Latinos with incomes below the poverty level remain uninsured. Immigration status is one factor, but it does not fully explain this disparity between low-income Latinos and other groups struggling with poverty. (Latinos *with* U.S. citizenship remain uninsured at twice the rates of poor whites.)

One factor is state eligibility standards, which are sometimes set below federal poverty levels. For example, in Florida and Texas—where a third of uninsured Latinos live—a single mother with two children and a minimum-wage job would not be eligible for Medicaid if she worked as little as 16 or 17 hours a week.⁵

Beyond Access, Unequal Treatment

Lack of insurance has many direct consequences that adversely affect health, such as postponing or even forgoing needed care and missing opportunities for screening that can detect emerging chronic conditions while they are still treatable.

Several recent studies paint a disturbing picture of unequal treatment even among those who do have access to care. The National Academy of Science's Institute of Medicine, for example, released findings from a report that found that "racial and ethnic minorities tend to receive lower-quality health care than whites do, even when insurance status, income, age, and severity of conditions are comparable." These differences in treating diseases such as heart disease, cancer and HIV infection contribute to higher death rates among minorities.⁶

⁵Ibid.

⁶Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, D.C.: National Academy Press, 2002.

The Commonwealth Fund's 2001 Health Care Quality Survey supports these findings, noting that "Hispanics and Asian Americans frequently stand out as the least well-served by the health care system."⁷

In a compendium of financial and cultural barriers to care, The Commonwealth Fund researchers reported the following survey results:

- ✎ A third of Latinos (compared to 27% of Asian Americans, 23% of African Americans and 16% of whites) reported communication problems with their doctors that affected the care they received, such as feeling their doctor did not listen to everything they said, not fully understanding the doctor, or having questions they did not ask their doctor. Although these communication problems were reported more often by Latinos who did not use English as their primary language (43%), the problems were also significant among those who did use English as their primary language (26%).
- ✎ Among those who had not followed a doctor's advice, 41% of Latinos reported that they had not done so because of cost (compared to 30% of African Americans, 27% of Asian Americans and 24% of whites). Latinos were also the most likely to report use of alternative therapies as a way of cutting costs—and the least likely to tell their doctors they were using these therapies.

Communication problems also affected the tone of the physician-patient encounter: Latinos were most likely to feel they had been treated with disrespect (18%) by being talked down to, spoken to rudely or simply ignored. (The figure was 16% for African-American survey respondents.)

- ✎ Latinos reported low rates of screening and preventive health counseling. For example, among those over the age of 50, only 18% of Latinos reported some type of colon cancer screening. (The rates were 31% for African Americans, 28% for

⁷Collins, K. S., D. I. Hughes, M. M. Doty, B. L. Ives, J. N. Edwards and K. Tenney. *Diverse Communities, Common Concerns Assessing Health Care Quality for Minority Americans. Findings from The Commonwealth Fund 2001 Health Care Quality Survey*. New York: The Commonwealth Fund, March 2002.

whites and 16% for Asians.) Similarly, although 82% of white smokers and 78% of African-American smokers had been counseled to quit, only 58% of Latino smokers reported this type of counseling. Latinos were also the least likely to receive clinical services used to monitor and control diabetes, high blood pressure and heart disease among respondents already diagnosed with these conditions.

- ✘ Latinos were the most likely to feel they had little or no choice about where they could seek and obtain health care, and the least likely to have a regular doctor.

Eliminating Health Disparities

Far from inevitable, disparities in health, income and opportunity strike many as uniquely *un-American*—an affront to the principles of equality that are at the core of our national identity.

The movement to reduce and eliminate health disparities is one that has been gaining momentum on both global and domestic fronts. At a global level, it is part of a broader notion of health articulated in 1978 at the International Conference on Health Promotion in Alma-Ata, which declared that:

... health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.⁸

Closer to home and more recently, the Institute of Medicine report that chronicled lower quality of care for minorities identified specific actions to reverse these trends at the clinical level, including training and deploying more minority health care

⁸World Health Organization. 1986. Health promotion: A discussion document on the concept and principles. *Public Health Reviews* 14 (3-4): 245-254.

providers, increasing the ranks of interpreters available to patients of clinics and hospitals in neighborhoods where these needs are most common, and increasing the availability of community-based health workers who can help patients navigate complicated systems. Authors of the report also recognized that while patient education and support can help minimize communication problems, the burden falls on providers to improve their interactions with patients through training that helps them understand different cultures. More research is needed to identify both sources of health disparities and promising interventions to combat them—and especially to understand the role and prevalence of bias, prejudice and stereotyping.⁹

At a broader federal level, *Healthy People 2010*, the U.S. Department of Health and Human Services' health objectives for the nation, calls for eliminating health disparities within the decade by concentrating on the six conditions and diseases that have the most glaring and persistent gaps between minority and mainstream health outcomes :

- ✘ Infant mortality
- ✘ Cancer screening and management
- ✘ Cardiovascular disease
- ✘ Diabetes
- ✘ HIV/AIDS
- ✘ Child and adult immunizations

The previous iteration of *Healthy People*, setting forth goals for 2000, called for *reducing* disparities—a goal that was ambitious, but fell short of the current goal of *eliminating* disparities. The rhetorical shift is significant, conveying at once an optimism that disparities can indeed be eliminated, and an urgency and scope different from the more gradual reductions implied in the earlier language. The optimism and urgency inherent in this goal are captured in different ways—all eloquent, passionate and persuasive—by the conversations recorded in this monograph.

⁹Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, op. cit.

Inspired by Public Health

ISABEL M. MARTINEZ



ISABEL M. MARTINEZ, MPH, is a Cuban American born and raised in Chicago. She has a master's degree and is currently pursuing a doctorate in public health at the University of Illinois, Chicago. Her dissertation work focuses on the perceived risk of occupational injuries of Latino migrant farm workers in northern Illinois and southern Michigan. Her long-term career goals are to become a researcher and professor in the field of public health. She is especially interested in training future public-health professionals to improve the competencies and the knowledge base of those who serve and work with multiethnic communities.



Translating for My Family

For as long as I can remember, I've been interested in the health field. It just seemed natural to me to help someone feel better; after all, I considered myself to be some sort of medical assistant from the age of seven. As the American-born daughter of Cuban

immigrants, I did a lot of translating for my newly arrived, Spanish-speaking family. One of my most important “jobs” was interpreting during doctor visits.

Through these visits I learned the basics of the U.S. health care system, like how long it could take to get an appointment with a doctor, and the big differences between private and public health insurance. I also grasped how difficult it can be to navigate through the system without help, especially for recent immigrants with language barriers. I think I knew more about sinus infections and arthritis than other kids whose parents were born in the U.S. and spoke English fluently. Most important, I discovered that when I grew up I wanted to continue to help people get the health care they deserved.

Finding My True Interest

In my teens, I let my parents know of my interest in the health field and my idea of going to medical school. Well, they expressed their “traditional ways” when they told me that I should consider becoming a dentist because it would be easier to raise a family. A doctor would have to be on call and it wouldn’t be *apropiado* (appropriate) for me to leave my future husband and kids “in the middle of the night.” So instead of fighting their Cuba-circa-1950s ideals, as I often did, I thought about it. I always had good experiences at the dentist’s, contrary to the general belief that the dentist equals pain. Soon enough, I was on a mission to eliminate the fear people have of the dentist by becoming the most gentle dentist the world has ever known—I would change the attitudes of millions one by one!

When I finished college, I worked for a dentist while I studied to take the dental school admissions exam. It was one of the best decisions I have ever made because I realized that what I really enjoyed was educating people about health, rather than actually treating them. Honestly, the sound of the drill and the smell of decayed teeth were making me ill. I also wondered how I, as a future health professional, could spend my time sending out messages to the public about the importance of regular

check-ups in order to avoid unnecessary suffering later. My question was answered when I met a DDS with an MPH after his name, and learned of a career in public health with its base in prevention. That was it! A couple of days later, I submitted my application for the MPH program at the University of Illinois.

Believing in Public Health

I began the program thinking that I would finish with a master's degree. Through the program I became an adamant believer in public health and I caught the investigation bug while I was working as a research assistant for the dean. Soon after, I thought about going on as a doctoral student to further develop my interest in minority health issues, as well as research and work with Latino communities on improving our health status.

I probably wouldn't have actually applied for the PhD program if it weren't for the support and encouragement of my MPH advisor Dr. Scrimshaw, who later became my PhD advisor, the staff of the Health Careers Opportunity Program, and the support of one of my friends, an advanced doctoral student at the time. They gave me the opportunity to work on a variety of research projects during my MPH program, in which I learned to be part of a research team while studying health issues affecting minority populations. One of my first projects explored the reinforcers of adolescent pregnancy from Latina and African-American teens' perspective using qualitative methods. I was thrilled to have coauthored my first publication through this study. I enjoyed talking with the teens, finding out what was meaningful for them, and then, through presentations and writings, trying to communicate their experiences and concerns to those who serve this special group of adolescents.

During this time I also became more involved in community service. That, for me, was a perfect balance with the research. I collaborated with *promotoras de salud* (community health workers) from a center serving several Latino communities in Chicago, Centro San Bonifacio, on developing a culturally sensitive domestic-violence awareness

project. Public health students can gain valuable insights when they have the opportunity to exchange knowledge and work with people like *promotoras* who are practicing public health almost door to door in the community they live in. I've learned so much about doing outreach and building trust within a community through my time with the folks at the center.

Be Open to All the Opportunities

Into the doctoral program, continuing my research assistantship, I became more familiar with health disparities as I prepared background material for the Institute of Medicine reports on cancer. In addition, I had the chance to study minority teen health again as a coauthor with my advisor on a paper on health disparities among adolescents.* Both papers emphasized that the health status of some ethnic groups is worse than that of white non-Hispanics.

African-American and Latino populations are the fastest growing populations in the United States. Our health system needs to respond by reducing the barriers to accessing health care, especially preventive care, that these groups have encountered in the past. These papers also recommended that, to better reach and engage the nation's diverse populations, health care professionals should try to provide more culturally appropriate approaches to health. Having the chance to contribute to the significant content of these publications moved me to become one of the public health professionals who dedicate themselves to closing the gaps in health.

My interest in Latino health has even brought me to several Latin-American countries. I visited my family's native Cuba through the Medical Education Cooperation with Cuba program (MEDICC), to study their public health-care system. Just this past summer, I was in the rain forest of Costa Rica as a teaching assistant for a new course on global health and nutrition, cosponsored by the University of Illinois

*Martinez, I. M., and S. C. Scrimshaw. 2001. The changing ethnic makeup of America's adolescents: Implications for health. *Adolescent Medicine: State of the Art Reviews* 12 (3): 427-444.

at Chicago School of Public Health and the Monteverde Institute. Aside from the tremendous travel adventures, I now have a better understanding of these particular Latino cultures, which I hope will some day help me address the health care needs of members of those communities who have moved to the United States.

My participation in another research study, looking at the occupational health of Latino migrant farm workers, helped me develop the topic of my dissertation. I didn't know much about occupational health before joining the project, but being bilingual and bicultural helped me and the other project members understand the experiences of this group of workers. I never knew a career in public health could bring me all these unique opportunities. This is why I encourage students to consider a career in public health.

Feel Proud

There are so few Latinos in leadership positions within public health, yet our population is the fastest growing group in the U.S. Imagine the *orgullo* (pride) one feels going on to higher education, getting your master's and striving toward a PhD, working to improve the health of your own community. I know this feeling very well. It's what has helped me to keep going forward through all the hard work, and it's been an honor. I hope my experiences and words challenge and inspire other students to pursue a career in public health. ¡Deseo salud para todos! (I wish health for all!)

Grit and Grace

HELEN RODRIGUEZ-TRIAS



HELEN RODRIGUEZ-TRIAS, MD, was a physician and public health advocate who spent her life fighting for the health care rights of women, children and poverty-stricken families. In January 2001, she received the Presidential Citizens Medal from President Bill Clinton for her work on behalf of women, children, people with HIV and the poor. She also served as the first Latina president of the American Public Health Association (APHA).

Her career as a pediatrician spanned more than four decades, took her in many directions and touched many lives. She helped develop the first center for the care of newborn babies in her native Puerto Rico. She was the medical director for the New York State Department of Health AIDS Institute, codirector of the Pacific Institute for Women's Health and an associate professor at Columbia University.

Being a member of a family was important to Helen. She wanted people to know that women can render social good while maintaining cohesion in the family. She was always grateful for the support of her four children—Joellen, Laura, David and Daniel—her grandchildren, and her husband and collaborator of 20 years, Edward Gonzalez, Jr.



Who has inspired your work?

My mother was a schoolteacher in Puerto Rico, as was my aunt. They were graduates of Puerto Rico's Normal School, which was equivalent to maybe high school, and both taught at rural schoolhouses in the hinterlands of Puerto Rico coffee country. They

My mother was a very avid fighter for what she thought was right.

used to go on horseback when they were 15 and 16 years old to teach. I think something about their shared commitment to the welfare of children became part of my inheritance. My mother was a very avid fighter for what she thought was right. She was one of those who argued for school lunches for kids. She kept saying that these kids cannot learn because they come to school very, very hungry. We are talking about the Puerto Rico of 1915–1925, when my mother taught.

As a child I really saw the terrible poverty around me—it was the depression, which in Puerto Rico was much deeper than it was in the States. I remember a time when a friend of my aunt's brought a pear to our house. He had this precious fruit and I really wanted it. My aunt said, "No, no, no, you can't have it. He's taking it home to his four children." You get a sense of what a luxury a piece of fruit was.

I went to a Catholic grade school in Puerto Rico with lay teachers, although there was a heavy emphasis on religion, as in all Catholic schools. I had a really good science teacher. In second grade she had us doing experiments, for example, on why things burn and what happens if you take oxygen away from something that's burning. That really was a tremendous eye-opener for me—this interest in science.

At age ten, my mother and I moved to New York because she had divorced my father. I'm the youngest of three in the family so I was the one she felt most responsible for. It was a struggle at first to adapt. I didn't know enough English and they paired me up with these twins as guides who knew English already. But of course, we would tend to speak Spanish and they would punish us for speaking Spanish in school. No way was bilingualism going to be accepted in New York schools in 1939.

My mother did whatever she could in New York to make a living—including piecework, embroidering pearls on collars and so on. It was the end of the depression and a lot of people were on relief. But my mother found it very demeaning—whatever they required for you to get on relief was more than she could tolerate. So instead she did very menial work. But we made it. In public school, here and there I had somebody who was an inspiration in terms of encouraging me by saying I was a good student.

Why did I decide to study medicine? For me, the sense of wanting to be part of the healing community was very strong. Also, I liked science and I liked people. So, medicine combines those interests really well.

Quite a few people in medical school inspired my work, particularly Dr. José Sifontes, one of my professors. He was one of the pioneers in pediatric tuberculosis and participated in a lot of the studies showing that if you treated the kids who had a positive tuberculin test prophylactically, you decreased the likelihood of progressive tuberculosis and particularly tubercular meningitis, a real problem in young kids.

He had a very humble way about him. Dr. Sifontes would sit down and listen to the story about a family I had interviewed and would say, “Oh, what’s the father’s occupation? Oh, he sells oysters—now that’s interesting.” He was definitely an inspiration because he had a sense that what was happening in the community was something that affected health. He said that tuberculosis is a disease of poverty, of malnutrition, of overcrowding.

Many other people have been great inspirations for me. If you talk about global leadership, I think of Bill Foege. When we were both on the board of APHA I got to know something about his thinking and how he presented things, his forcefulness.

For me, the sense of wanting to be part of the healing community was very strong.

Wasn't it an extraordinary time for a woman, especially a Puerto Rican woman, to become a physician?

I was in New York from age 10 through 18. Then, because college was so expensive in the States, my mother had the idea of sending me to the University of Puerto Rico because that was a state school. I found myself in that peculiar position of someone who has returned—my Spanish certainly wasn't at the same level as the others'. I was talking to people who had studied *Don Quixote* in high school. All I could talk about was Shakespeare, so it really was a big cultural gap. But I made it up enough to pass the entrance examination, and kept my grades high enough that I was awarded an honor scholarship, tuition free. There was also a bit of a subsidy for housing in the dormitory.

I dropped out after one year at the university, for various reasons, some of which were political. I think it was part of my formation, too, to have been part of a movement to change society. In Puerto Rico, that also meant being in favor of independence. That year the Nationalist leader, Don Pedro Albizu Campos, who had been in federal prison for ten years, was released and the students wanted to have a meeting and invite him to speak. The chancellor of the university refused permission even though the student union had voted for it. He said, "Absolutely not, no political figures on campus. This is a house of studies and this vitiates the whole purpose of the university..." And the students went on strike. The response was to shut down the university.

So in April of my first year—which had started in August—the university was closed by the administration. They barricaded everything and refused to let the students in, and they began to expel students. I was identified with the struggle. I can't say I was in the leadership or anything like that, but I was supportive of it. My older brother (ten years older) was helping me in school and he was very upset about my participating in anything. He said, "You just go to school. If you're going to be involved in anything political, forget it. I'm not supporting you." So I packed up and went back to New York and shortly thereafter I met the man who became my first husband.

I think my sense of what was happening to people's health at that time—and it hasn't changed much over the years—was that it was really determined by what was happening in the society, by the degree of poverty and inequality you had.

I was inspired to try and change things by the reality I knew—that there were children who just didn't get enough to eat and didn't grow, or who died at an early age.

What's missing in some people's experiences is that they don't learn how other people live because they live in their own insulated world. The world I grew up in, in Puerto Rico, was not that way. You knew the doctor who lived across the street who had this little girl you played Monopoly with, but you were also friends with the kids next door whose place had just a dirt floor. You got a sense of class differences in a very real way.

I think my sense of what was happening to people's health was that it was really determined by what was happening in the society, by the degree of poverty and inequality you had.

What lessons do you have to share with others?

One of the lessons I learned very early on is, don't think you're right all the time or even most of the time. Be willing to really listen very carefully to others and hear their points of view. As a young person who wanted to do so much, I alienated a lot of people, and totally unnecessarily, because of a certain kind of righteous view of the world. So I guess the first lesson is humility. You realize that there isn't any one answer and that even if there were, you're only going to get people moving around the one answer if they are persuaded it's their answer as well.

Another lesson was to realize how limited medical care was in addressing people's issues. No matter how good you were as a physician, or a teacher, or a writer of programs, you were dealing with so many other factors. Pediatrics attracted people who were more public health minded, because a child is dependent on his or her environment. Besides that, I had three children before I went back to medical school [*laughing*]. I had the minor in child care, I wanted to get the major. You can't ignore the

fact that where the kid lives, what the father and mother do for a living, whether they earn enough and know enough to feed that child right—all that has to do with whether a child ends up in the hospital with a bad case of diarrhea at age three months or grows up healthy.

There were epidemics during the time of my training, from 1956 to 1960. We had a major polio epidemic in Puerto Rico, and a major measles epidemic. I hadn't learned from the books that kids could die of measles without even getting a rash. A little seven-year-old girl came in without a rash and she died of measles carditis. There were kids who came in with measles encephalitis and died. And we had kids who had undetected positive tuberculosis signs and got TB because of measles.

It's not so much about being a great diagnostician as it is about making sure the kids get immunized.

So, that sense that many diseases were preventable, and that's where the efforts had to be, was very much a part of my formation. It's not so much about being a great diagnostician as it is about making sure the kids get immunized.

This is something I observed even before thinking of becoming a public health person. In Puerto Rico there had been major health reform in the 1950s. The government took over some of the utilities, and there was an agenda of social justice and ending poverty. During that time, the health care system was regionalized. The government was providing care for two-thirds of the population, all of whom were considered medically indigent—below the poverty level, very, very poor. The medical school was training us to work primarily within that system. We had a social service commitment—year for year if you received any scholarship support. Those of us who had received four years of support were going to work in the system a minimum of four years. And, of course, if you stayed at the university hospital, it was the best post-grad training you could get in Puerto Rico.

Maybe six or seven years after my graduation, there were some winds of political change in Puerto Rico. The other, more reactionary party was gaining momentum. At that time, the health system was relatively good inasmuch as there was free health care

for everybody—not necessarily the best quality care, particularly at the local levels (that was a big variable)—but when people got to the university hospital level, they received the best that we could offer.

This system had a process whereby doctors from the university hospital visited the referral source and did some consultation on patients. Local health centers were built on the premise that you had to have three kinds of services working together. One was the welfare system. Another was the community sanitation efforts—that's where the prevention went on, where you investigated. (If it was an outbreak of hepatitis, was it from the overflow of sewage somewhere?) And the third was direct medical care. So you had a sense of collaboration, with health educators, sanitary engineers, public health nurses—the other parts of the system that did a lot of outreach. It was a good system. There was a period of time when it was considered a model and we had people from Latin America visiting to see what Puerto Rico had done in terms of regionalization.

There was a period of time when we had people from Latin America visiting to see what Puerto Rico had done in terms of regionalization.

But if other folks got elected and wiped it out, nobody was going to fight for it because they never really, truly involved the community in those changes. They worked from the top down. People didn't understand what it meant to have such a system, or how they could work to improve it. What they saw was a doctor who sat there in the morning to do *le receteo*, the prescription clinic, sometimes without even looking up and checking a patient, issuing preprinted prescriptions and seeing 200 people a day.

What is the alternative? I guess one of my major lessons was that nothing has the seeds of improvement and betterment unless there is really broad, conscious, educated community participation on an ongoing basis—not just a token thing of getting three people from the community on the board, but nobody paying attention to them because they haven't read through the stacks of materials that everybody else had read.

Nothing has the seeds of improvement and betterment unless there is really broad, conscious, educated community participation on an ongoing basis.

Now, in Puerto Rico, the whole privatization mode has really swung in. In terms of government programs and interventions, the system has been ripped apart and very few people defended it. They thought they were getting access to a better thing, but it's meant no access for some people now.

What have your life experiences allowed you to accomplish?

For me, a watershed in life was getting divorced in Puerto Rico—that was my second marriage—and leaving Puerto Rico to become part of the women's movement. In my formation as a professional, there was always a kind of pressure to deny or not use a lot of your personal experience. The science of medicine, to some degree, negates the human, feeling, experiential part of it. But I was now discovering a whole other world out there through my personal experience of a deceptive marriage. That triggered quite a bit of growth in me toward understanding what happens internally to people, what happens in their lives and what they can do or not do.

One of my young professors when I was in residency had had some prestigious specialty training at Cornell, and was a very bright woman. We became good friends. One day, after I separated from my husband and was going through this whole crisis, the failure of a 16-year marriage, I was sitting across from her in her office and I said, "You know, I'm breaking up with my husband." She said, "Oh, my God! Me too." And we both started to cry. I suddenly realized I had never considered my personal life, my feelings, important enough to talk about to a friend because so much of professionalism is negating your experiences and talking about common denominators.

So I went back to New York and I got very involved in reproductive rights. I began to join in the women's movement. At Barnard College there was a conference called the First International Conference on Abortion Rights that was attended by a few

thousand women. I met a friend there whom I had not seen in years. She was married to a Puerto Rican and had lived in Mexico for many, many years, so she spoke perfectly good Spanish and had done a lot of community organizing in the Latino community.

We organized one of the first consciousness-raising groups of Latino women. A number of incredible things emerged from women talking about their experiences. They ranged from our age to the ages of our daughters and even younger. A group of about seven or eight fluctuated a little, but there were three or four who stayed as the core group. We shared and we became very bonded. That was the beginning of my identification with women's issues and reproductive health.

A number of incredible things emerged from women talking about their experiences.

What was an important undertaking in the women's movement?

The development of an informed consent process for sterilizations—what we called the end to sterilization abuse. In the 1970s and even way before there was a long tradition of forced sterilizations in this country. It came to light and forced those of us who had been in Puerto Rico, where sterilization had become the main thrust of family planning activities, to start re-examining the situation. By 1968, over 38% of Puerto Rican women of reproductive age (16 to 44) had been sterilized. It was amazing for that day and age. If you talk about it now, sterilization has become common enough—there are very high percentages in industrialized countries as well. But then it was just totally startling.

It had a lot to do with how family planning policies were implemented in Puerto Rico—again, from the top down—and with what choices were given to women in a country that was rapidly industrializing, on the basis of women's labor more than anything else. Textiles, clothing manufacture and small electrical parts industries employed women and left men out of the labor market—which also had tremendous sociological implications for the structure of the family in Puerto Rico.

It is possible to work in partnership with people who are outside the system if you get your coordination done really well and in a respectful way.

I started looking at it through the lens of the women's movement. I'm very proud to have participated in changing things. We got guidelines for the city hospitals in New York and then got a law passed by the city council that mandated informed consent for both men and women who were getting sterilized. (Men had had vasectomies and did not know that these were not likely to be reversible.) This experience taught me that it is possible to work in partnership with people who are outside the system if you get your coordination done really well and in a respectful way, so that you each respect the roles you have to play to accomplish something.

Then we got an informed consent resolution adopted in APHA which became really controversial, maybe partly because of the wording. We recognized that there had been abuses, and the people in Family Planning and Population were not keen on such an admission. So it got passed on to the action board, which then passed it on for a position. It was my first foray into APHA policy.

Another thing I've been very much involved in is trying to ensure that HIV is addressed in family planning discussions. There's a project that Jane Boegess has been directing, funded by Packard, to make emergency contraception available in pharmacies with the pharmacist able to dispense it. It's very successful.

When that project was being hatched at the Pacific Institute for Women's Health, I said to Jane, "I'm at a point that I don't talk contraception without talking STD and HIV. We've done everybody a great disservice by separating these things. Nobody wants to push dual methods of birth control, but that's where it's got to be if you want maximum protection. And if you're going to use only one way, it's condoms and it's not negotiable."

And she said, "How are we going to weave that in?" We talked it through and she was able to get it done, not only in terms of educational materials but in terms of a move

to enable people to get condoms using their MediCal cards. What's important is that information be accompanied by access. It's necessary to keep bringing this information up over and over again, especially to minimize the risk for women. This has been a major problem in the HIV field from the very beginning—recognizing the vulnerability of women.

What are the most important issues related to health disparities?

One is what we mentioned before—the social and economic determinants, the attitude toward immigrants. Not that Hispanics as a whole are recent immigrants, because the landed people were here way before the territory was taken over from Mexico. But the immigrant issue keeps coming up as a reason to discriminate, even against people who are legal immigrants. I believe that the social and economic determinants are very deep in terms of what are considered legitimate services. And, of course, there's the problem of a health care system that has maybe 44 million people uninsured. Latinos are over-represented in that group because the majority fall into the lower-income categories where they don't qualify for insurance. That's a major issue.

The immigrant issue keeps coming up as a reason to discriminate, even against people who are legal immigrants.

Another one is sort of a global issue—the United States doesn't really want to accept our cultural complexity, so there isn't a genuine effort in many places to address the different issues.

For example, my sister is now in an extended care facility in Arizona. She's probably the only woman there with any pigmentation. Everyone else is white and from middle America. Somebody said to her, "Oh, is Castro still the president in Puerto Rico?" My sister said, "We'll have to start with Puerto Rican and American History 101." She's equal to the task.

It's only been in the last decade or two that there's been recognition that we are many countries, many cultures, many ethnicities. And, yes, that makes it hard to address issues. But we're just going to have to find a way of dealing with it.

Clearly there's a lack of understanding about other societies and cultures among the general population.

In my teaching with residents, we used to struggle with this. There are no blueprints out there, but it boils down to the sensitivity to ask somebody, "What is it like where

You need some very good interviewing skills, and the ability to listen to the response.

you come from? What do you think caused this disease? Is there anything that's done in your family, or was done before you came here, that promotes health or takes care of disease?" You need some very good interviewing skills, and the ability to listen to the response.

Find out what people do, why they do it, what they believe. Then think in categories: Is what they believe and do harmful? Then we've got to work on that. Is what they do or believe something you don't know about? Maybe you better find out a little more about it. Is what they believe and do beneficial? Then learn from it. When you come right down to it, we all have different cultures to some degree because we have our family culture as well as the overall group culture we identify with.

Part of the American dilemma is a kind of negation of social class. The big label of ethnicity or race, in our eyes, distinguishes groups of people. But there is no understanding of class. This is about chronic poverty. This is about a middle class that left their neighborhoods 40 years ago so the people remaining in those neighborhoods don't have professional role models. This is about the stratification of our society, with its attendant isolation and lack of concern. There are a lot of factors to take into consideration. I think we're making some progress, although I'm worried about hard times coming. When hard times come, people get even more competitive and angry and less likely to share.

What is your passion, your vision, your hope for the future?

I hope I'll see in my lifetime a growing realization that we are one world. And that no one is going to have quality of life unless we support everyone's quality of life. We breathe the air, we drink the water. That's one obvious thing. But we also walk the streets, drive on the roads, go to the schools—everything else that's part of a much larger community. If we begin to identify our personal desires for safety, for beauty, for healthy environments as being totally interrelated with the desires of others, I think we're going to build a real movement for eliminating disparities. Not on the basis of do-goodism, but because of a real commitment and understanding that it's *our* collective and personal health that's at stake.

So that's my dream, that we're going to see it. I think there's a flicker of that understanding that can become more widespread. At the International Women's Conferences in Cairo and Beijing, participants accustomed to community involvement became very sophisticated in working at parliamentary, international levels. My hope is that it will continue. And I'm also hoping that we'll become less selfish and less violent in our homes as well as in every other place we set foot.

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everyone's quality of life.*

Focusing on the Voice of the People

AMERICA BRACHO



AMERICA BRACHO, MD, MPH, is the executive director of Latino Health Access, a center for health promotion and disease prevention in Santa Ana, California. Created under her leadership, the center uses participatory approaches to community health education and trains community health workers to be advocates for wellness and change.

After working as a physician in her native Venezuela for several years, Dr. Bracho came to the United States to obtain a master's degree in public health at the University of Michigan. She created and directed the AIDS projects for Latino Family Services in Detroit and has been a trainer, presenter and consultant for numerous government and private agencies. She serves as a consultant for the Pan-American Health Organization, has taught international courses in Latin America, and has been the host of a daily Spanish-language radio talk show and TV program on health-related topics.

Recognized as an expert in the areas of Latino health issues, health education, minority women, cultural competency, community organizing, diabetes education and HIV, she has received several awards for her contributions to the Latino community.



Who has inspired your work?

Probably the main inspirations were my parents. Both were professors, who retired in Venezuela. They taught in high school and then college and were always very involved not only in the education of their students but also in their lives. They always believed their students had the capacity and the ability to reach the stars. They would go to students' homes and talk to their parents when they were not coming to school, and assisted with anything. What was the issue? Was food the problem? Clothes? I'm talking about Venezuela, third world, and the lowest-income areas in Caracas. And my parents dragged me along because they didn't have a person to take care of me.

I was witness to a lot of miracles that happen when you do this intervention, when you basically trust that people will be able to change and explore the barriers with them. My parents were always very committed to social change and still get involved in anything wherever they live. Also, of course, they trust me and always thought I could do things.

I was witness to a lot of miracles that happen when you basically trust that people will be able to change and explore the barriers with them.

The work of Paulo Freire has also been an inspiration for me—the basic belief that people can change and should embrace their own change, and that we should be a part of other people's change without imposing our idea of how to do it. We must honor how people learn. We must respect their thinking process.

Another inspiration is Nelson Mandela, his life and his perseverance and commitment, that incredible commitment and love for the people.

And then I think, also, the HIV movement in the United States was critical in my work—seeing how the people who were actually infected and their families were the main element in changing health policies around HIV. It wasn't doctors or politicians; it was people saying, "You are going to change the way you approve the medications in the FDA or we don't move from here."

When people have the issue, the concern, and include themselves in the process, it changes.

When people have the issue, the concern, and include themselves in the process, it changes—speeds it up, makes it more respectful, more focused. They even changed how an HIV conference looks—less medical, more of what the client or the person affected needs.

Finally, there are the community workers, the *promotoras*, who worked with me in Venezuela, and in Detroit during my time as HIV program director, and right here in Latino Health Access. They are people in the community who have leadership skills, whom we recruit and train. Then they go out and do their work. Again and again they come back with lessons that have inspired my work in public health.

What lessons do you have to share with others?

One of the things that frustrates me is that we want to engage in a process that will be conducive to change, but we keep thinking that if we just provide knowledge to these families they could change. But it's not enough. Nothing happens. Some providers go a little beyond knowledge and provide a few needed things, again expecting people will change. And nothing happens. We want to come up with a formula, those three or four things that will make people change. But I've learned that, depending on the individual, the family or the community, any formula needs to be adjusted. It starts by listening to what people are saying, by looking at the assets and the skills people have, by looking at the context. And then we really need to bring resources and be there with people while some sort of action is being taken.

In the area I work in, which is direct public health in the community, in the streets, we go into the apartment buildings to work with families. I direct an organization that has 64 employees; 42 of those are community workers who live here. Every time we are doing an activity in the community we see 60 to 100 unsupervised kids all around.

I'm not making any judgment, but I can tell you that if we want to strengthen the families of these neighborhoods, to work on prevention, or detection of conditions,

or just improve the overall health of the community, we need to get involved on a personal basis with these kids and these families. We have to really assess what it will take for them to be included in the system and the society, to take advantage of programs and opportunities and education.

What is happening is that we have a tutoring program, for instance, but these kids are not participating. Or the recreation department has a program for baseball, but nobody knows about it. So then people come up with a resource list: here's how you get involved in baseball. But, you know, these kids don't have anybody to take them to the park to practice.

These adults need help with the basic structure in order to function in society. If you want to implement something, you have to see whether the structure of these communities will help a program succeed or not. And many providers are not analyzing that.

Many of our programs at Latino Health Access are very successful because we try to walk beside people, to support, and to add and add until you can actually see change. And we stay there until the person is saying, "You know, this is how it is." And then you can move on. It means you have to combine mass interventions with very personalized family intervention. Maybe you have to serve 3,000 members of a particular cardiovascular training program and work with 40 families in depth. That's what it takes. It cannot be only mass interventions, and it cannot be only the personal intervention because some people are more ready to change. It must be both.

I believe a lot in comprehensive interventions. People who are afraid of these say, "Oh, you're going to be all over. You're going to lose the focus." And such interventions are hard to evaluate because you don't know exactly what produced the result. But

If we want to strengthen the families of these neighborhoods, to work on prevention, or detection of conditions, or just improve the overall health of the community, we need to get involved on a personal basis.

people are not little “departments.” A woman in my neighborhood is not “breast health” or “academic health.” It’s extremely difficult to improve the health of the community when the work is all divided into specialties. People have several needs and several requests and a range of assets and talents that you can incorporate better if you have a comprehensive way of working.

But I don’t think we need to do everything. We have to learn to reach other resources, to cooperate and bring in people who can do those other things.

I know that if you are working in community health you cannot address everything. But I don’t think we need to do everything. We have to learn to reach other resources, to cooperate and bring in people who can do those other things.

One of our challenges is that we haven’t learned how to cooperate, and we have individual ways of being in which our egos or problems surface. Sometimes, we don’t want to give credit or we don’t know how to get along with people.

Individual barriers based on your personal issues become a barrier to your community work. You cannot improve health if you do not believe that health belongs to that particular individual. If you don’t believe in the basic strength of that individual, family or community, you cannot do the work. When you do believe and include people and their strengths in solving problems, programs blossom. And people do improve.

We have very successful diabetes self-management programs in the hands of community workers who have diabetes themselves. We have great family mental health programs in the community with the people pursuing their own goals. The families and the *promotoras* decide together what training they receive, what retreats they go to—and things improve. How expensive is this? Not that much, because our main asset is the human beings we are working with, the trainers or the families who are our main clients, the consumers of these services.

Another question is, Are we giving opportunities for this community to actually express what they need? When my community workers say we are having a great

response from the youth in a particular area but adults are not responding, my question is, Are we connecting with those adults? Do we know what issues they want to talk about? Or do you only want to ask questions and have a survey completed?

People can and should participate in their own change and the collective change. It takes awhile for a person to tell you the problem is my apartment, my kid, my health—and go on from there to my apartment building, my neighborhood, my city or my nation. When people succeed in step one, it goes on from there. It's not that fast, but it moves.

We've seen in our daily work how hope flourishes in these small projects, such as cross-stitching programs with women. One woman may start teaching other women, and after a while these women are talking with each other about the friend who doesn't have anyone to take care of her, the little kids who don't go to school when the mother is sick. Next thing you know, they're cooking for each other. Three weeks later they're meeting with the mayor to advocate for a clinic to remain open because it's the only clinic that serves those women. Four months later this group has a stake in democracy.

When people do not participate, it's because they're not being given the mechanisms for participation. You may say, well, we gave them this and this. But sometimes it takes individual mechanisms you can't define for people. The people have to define what participation is and how they want to be involved.

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I've also learned that you can be accountable in your program. Everything can be evaluated—not only programs but money, time, your vision. You can be a very good business. You can be accountable and still be community oriented—treat people with respect and dignity and do community work. *Because* you are a community organization, you should be very accountable. And, *because* you are a community organization, if you are doing a good job, you need to find ways of sustaining your

program. It won't happen unless you are credible and accountable, do good business and treat people right.

We offer salaries competitive with other organizations because we spend a lot of money training the community workers we have. We have created an internal ladder for them to go from *promotoras* to program assistants to coordinators so we can keep their experience in-house. We have moved them from minimum salary when they started to above-average hourly wages for some of the community workers. They all

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have health benefits. And we are very competitive in the salary of a program coordinator. We have a business that is stable, and so could other community organizations.

Any other thoughts on lessons you've learned?

I went to school to help people and I remain committed to the reason I went to school. If we don't keep ourselves connected to those dreams and values and principles, we lose out. Sometimes we see this in people who are truly wonderful, but because it's just paperwork, and more paperwork, there seems to be nothing left to feed the soul. If we separate ourselves from who we are and what we want to accomplish in life, our vision will be distorted and we'll burn out.

What have your life experiences allowed you to accomplish?

When I graduated from the Universidad Central de Venezuela in Caracas, I went to work in rural Venezuela, where you really don't have a lot of resources. This is not only third world, it is the rural area of the third world. About 25 years ago there was the International Conference on Health Promotion in Alma-Ata in the Soviet Union. In that conference, participants from the third world decided there were a lot of gaps in health care and that no specialist was going to fill them. So they decided to move the entire planet to primary care. They talked about family practitioners, community

workers, the role of nurses—all of that. Then they mandated to the world, Go ahead and implement primary health care systems that can resolve more problems and address more concerns at less cost.

Countries like Venezuela implemented these ideas. Venezuela uses community workers within the health system, and these workers actually do clinical work. In Venezuela I was the doctor of this town and I worked with community workers (*promotoras*) based in very remote areas. I remember the *promotora* saying, “Many women have had babies. I want you to visit them.”

I also remember having all the kids in those towns fully immunized. They kept immunization cards in shoe racks and with this very rudimentary system kept track of their kids. That’s a lesson I share when I lecture in the school of medicine and many other places, because here we have computers and advanced computer programs to track and project and to do so many things. But we don’t have our communities fully immunized.

Maybe if we combine the human will and human power with technology, we can do something much better. The people in that place in Venezuela are very hard-working and very poor but very creative.

You see that just with your hands and your head, you can do these marvelous things, and people can change.

When I work here in the United States, I sometimes feel like Pelé, the football player from Brazil, because Pelé learned to play soccer without shoes. I learned to do public health with very, very little. So when we work in communities with very few resources, and combine that with money and technical support from the county and many others, we really can triple the outcomes. Our work is very creative. The idea of trusting the people’s skills and talents also came out of those experiences. You see that just with your hands and your head you can do these marvelous things, and people can change.

Another experience that really changed my life was to become an immigrant. I went from Venezuela to the United States, where I received my master's in public health. I then went to Detroit, where I worked with the African-American community, with which we have a lot of things in common. Seeing the people I worked with through the eyes of an immigrant was a different experience. I have so many things in common with those families who sometimes do not understand the educational system, or feel threatened, or feel rejected, or unwelcome. It makes me more open, less judgmental. For example, I understand that many of the opportunities we have in this country are there because of the Mexican Americans who opened the doors for us in the past, or the African Americans and many other people who worked in the civil rights movement.

Also, just to be a mother, a woman—if you are connected to that, you can relate to the mom who is bringing you her kid because he's sick and she's afraid something will happen to him.

I didn't grow up in a poor home environment, but I grew up around poverty. In Detroit my work was in a very, very poor community. Here, too. Poverty gives you a lot of experiences with how people perceive the world, and their limitations and lack of opportunities. I think that people are sometimes not clear about what opportunity really means. It's not just about having a school and a hospital. To have opportunity means to grow up thinking you actually could do something. It's to have support, daily support, to have dreams and to experience your dreams coming true.

To have opportunity means to grow up thinking you actually could do something.

What are the most important issues related to health disparities?

Prevention, access and early detection or early intervention for treatment. And when people speak of access to health care, it's simplifying the issue because then we need to go into the whole discussion of what is access.

For example, an apartment building in Santa Ana has a major problem with toxic mold. There's a particular kid there whose nose is bleeding. He has a rash and asthma because of the mold. So the doctor gave something in writing to his mom that said she needed to move. But this is an apartment she's buying. It's a low-income housing deal. Everything she had in her life went into buying this place. Now she has to continue paying for an apartment that nobody wants to buy, and she has to move to another place if she wants her boy to become healthier. What are her opportunities?

There are issues related to families and how they spend their time together that I take very seriously as a threat to public and family health. We have parents working two or three jobs to pay the rent. They're absent from the home a lot.

When we talk with their kids, they say, "I understand that my dad has to work. But I don't see him. And when I see him, he only tells me this or that, and he's fighting with my mom. And I don't see my mom either. I'm alone." Health issues are very complex.

Take the problem of diabetes. This is not going to be solved by telling people they need to eat better or exercise. In some communities the grocery markets don't sell what people are told they should eat. And you can't even walk in these streets after certain hours.

There are issues related to families and how they spend their time together that I take very seriously as a threat to public and family health.

The opportunities aren't there in terms of education. In the schools these kids don't receive the help they need, and their families sometimes don't know the language and cannot help with homework.

You could see these as hopeless situations. Or you could design comprehensive interventions in which you not only address certain conditions such as diabetes, cardiovascular problems or immunizations, but also come up with plans to create healthy cities and healthy communities. Put things in place to make it possible for families to engage in different behaviors. Bring a different set of opportunities to these kids. Even on a small scale we can work such changes every day with great results.

What should front-line providers do to address the disparities in access? How can they help bring people in for appropriate health care?

In this country, health care is a luxury, not a right. It's not something you have access to because you are a person who lives in this nation. However, I believe that health care is a basic right. And that it is the obligation of any country to offer it to everyone. Not only in terms of clinical care, but the whole gamut of services, including prevention and early detection.

In this country, not only do we not have that, but we have a major population that people want to ignore. I'm talking about the people who don't have documents. Because they are undocumented immigrants, they don't qualify for anything. People might feel this is fair, since they aren't citizens, but they get sick and they will need health services. And they will have kids here who are citizens of this nation. It's not good business. It doesn't save money to ignore this population. And that's one of the sectors of the population that our organization works with very closely.

This country has also decided to ignore the people who cannot afford health insurance. We work in communities in which people work two or three jobs and still

This country has also decided to ignore the people who cannot afford health insurance.

cannot afford insurance—the working poor. The lack of access to clinical care is a major issue. Many times, even if they go for care, people are not satisfied with the services because they are not understood. They get lost in these hospitals. Translation continues to be done in a very disrespectful way—whichever is around who can speak a little bit of Spanish will become the translator.

I'm not saying this is always the case. And things are improving. But we still find that there's a lack of understanding of the Latino community in cultural terms. Even if the doctors are Latino, it's not a guarantee of anything. The doctor could be a third-generation Latino working with an immigrant who just came here, and they are very distant from each other.

Providers should be advocates for the people we serve. And that goes beyond policy level. I'll give you an example. When I was in Detroit we were doing a lot of outreach for people who use drugs. We were, of course, working on HIV and trying to prevent infections. We finally got this particular person to go to the hospital, and they made her wait forever. She was in a lot of pain. When she came back she said, "I didn't wait any more. They were making me wait because I'm an addict. That's the way they treat addicts there." I called the director of that hospital and they ended up apologizing.

If we don't establish basic respect in our relationships with this community, its members are not going to use the services. We need to know how people feel about their treatment. We need to hear what these patients are saying. "The nurse told me this." "I waited for three hours." "My mommy's at home because she doesn't have insurance."

If we don't establish basic respect in our relationships with this community, its members are not going to use the services.

What do we do when we hear this? What's our reaction? Oh well, that's not my business? Oh well, I don't have time? Oh well, we can't solve all the problems of the world? Instead, we should say, "There must be a level at which I can get involved. I can advocate in my daily practice for better, more responsive care. I can advocate in my hospital for services to be of better quality and more sensitive to these communities. I can advocate for my hospital to support community programs."

I'll give you an example: An emergency pediatrician at the University of California at Irvine (UCI), Dr. Federico Bacca, came to me one day very worried. He'd seen a lot of kids in the emergency room with lesions on their backs because they were not in a car seat or were in a wrong car seat or were without seat belts or with the wrong seat belts. He said, "I want to do an injury prevention program." We didn't have any injury prevention program in this organization, and here I had a doctor in front of me who wanted to do one, with the heart and the skills to do it. So we wrote a proposal together to train community workers on educating people about injury prevention. We just got the money to do it and Dr. Bacca is leading the program.

You are an individual, an advocate, and you are part of the solution.

This approach is very direct. You are an individual, an advocate, and you are part of the solution—you realize that you can change the system. This is not only a policy fight, it's a personal thing. The schools of medicine tell you that personal and professional do not mix. But personal and professional have to mix. Either this is right, or it's not right. You need to bring your personal values with you when you come to work. If somebody's mistreating a person in your hospital, it's wrong. And when things are wrong, you do something about it. It's very simple. Think in solutions—don't think that things cannot be done.

We are involved with the family practice rotation for UCI and Kaiser. We take these doctors into the community and put them inside the houses where families live. In this way, they get to know a different story, not just the receptionist in the clinic telling them, "Mrs. Martinez is coming late to her appointment." Instead, they listen to Mrs. Martinez herself talk about her tribulations, her issues, her dreams and everything that she wants for her family. Community work brings perspective and gives you the other side, which makes you a more balanced and committed professional.

Who has mentored you and what do you do to mentor others?

I was very proud when Dr. Bacca said people had told him to go to Latino Health Access if he wanted the project to become a reality. I want to have that reputation. I want people to believe that if they want to do something for this community, Latino Health Access could be an avenue. The mechanism of participation to make this a better community is not just for the residents, for the low-income families, it's also for the doctors, nurses and others who want to create change. Sometimes they don't find that mechanism on their own.

So I encourage people to come here and put together projects. I recruit people who are recent graduates. They usually start working here to help me with data analysis and they often end up in public health. Two of them just decided to go to medical school.

One of them, a Latina, started working on data and then I started training her to teach classes. She's extremely smart. She became my program coordinator for the Diabetes in Children program, and now she's completing the requirements to become a doctor, to later become a pediatrician.

This organization provides the support for people to connect and give to this community. When they first come in, they are full of insecurities. Many times they've been criticized and the university taught them that they need to lecture people. It's incredible to see the transformation when they start working with the community and become more open and more secure. They start seeing things with more balance. It's just terrific. I do training on an ongoing basis, not only with my coordinators but with the community. We have 42 community workers. Three of them—men involved in *Proyector Honor*, the project on alcohol—are men from this community who were leaders in creating groups such as AA and NA and want to help others. We recruit and train them. Their skills improve by doing other interventions, and they have jobs and health insurance and support for their families.

I'm a volunteer faculty member in several schools of medicine. Every time I have the opportunity to lecture to medical students I tell them to challenge their schools and to protect their dreams—the reasons they wanted to come to medical school. I love to talk to them about adult education and their relationship with their patients. And they end up coming here and volunteering. We have a great group of medical students from UCI that come with us every Saturday to immunize in the streets. I don't have time to mentor each of them, so my way of doing it is to involve them in programs to make them believe this is worth it. Then the community will do the rest. Those doctors come out of the community rotation saying, "Can I stay?" They want to do more community work.

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So when providers take steps to eliminate disparities, they enhance their own quality of life by realizing the dreams that brought them into providing service.

That's exactly right! We're all in this together. But the awareness of that togetherness goes away in college. You learn to think in terms of theory. You come out thinking you are so special and so different that when you want to connect with the common people the path has been buried underneath all those books. So you need to do community work in order to recover your common sense.

The main answers to my life as a professional, as a woman, as a mother are found when I connect with common sense, when I become human, when I'm not a doctor with all this training. When that humanity is mixed with knowledge, it's much better. In this regard, health professionals can make a great team, since they do have the training and the knowledge. But we also need the human connection. And we need to be brave. That's why we also need mentors who are brave.

One of my mentors is Dr. Noreen Clark, who is now the dean of the School of Public Health at the University of Michigan. She was my advisor when I was doing my master's degree and I remember her advice about daring to challenge the rules. If the rules aren't working for the good of the people, then we need to change those rules.

Another mentor is Barbara Israel, one of my former professors who is very much into community organizing and public health. A third is Fran Jemmott from the California Wellness Foundation, whom I call the Monet of public health. She has such a way of sharing her vision of community health that it looks like a painting. Also, she encourages people to challenge themselves to change. That's critical.

What is your passion, your vision, your hope for the future?

What I would like to see happen is true reform in which everybody can have access to health care. But that has to be combined with public health intervention in which

we offer opportunities for prevention, early intervention and detection, and treatment. In the Latino community, we need to have special initiatives in areas such as chronic diseases and family mental health, in which we deal with everything from prevention to treatment. That needs to be mixed with comprehensive interventions such as healthy city programs in which we also pay attention to social and spiritual health. Things are not going to get better doing business as usual.

Look at what's happening with HIV. People are not dying as quickly in the United States, but the level of infection in minority communities continues to be high. The number of women becoming infected is increasing. Tuberculosis is an increasing problem in minority communities. So unless we do something, we are just dumping all the diseases in poor neighborhoods.

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We need to have comprehensive interventions that address general issues—mental, physical, academic—together with special initiatives for particular conditions. We need special initiatives for diabetes, heart disease and sexually transmitted disease. We need comprehensive interventions for mental health, particularly the issue of substance abuse. We don't need to wait for health care reform to accomplish these objectives, but it would be nice if these things could be done simultaneously. So some of us need to be advocating in Washington.

Is there anything you would like to say about your experiences working with Helen Rodriguez-Trias?

I worked with Helen on several projects, and it was always an inspiration. During her time with the American Public Health Association, she did a terrific job in terms of advocacy and leading. I also remember her from the Latino Coalition for a Healthy California—our long conversations and planning meetings to make California a healthier place for all people. Helen didn't like to drink much. But one day she said, "I'm going to drink a beer. And as usual I'm going to do it in a different way." So she

put ice and lemon in it. I love people who can do those things. Who cares if people don't do it that way—this Puerto Rican will drink it with lemon and ice.

She was always an advocate for women's issues. She did several presentations for my organization. I just adored her and respected her very much for her commitment, her advocacy, her heart and her passion for good health for all people.

The Challenge to Act

ROSA MARIA GIL



ROSA MARIA GIL, DSW, is the university dean for health sciences at City University of New York, where she provides leadership to more than 100 health-related academic programs. Previously, she served as chair of the board of directors of the New York City Health and Hospitals Corporation and as health policy advisor to Mayor Rudy Giuliani. Accomplishments during her tenure include prevention and wellness initiatives, expansion of primary care, improvement in quality of care in public hospitals, expansion of services for the mentally ill and implementation of programs to increase access to health insurance. She has held executive positions at several New York hospitals.

Dr. Gil was born and raised in Cuba and came to the United States as a refugee as a young adult. She has been an associate professor of social work at Columbia University and a lecturer at Harvard University's School of Government, Hispanic Leadership Program. She has served on numerous boards and her professional contributions have been recognized by many organizations. She was awarded the Helen Rodriguez-Trias Award for Lifetime Achievement in Latino Health. Dr. Gil has written many articles and is coauthor of *THE MARIA PARADOX*, the first authoritative book on self-esteem and Hispanic women.



Who has inspired your work?

Paulo Freire, the Brazilian educator who challenged us to truly think through what we are involved in. Reading his materials and later having the opportunity to meet him helped me get a framework as to whether I was working as a clinician or as a planner

It's not just about looking at and understanding the complexity of the circumstances. It's a call to action, to mobilize an individual to try to change his or her circumstances.

for mental health services, as an administrator and policy maker or as an educator. He forced us to look beneath what appears to be reality—a very systemic way of approaching things that was very enticing. It's not just about looking at and understanding the complexity of the circumstances of our patients and their communities. It's a call to action, to mobilize an individual to try to change his or her circumstances.

Then, Elena Mederos. I'm originally from Cuba, a Cuban refugee, and Elena was a compatriot. This is a woman who was privileged, upper class, who dedicated her life to helping others understand, work with and change the circumstances of those not as privileged. With no professional training in the disciplines of health and mental health, she did some remarkable work in Havana. During the Cuban revolution, Fidel Castro appointed her Minister of Social Services. That lasted about six to nine months during the regime until she questioned the communist ideology. She made it clear that she saw herself as bringing change, but not that kind of change. Then she came to the United States and did a lot of work internationally. She added something that Paulo Freire didn't give me—a feminine perspective on the plight of women and the role of women in society. She helped me understand the circumstances of the women who were my patients or clients or customers.

Of course last but not least is Helen Rodriguez-Trias. Helen brought to my life a passion for work in health, particularly in mental health. Her whole vision was about being an advocate and changing systems, and focusing on health policy and access to care.

I had a long conversation with her while I was in City Hall, in government. We talked about the need to create health and mental health services that respect cultural differences. And of course the problem of insurance for the Latino community is tremendous. How do we make sure Latinos have access to appropriate and culturally competent services? For many years, I focused on mental health and the rights of mentally ill Latino persons, and the need to stop constricting and undermining the health belief systems and cultural idiosyncrasies of Latino patients. Helen said that all of us must fully use our knowledge to modify the established disciplines in mental health that do not take culture into account.

What lessons do you have to share with others?

I have to put this into the context of my life. I am still a Cuban refugee although I am an American citizen. I came to this country as a refugee 41 years ago. I learned about being totally uprooted, losing everything, not only materials or wealth but social relations and systems. It was very traumatic. But I knew that if I was going to develop a coping and adaptation mechanism in a totally new society, one very different from mine in language and customs, then perhaps I could bring some equality to what I saw as the plight of the Latino community in the United States.

One of my biggest disappointments is that I fell for Fidel Castro. I was very much on the same ideological page that he was on originally in terms of social change and bringing about equality for human beings in my country of origin. But I felt betrayed when it turned into a more constricted regime where I thought my own rights and freedoms were being violated on behalf of a larger principle that I didn't adhere to. So I learned very early in life that you can put all your energy into a cause and that cause may turn out to not be what it seemed. During that early part of my life, I didn't know about Paulo Freire. But later on, through his work, I understood that the reality I thought *was*, was not.

I learned very early in life that you can put all your energy into a cause and that cause may turn out to not be what it seemed.

Living in the United States—and I guess I learned this also in my own country—I learned that one has to risk. You have to have the courage to take steps on behalf of bringing change. Those risks sometimes are going to be fruitful and you're going to see changes, and sometimes those risks are going to be really difficult. It's not going to be a win-win situation—you feel bad that you risked and didn't bring about the change. But that's part of coping, adaptation and life.

I learned to value my cultural values, my heritage. That's a lesson I'd like others to understand: once we give up our own cultural heritage, we are really, truly giving up

Once we give up our own cultural heritage, we are really, truly giving up who we are—our self-identity.

who we are—our self-identity. I've been in this country for 41 years, and sometimes someone who hears me for the first time says, "Gee, you have an accent." And some have said it sounds like a French accent. I say, "No, no. This is a Cuban accent." It gives me great pleasure to reinforce it, to say I'm very proud of my cultural origin. I am Cuban, part of the Latino community in New York City, in the state and in

the country. The issue of cultural heritage is important not only for health and mental health professionals to be very clear about and to treasure in themselves, but also to help the people we work with.

Needless to say, there's a process of acculturation and there are certain things that are not practical. I couldn't behave the way I would in my own country because I have to adapt to reality. If I wanted to have an impact on the lives of poor Latinos and bring equality, I had to acquire new ways of thinking. But it wasn't necessary to give up every single aspect of the cultural heritage I had brought.

The other lesson I learned and treasure is that we have to be very clear about our values—what's right, what's wrong, what's ethical, what's not. And to be very, very clear that you can compromise to a point on behalf of bringing change, but there is a line beyond which compromise is totally unacceptable.

I was the health policy advisor to Mayor Giuliani and the chairperson of the New York City Health and Hospitals Corporation (HHC), the largest public hospital system. It was a job I didn't choose. But I was determined to use that position to better understand the systems and reality on behalf of my own community. At times I clashed with expectations of policy changes. As I've said, taking a risk is important, to say, "I don't believe in this. I'm just not going to do it. You can fire me tomorrow if that's what you wish to do." It's very tempting sometimes to trade off values for a position that brings prestige and power, but the bottom line is that if you really want to bring change to our communities, those values can't be compromised.

Another lesson is that to really have an impact or the ability to make changes, one has to have a vision. You have to know what's needed, what the deficits are, and what the health and mental health disparities are; have a very clear vision of what your objectives are; and be very faithful to that vision of what needs to be done. Don't lose sight of that vision and always keep it in focus.

To really have an impact or the ability to make changes, one has to have a vision.

What have your life experiences allowed you to accomplish?

As a clinician, originally I thought I was quite successful in helping patients. Then I really began to question the theoretical basis of what I'd learned. This is when Paulo Freire and others helped me rethink the way I approached and worked with patients. Basically, my clinical practice changed from a focus on helping my clients to a focus on understanding their realities, which were often the realities of poverty, and enabling them to get the tools to change or improve the circumstances of their lives.

I've always been troubled that we professionals assume a position of power. And whether you're a physician, a psychiatric social worker, a psychologist or a nurse, you have the power because you have the knowledge. That type of thinking puts the

I've always been troubled that we professionals assume a position of power. I became more successful in clinical practice when I began to question that assumption.

patient in a “down” position. I became more successful in clinical practice when I began to question that assumption.

I began to say to my patients, “Well, you know, I bring knowledge here but you also have knowledge, so why don’t you tell me what you know and I’ll tell you what I know and we’ll try to figure out whether you have diabetes, or another disease, or are suffering from mental illness. Let’s share knowledge and figure out how you can improve or change your own circumstances.” Were they able to change 100%? No. But my patients were much more energized to take action, any action, from questioning the health system to questioning the school where their children were going.

During the 1980s, I was teaching full-time at Columbia University, School of Social Work, and brought my views on education to the classroom. They had never used the work of Paulo Freire or talked about Helen Rodriguez-Trias or Elena Mederos. I exposed my students to new ways of thinking—for instance, that the way we think in the United States is not the only way of thinking, not the only way of approaching problems and solutions. I don’t know if I was successful in academia. I eventually decided to leave because I felt that I was the token Latina on the faculty and that I had no power to influence the curricula. My only power was in my classroom; whether I had 30 students or 60 students, that was my audience.

But I was very successful as an administrator of community mental-health services. I became an administrator because I felt I wasn’t reaching enough people just working one-on-one with patients, or seeing them in groups or in families. Basically, I could not do prevention in that kind of setting. When I got those patients, they were already suffering from some type of serious disability.

As an administrator developing programs in community mental health, I was able to integrate health and mental health programs into the school systems. I worked with

teachers, parents and principals to help them understand the Latino culture. If a mother brings her teenager to school every morning and picks him up at 3 P.M., it doesn't mean it's a dependent relationship. The teachers need to understand that the mother feels very threatened by the urban environment and wants to protect her child.

I did a lot of work with community organizations and the hospital I worked at to help staff understand the culture. My personal values of taking risks, of valuing my cultural heritage, of having a vision, really helped me move up the career ladder to senior vice-president of mental health.

My personal values of taking risks, of valuing my cultural heritage, of having a vision, really helped me.

I administered a network of three HHC hospitals, all of them highly populated by Latinos (about 80%), and from that position I was able to open the doors of those institutions to the Latino communities. I asked the community, "What do we need to know in these hospitals to make access better for you? What do non-Latino doctors need to know? And how can we teach them?" It was interesting to ask patients to become teachers of Spanish for their physicians. That was a small success in reversing the power equation. In that particular instance, patients were the teachers, and they were "on top." Physicians were learning and they were further down on the ladder.

At City Hall, I was successful in persuading the Mayor not to privatize the public hospital system. I developed access to insurance programs for small businesses, a majority of them minority businesses run by Latinos or Asians. As a chairperson of the board of trustees at HHC, I brought accountability to the public hospital system to make sure there was quality, because one of my big concerns has always been the poor quality of services for Latinos. Just recently a research publication showed what I've suspected for a long time—that even if they have insurance, the quality of care is influenced by their surname or accent or inability to speak English.

I fought very hard with the medical schools we had contracts with at HHC to make sure that quality was a priority. And we penalized the medical school when we saw

failure in quality of care. We didn't hesitate to dismiss staff, at top levels, if we felt they weren't protecting our patients by providing the highest quality of care. Many people said to me, "The medical schools are very powerful in New York City. You're going to have a hard time getting a job after you do this." And I said, "Well, so what? I came to the U. S. with \$5 in my pocket. I'll start all over again."

I decided a year ago to go back to academia but didn't want to be in a classroom. I accepted an administrative position as the university dean for health sciences at the City University of New York. I want to see if I can bring some leveling of the power structure to increase the number of Latinos and African Americans going into the health sciences and the health professions. It's too early, after just one year, to say whether I can call this a success or not. But that's where I am.

What are the most important issues related to health disparities?

The heterogeneity of the Latino community in the United States is so important. Often that's missed. Health disparities cut across all the Latino communities—in terms of access to care, quality of care, type of diseases prevalent and incidences of diseases.

Health disparities cut across all the Latino communities.

There's a tremendous disparity in the number of Latino health professionals. Only 2% of all registered nurses in this country are Latinos. That's totally unacceptable when we constitute such a large percentage of the population. I think we don't even make up 3% of psychologists in this country. I believe my own discipline, social work, was about 5% Latino about five years ago. But in that discipline, the numbers are going down. One or two years ago we were down to 4%. It doesn't matter whether we talk about nurses, physicians, social workers, physical therapists or radiologists, there are just disproportionately few Latinos who are clinicians.

You also don't see enough Latino administrators, in positions of decision making and power. It's mind boggling that in New York City, where there are probably 80 private

hospitals, we have only one Latino in a high position, a Cuban who is president and chief executive officer of a private hospital. If you look at the boards of trustees of these private hospitals, Latinos are nonexistent; however, in the public hospital system there are currently three Latino chief executive officers out of 21 hospitals.

You can go further in terms of the number of Latino policy makers in New York City or in the state. During the Giuliani administration, we had two Latino high-level health care executives—the president of the HHC and myself as the chairperson of the board. We're very lucky now to have Antonia Novello as the State Commissioner of Health, but that's it. Something needs to be done in terms of that disparity. I get very, very troubled about it. Not that I think every Latino needs to be treated by a Latino provider, or that every hospital has to have a Latino executive director—I'm just talking about equity, Latinos having the power to influence the way we deliver health and mental health services in this country.

Also troubling to me in terms of health disparities is the fact that the majority of researchers who are now doing work on racial health disparities are non-Latinos. Not that I think they can't do a good job, but why aren't more Latinos doing research? A tremendous amount of money at the federal level goes to fund research on health disparities, but it is not going into the hands of Latino researchers.

From Paulo Freire, I learned to question and look beneath what seems to be the reality. And what seems to be the reality is that during the Clinton administration, we finally discovered that there are health disparities and the government was going to try to do something about it. But I wonder what's beneath all this research enterprise that will end up showing what many of us have already known. It speaks to the inequalities of distribution and allocation of funding. If we go beneath the surface, we have to ask, Why is it that we have so few Latinos as researchers, directors, policy makers and clinicians?

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We also have to look at public education in this country, and that is a disaster. I work now in the public university in New York City and we have thousands of Latino students who declare as freshmen that they want to go into the health sciences, to be physicians, registered nurses or biomedical researchers. But they can't be accepted into the clinical or science programs because they have so many deficits in reading, writing and mathematics. We have thousands of Latino students in remediation.

We need access and quality in health care, and access and quality in education, to prepare our Latino students.

If we really want to increase the numbers and bring equity in terms of Hispanics working in powerful positions or as clinicians, we need to challenge and address the role of public education in this country. The system is creating a second tier of citizens who will always be marginalized if they don't have access to a quality education. The reality is that education is power, intellectual knowledge is power. We need access and quality in health care, and access and quality in education, to prepare our Latino students.

We talk about educating people about behavioral changes that could lead to prevention of chronic diseases such as cardiovascular disease, diabetes type 2, HIV/AIDS and so forth. But how do we close the gap? We need to think about what behavioral changes are necessary for the patient to improve. For example, let's talk about smoking. The research shows that if you're a foreign-born Latino, there's a very good chance you won't smoke. But Latino teenagers born in the United States have a higher incidence and prevalence of smoking. So why not develop strategies in the process of acculturation that create fewer "risk behaviors" for the Latino population?

Cardiovascular disease is the leading killer for Latinos, as it is with any other group. When we talk about preventing cardiovascular disease and high blood pressure, we're talking about educating people about exercise and diet. But if we're going to try prevention initiatives in Latino communities, we need to understand their values and customs. In some Latin American countries, for example, women don't want to look

like Twiggy—we like to have a little bit more fat. Weight also reflects cultural perspectives and cultural values.

Another area of concern is HIV/AIDS. In New York City, it's the third leading cause of death for Puerto Rican women, and for Latinas from Ecuador, Colombia and other countries, it's seventh. In terms of reducing those disparities, the health policy makers in the city of New York really need to focus on Latino communities to reduce the incidence, prevalence and mortality rates of HIV/AIDS, particularly among Puerto Ricans.

Asthma for the Puerto Rican community in New York City is just off the charts, even in comparison to other Latino communities. You see the highest rate of admissions to hospitals for asthma in El Barrio and the South Bronx and other poor communities that are highly populated by Latinos. This disparity obviously speaks about the issue of poverty and lack of access to health care.

Other issues that must be addressed are child and adult immunization, cancer screening and depression. Latina women have a higher incidence of depression than the rest of the population. About 28% of patients present their depression to a primary care provider in terms of psychosomatic complaints. But the provider misses the diagnosis because of lack of training in identifying the signs of depression or the way it's expressed through the cultural language of Latina women. So a tremendous amount of education needs to be done. Primary care providers need to understand the cultural idiosyncrasies of Latinos and Latinas.

The belief in Western medicine that physical illness and mental illness are separate is not helpful to the Latino community.

In Latin American countries the body, the mind and the soul are one. The belief in Western medicine that physical illness and mental illness are separate is not helpful to the Latino community. We don't see it that way. In the realm of depression and mental illness, we have different explanatory models and treatment. We have the *curanderos* and the *espiritistas* and the *santeros* that treat this population. It is always

amazing to me that Western-trained mental health providers are unaware of these belief systems. Psychiatrists are prescribing Zoloft for depression to women who are throwing the pills in the garbage because they are consulting an *espiritista*. Many people think that those health belief systems are only maintained by Latino patients of very low socioeconomic class. I don't think so. Regardless of education and socioeconomic status, these beliefs are part of the cultural subconscious of patients.

The disparities in mental health services is truly troubling. We have less access, Hispanics tend to receive mental health care of poor quality, and the Surgeon General's Report shows that Hispanics are only marginally represented in the mental

Until mental health practitioners understand cultural dimensions, Latino patients are going to continue to experience disparities in health care.

health research arena. Culture plays a pivotal role in mental health, mental illness and mental health services, and until mental health practitioners understand those cultural dimensions, Latino patients are going to continue to experience disparities in health care.

It's been well documented in the literature that poverty has a measurable effect on rates of mental illness, regardless of ethnicity and race. But if to poverty you add racism and discrimination, the adverse effects on mental health will increase. Latinos have a lot of mistrust of mental health services—an important reason they don't seek treatment. Why would they go to a mental health system that has no respect for Latino culture, that is uncomfortable with Latino values? It's no wonder we have such a high rate of depression among Latina women and such high rates of addictive disorders among Latino men.

Who has mentored you and what do you do to mentor others?

For me, what's important is to assess and find the strengths of the person I'm mentoring, to show her or him the ropes and share my own perspective on practice or policy or administration or education. That leads me to think about the

frameworks of Freire and the impact that Helen and Elena have had in my life. Mentoring is sharing with others. It gives me a wonderful opportunity to nurture, to empower someone else to continue the important work of advocacy for Latinos.

Usually, the mentor is in a position of power and the mentoree is in the “down” position. I try to equalize the relationship, to say, “I have many years of practice, and I’m going to share with you what I know. But you also come to this relationship with knowledge and you’re going to share that with me. Together we’re going to enrich ourselves to improve the lot of the Hispanic community.”

More than anything, you have to be very, very honest as a mentor and say, “Well, I don’t know the answer to that question. Why don’t we research it together? And let’s see if we can come up with answers.” The mentor has to assume the role of a very humble individual because, if I understand Paulo Freire correctly, we have to consistently remove layers—like with an onion, you continue to peel and peel and peel to get to the essence of the problems. I think the role of the mentor is also to enable the person to create her or his own vision. I don’t want to impose my vision on someone else. A mentor should give you enough tools to help you create your own vision or quest.

A mentor should give you enough tools to help you create your own vision or quest.

I’ve had students who don’t call for quite a while, but then they’re dealing with something and want to get together and do some thinking. It’s an ongoing process—you have to make yourself available to support their quest. It’s a true commitment to empower and prepare somebody else to help the Hispanic community.

What is your passion, your vision, your hope for the future?

My passion has always been to reduce inequalities, whether they are economic or health inequalities. I’m always fascinated when new jargon is introduced in the public discourse to express something we already know about in plain terms. Here we are talking about health “disparities.” For me, there have always been health inequalities—

I've seen it in hospitals and I've seen it in city halls and I've seen it in the governor's office, despite the fact that this country's foundation rests on principles of equity and fairness.

The issue for me, in terms of hope for the future, is that we don't allow this focus on research into health disparities to become one more volume on the shelves of academics, clinicians and policy makers. Unless a strategic plan of action is created to change the health status among Latinos, the research volumes will just gather dust. The challenge for all of us is to push, to fight for equity and fairness in health care.

Don't just give us money for research. We already know some of the behavioral determinants of heart disease, so give us the money to help the Latino community with education, access to quality health care, and prevention strategies.

If we don't get to that second stage, the state of action that Paulo Freire talks about, then my hope would be diminished. We need to be advocates, to mobilize ourselves, to be politically active. Go to a senator or an assemblyman or a mayor as a group and

say, "Hey, you know, this cannot continue to go on."

If we don't get to that second stage, the state of action that Paulo Freire talks about, then my hope would be diminished.

Helen was a wonderful model of that, with all her knowledge and her expertise. She never doubted. She never hesitated to take on the system or to become politically active if it was necessary.

So take that second step—act to empower the Hispanic community to deal with our health disparities. We have a responsibility not just to research and document the disparities, but to do something more—to take action to secure funding and commitment by policy makers at the national, state and local levels to fix these problems.

Servant to the People

HENRY MONTES



HENRY MONTES, MPH, was born and raised in California. He works at the Health Resources and Services Administration within the U.S. Department of Health and Human Services (DHHS). Recently he served as senior advisor to the American Public Health Association (APHA) on public health workforce development. He previously served as director of the Division of Public Health and Allied Health in the Bureau of Health Professions, and, among various federal positions, was associate director for external programs with the DHHS Office of Minority Health, where he developed a national minority health resource center and oversaw the development and funding of a community coalition demonstration grant program.

As program officer for the Poverty and Health and Health Promotions Programs of the Henry J. Kaiser Family Foundation, he was responsible for grantmaking related to minority health and community health promotion interventions. In 1993, he served with the Presidential Health Care Reform Task Force dealing with special issues of urban and rural populations.

He has also served as chair of the Multiethnic Health Promotion Steering Committee for the California State Department of Health Services; as an executive board member of APHA; as an advisor to the American Red Cross, the March of Dimes, the American Cancer Society and other organizations; and as chair of the Hispanic Advisory Committee for the District of Columbia Commission of Public Health.



Who has inspired your work?

My father and mother were the first to inspire me, from two different points of view. My father was a common sense kind of guy. He had a certain justice about him in terms of how he valued and evaluated situations and people. My mother, on the other hand, was more of a risk taker. She would get involved in a number of things in which the outcome wasn't clear, but she felt they were important enough to take the risk. As parents they introduced me to my religion, which has been a strong influence in my life.

At one point I went to the seminary for four and a half years to become a Catholic priest. My undergraduate degree is in philosophy. Experience at the seminary brought me closer to Jesus Christ as part of my spiritual ascendancy toward understanding the greater reality around us. This spiritual sense is an important part of the experiences I've had in working with others.

Cesar Chavez has been a hero to me in that he overcame a number of very difficult obstacles to achieve not only recognition but actual change in the lives of migrant farm workers.

Then I was introduced to Cesar Chavez through my brother-in-law, Ruben Diaz, who was a union organizer for the AFL-CIO in California. Ruben was helping Chavez put together his United Farm Workers organization back in the early sixties. I went to Delano, California, with Ruben where we took part in the march. It was an impressive display of people coming together for empowerment of their rights. Over the years, Cesar Chavez has been a hero to me in that he overcame a number of very difficult obstacles to achieve not only recognition but actual change in the lives of migrant farm workers.

When I went to Washington, I was working in public health in the mid-seventies. There was a very small contingent of Latinos and we were called "Spanish speaking" so you know how long ago that was. One of them, a woman I came to know and admire and respect, was Henrietta Villaescusa who, coincidentally, happened to be the

public health nurse at my high school in Los Angeles. She was working with the federal maternal and child health programs and I found her tenacity an important part of her success in working with the Hispanic population. One has to be very persevering, yet always professional, which she was. She was a leader who did not need to blow a whistle to show she was in front of the group. People recognized her leadership in a number of ways; the National Association of Hispanic Nurses, an organization she helped to form, named one of their highest awards after her.

Another influential person was Mickey Moure, who was second-in-charge of the Public Health Service in the mid-seventies. He had come out of the FDA with Dr. Charles Edwards, the Assistant Secretary of Health, and was appointed as executive officer of the Public Health Service. Mickey was part Cuban and part Spanish. He would not necessarily blow the trumpet for the Latino agenda, but he was supportive of trying to enhance it. In those days, the Latino health agenda was not necessarily high on anybody's priority list.

Mickey had the ability to work with a large and diverse portfolio of operations, activities and people, and manage the whole so that he achieved what he saw as important for the Public Health Service. He could put together different kinds of issues so there was some kind of logic to them and they could be addressed as solutions rather than problems. I learned a lot in three years working with him.

Looking at health promotion and disease prevention, two people who were particularly inspirational and whom I admire are Michael McGinnis and Larry Green. I worked with Michael in the late seventies while we were developing the first Surgeon General's Report on Health Promotion and Disease Prevention, *Healthy People*, and on the 1990 Objectives for the Nation. Larry came to the Office of Disease Prevention and Health Promotion in the early eighties and took over the part dealing with health information, health education, and physical fitness and sports medicine. He really set the agenda for technical as well as policy directions for that particular office, very

much in concert with what Michael had in mind when preparing the Surgeon General's Report.

Michael was inspiring in that he was able, over many years in different administrations, to keep prevention on the front burner. He was able to maintain a strong focus of attention and buy-in from the assistant secretaries of health, who were Republicans under Reagan, even though he was appointed during the Carter administration. He basically created a strong public agenda for health promotion and disease prevention. He's much to be admired for his far-sightedness.

Larry was inspirational in how he looked at the theory of health education and health promotion and applied it to programs, and he was a really good person to work with. He was willing to be a teacher and a bureaucrat at the same time. We traded experiences. I tried to help him understand the bureaucracy and he definitely helped me with health promotion and health education, in terms of going after new knowledge and not being satisfied with what we already know.

What lessons do you have to share with others?

I'll start by saying that public service is a very important thing to do but it means commitment to the public good and not to a personal agenda. That's one of the most important things to recognize for a person entering public service. You are literally a

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servant of the people, and it's important to put personal wants and needs behind those of the public. If they're synonymous, well, so much the better.

Then, I would say, you must be persevering in pushing an advocacy agenda. Within the public policy arena, there isn't a lot of advocacy. There are more people wanting to gain power and wanting to satisfy their egos. True advocacy exists as well, but you really need to be persevering to keep it in the forefront.

Be sure you know what you are doing and admit what you don't know. That's important to your credibility as an advocate or a policy maker. You have to know what you're talking about. A lot of people say good things but don't really understand what it is they're saying. When we talk about community, for instance, we must understand people and organizations and relationships, and so on, not just a geographical area.

I would also say stay true to your principles. That assumes you have principles and that you know what they are. It's very important to know where you are, where you stand and how you stay true to yourself. I

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don't mean that you should be a stubborn person, but rather one who has a sense of values and direction and knows how to apply them to a given situation. And include in that idea knowing how you can compromise for the bigger and better common good. It takes good judgment to do that and still stay true to your principles.

Get the ego out of the way of achieving the common good. It's very easy to be upset when your idea isn't accepted by the group you're working with, but it's important to know your own limitations and to recognize the strengths of others.

To maintain control over your own destiny requires a solid understanding of yourself, your limitations, your strengths, and so on. Where do you come from? What's important in the bigger picture of life? What is your responsibility to yourself and others? There are a lot of people who want to determine your destiny—people you work with, for example—or who for one reason or another want control over what's going on in your life. You really need to have a good sense of self in terms of what you're trying to accomplish.

One of the things I do in the morning is to think about what I have to do that day. If I'm going to be in meetings, what will they be like? And if I'm writing something, what points do I need to make? If I'm going to be meeting with a group, I visualize standing in front of them and making the necessary points. When I have presentations at

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conferences, I visualize the event, what people are expecting and what I expect to do, and I try to see how these expectations could coincide so that people want to hear what I have to say.

Thinking about things as scenarios before acting is a good method of preparation, of being respectful of people's time and energies, and of making them want to listen to what you have to say.

Who has mentored you and what do you do to mentor others?

A lot of people have mentored me in various aspects of my life.

When I first came into the federal government, I'd just come out of the Army and applied for a federal job. I was selected to be an intern with the Civil Service Commission in Los Angeles. I was pretty naive about what was going on with regard to Latinos and public policy issues. There was a woman working there, Kathy O'Brien, who was very interested in the Latino agenda. She wasn't Latina, but she was very concerned about the populations. So she was really a mentor to me with regard to the issue of Latinos in the civil service and the public arena—not all the details, but the fact that these were things one had to pay attention to.

Also, Dr. Kathleen Roe was advisor to the MPH program when I was going to San Jose State University in the early nineties. She and I had worked together with Michael McGinnis when she was an intern, and now the tables were turned. I learned a lot from her in the academic arena.

What have your life experiences allowed you to accomplish?

Connecting the right people to the right situations is one of the accomplishments I feel good about. Sometimes it works out that a person in Situation A fits as a resource

in Situation B and folks get to know one another and get into positions that are very good for them. I've been somewhat of a catalyst in that regard.

I have confidence that people will produce when provided appropriate opportunities. Working directly in an organization or indirectly through professional and friendly relationships, I've had the opportunity to gain people's confidence, which helps me be more effective in what I do, as well as helping others realize certain opportunities with regard to their own work and lives. I feel that's an accomplishment. And I've been honored by a variety of awards, which I've always considered a shared opportunity with the folks who were giving the award.

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Being recognized for innovative thinking and problem solving, being asked to engage in a variety of things, and being recognized for the input that I've been able to provide—I consider that credibility with peers to be an accomplishment.

Doing what I believed was the right thing to do has gotten me in trouble sometimes. But I've always felt it's more important to be true to yourself and maintain control over your own destiny, as I mentioned earlier. In retrospect, I've often seen that it was the right thing.

Is there an example of a time you took a risk and got in trouble but in the end were persuaded it was the right thing to do?

I needed to develop a resource center for the Office of Minority Health. At the time it was verboten to talk about clearinghouses and resource centers, and so on. This was the mid-eighties, the Reagan years, and they didn't want a lot of information flowing around, particularly with minority health issues. So taking on that challenge was a little risky in the sense that I could be seen as a troublemaker. I personally went to all these different review levels. I would go and visit with each person at each level and

make my case, eventually getting it done. On a scale of 1 to 10, this was probably about a 2 or 3 as far as risk was concerned.

But there was one situation that was pretty much a 10. I was brought to an agency by a particular Latino supervisor who wanted me to work with him. Then that supervisor fell out of favor with the powers that be and they were going to get rid of him. So I tried to garner support for him, which in the bureaucracy is a risky thing to do. You have to be careful that you're not getting into a conflict of interest—a situation of lobbying or trying to unduly influence.

I was trying to be supportive and at the same time not cross over those particular boundaries. Then an anonymous letter went to the authorities in charge, saying what a terrible thing I and several colleagues were doing, and that it was against federal rules. But, after several months, the investigation found that there was nothing to the allegations. I knew it was going to be somewhat risky to support someone whom the top bureaucrats were against. But I did it anyway, out of a sense of loyalty and a feeling that it was the right thing to do.

What are the most important issues related to health disparities?

Overall, it's improving the public image of Latinos as major contributors to our society. We're getting there but it's slow. It's taken a long time getting to a public understanding of Latinos as valuable populations in the United States, and I relate that directly to

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health disparities. It's what happens when a group is marginalized—it's not important to put their health agenda at the top of the priority list. That's one of the reasons I talk about the public image.

Being uninsured and underinsured, and issues of health access are tremendous problems for Latinos. So are diabetes and asthma from a disease point of view. And we need Latinos in public health making decisions on policy.

Very few work in top-level decision-making positions. When I was running for president-elect of the APHA, I looked out over the governing council as I was addressing them, and there were very few Latinos. There are still very few in key public health positions. I think this is a major issue. Without Latinos in those positions, it's hard to vocalize and make real the impact these disparities have on the Latino populations. We Latinos in public health know about them because we have done epidemiology studies or some other research, and we know our populations, but we really don't have a voice in making change.

It's really important to have support for the family, also, so its members have a chance to stay together. That may be an across-the-board issue in the United States, but it's particularly important for Latinos, who are very family focused. Having health or social policies that split families apart or don't treat the whole family as an integral group is really counterproductive for Latinos.

What advice do you have for practitioners?

One of the fundamental things for practitioners is to know Spanish if they are administering to Latino populations. You don't have to be fluent. But know some of the key phrases, some of the key greetings. Just provide a certain comfort level at the initial meeting with the Latino-Hispanic patient. I think that goes a long way in encouraging a relationship between the provider and the patient/client. And see yourself as a servant to the people you are ministering to. You're not their boss, you're not necessarily smarter than they are. You're there to help them improve their health, and they *want* to improve their health. A good book on the APHA publication list is *An Introduction to Spanish for Health Care Workers*.

Practitioners [should] know Spanish if they are administering to Latino populations.

We also need to address the entire person, not the person as a disease. This isn't "the cancer patient." This is Ms. Ortega. It's also a question of being smart with regard to what diseases require of people and knowing what a patient is going through—being

able to help the individual understand the natural consequences of the disease as well as the treatment regimen.

Then, don't rush. Time is more than money. It is a show of respect. Rushing people through is really disrespectful. You have to take your time with them. Or figure out ways to spend time that doesn't seem to be a rush but is efficient for you as a clinical practitioner.

Finally, deal with people's expectations and not your own. Listen to them. In fact, you should solicit what their expectations are so that you're better able to serve the individuals you're working with.

What is your passion, your vision, your hope for the future?

My real passion is for justice and mercy in the world. I think we human beings need to strive for that in every decision and action that we undertake. If we do that, these other issues will take on a solution focus rather than a problem focus. I would really like to see the human experience as one that is very thoughtful about justice and mercy in relationships.

I believe we have to have a vision of what a peace-filled life is like in order to achieve it.

I believe we have to have a vision of what a peace-filled life is like in order to achieve it. I don't think there's enough attention paid to that as an end point as we look at improving people's health or try to get a more equitable distribution of people involved in health issues. This vision is important because it speaks to people relating to one another as well as to the world around them.

There's a certain hypocrisy in wanting to do good for others without giving them any of the power to do good for themselves. Some of those who have much don't want to share with others, or don't want others to have any. By that I mean things such as power, wealth, quality of life. This is particularly poignant when various groups have control over the resources that can improve people's lives. Often there's not a

willingness to be open, to have that power shared, especially when it's going to benefit the populations that don't have the power. I think these are important things to expose—why we have health disparities, and why we have the societal imbalances so many people experience.

We need to progress toward understanding that the things we think are merit based really aren't. The fact that you are a human being living in this society gives you the right to education and the right to health care. And, also very important, is that people have a right to peace in society. There are a lot of other rights but I think these are fundamental.

My hope for the future is that there will be an equitable distribution of power among all the nation's diverse peoples. Then we really would have a democracy. We would have a balance of healthy people and healthy communities, and a balance of educated people and educated communities. We would have a lot less discord among people and fewer disenfranchised groups. Equitable distribution of power is essential.

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Anything else?

Eliminating health disparities can be done. It's not something that just sounds good—it's something we can achieve. People need to understand, though, that it's going to take every person—those who have the power and wealth and resources, along with those folks who might not have as much and those who have nothing. I think it is possible to eliminate health disparities and improve the health of *all* Americans.

Toward a Collective Understanding

JOSÉ SZAPOCZNIK



JOSÉ SZAPOCZNIK, PhD, is professor of psychiatry and behavioral sciences, psychology and counseling psychology at the University of Miami. He is also director of the Center for Family Studies, the nation's major systematic program of minority family therapy research, and the Spanish Family Guidance Center at the University of Miami School of Medicine.

Born in Havana, Cuba, Dr. Szapocznik has received national and international recognition for his groundbreaking contributions in the development and implementation of family interventions. Internationally, his work led to the designation of the Spanish Family Guidance Center as a World Health Organization Collaborating Center.

He has contributed to over 150 professional publications, including the book *BREAKTHROUGHS IN FAMILY THERAPY WITH DRUG-ABUSING AND PROBLEM YOUTH*. A frequent guest lecturer and plenary speaker on topics such as Hispanic or minority families, families and HIV, family therapy and family-based prevention, and mental-health and drug-abuse policy, he has also served on the National Institute on Mental Health National Advisory Council. Currently he is a member of the National Institute on Drug Abuse National Advisory Council and chair of the National Hispanic Science Network on Drug Abuse.



Who has inspired your work?

In the beginning of my professional life, psychologist Mercedes Scopetta hired me for my first job when I was a graduate student. I am essentially at this same job, practically 30 years later. Scopetta is a very spiritual woman who viewed the Hispanic community very much through the lens of families. The major theme of all my professional work is families. So if I think about who has had the greatest impact on my entire professional experience, development and career, it has been Mercedes Scopetta, the way she viewed the world and in particular the Hispanic world. I also inherited her belief that the family is never to blame for not doing well in therapy. The therapist should always ask, “What can I do differently to help this family change?”

Can you explain the views of Mercedes Scopetta more fully?

The term *familialism* describes the notion of the family as central in Hispanic culture. It refers to our thinking about our families as a point of reference for our beliefs, our behaviors and our views.

Mercedes Scopetta introduced me to the work of Urie Bronfenbrenner, which had a great impact on me. If we think of the world around a child, we think of the social networks nested around that child. The most intimate of these networks is the family. When members of a network are interdependent, we call that a system. It’s a systemic relationship when a change in any one individual has an impact on all the other individuals in the system.

Urie Bronfenbrenner takes that principle beyond the family to include all the other social systems that surround the child and the family, so that we are attentive to the relationship between the family and the child’s friends, school and neighborhood. In my own work, I am interested in the pivotal role that parents play in providing leadership in the child’s worlds—in the family, in schools and with friends.

I am interested in the pivotal role that parents play in providing leadership in the child’s worlds—in the family, in schools and with friends.

For example, many Hispanic immigrant families don't have a good sense of how to function when they come to this country because in their country they usually lived in small neighborhoods. Everybody knew everybody else, and they had all known each other for several generations. Your child's teacher was the daughter of your cousin. The teacher went to the same places as the parents, to the same grocery store, to the same church or to the same doctor. The parents had grown up together and collaborated in parenting each other's children, so that if a child went three blocks down the street and did something good or wrong, the whole neighborhood would let the parents know. There was a tremendous amount of connection, which led to collaboration around parenting.

A very important part of the work that needs to be done with these families [is to] help them develop skills they didn't need where they grew up.

When one of those families moves to Miami, they've lost that entire "tribe" of connections. They come here and they don't have an understanding of the nature of their isolation, of the basic functions required of parents for their child to grow up well adjusted in this society—for example, the role that parents can play in school to help their child, whether it's advocacy or collaboration with a teacher. They don't understand that if their child leaves their home and walks three blocks down, no one is going to know the child and no one is going to help with parenting. They don't quite understand that now they need to be active in knowing who the kid is with and who the families of the kid's friends are. This is a very important part of the work that needs to be done with these families. We not only help them understand, but help them develop skills they didn't need where they grew up.

What lessons do you have to share with others?

Collectivism is inherent in Hispanic people. In mainstream culture, it's often viewed pejoratively as dependence. But, truly, the interdependence that occurs in collectivism can be a very functional social state with important strengths. Hispanic people know this intuitively but not everybody is able to articulate it.

This collectivism has been important for me professionally. I began my work in the Hispanic communities surrounded by Hispanic professionals and, in that way, my experience is somewhat unusual. In Miami, very early on, Hispanics gathered together to create Hispanic institutions. We worked with Hispanic families, among Hispanic professionals, and we developed interventions for the Hispanic community.

We didn't ask how our interventions were similar to or different from Anglo interventions. While some think about how their interventions compare to the mainstream, we asked only, "What will help *our* families?" Most often, minority interventions are viewed as culturally sensitive but of little scientific value. So I am committed to working from a Hispanic perspective that is scientifically sound. I think about what fits the Hispanic population and how we build interventions for Hispanic populations in a scientific way. This means creating a theory, developing interventions from the theory, testing the interventions, and taking the results of the research to heart by using them to improve the theory and the interventions. The objective is to help Hispanics, using sound scientific principles, while making a contribution to all of science that emerges entirely from a Hispanic perspective.

The objective is to help Hispanics while making a contribution to all of science that emerges entirely from a Hispanic perspective.

I went to graduate school and studied psychology at a time when minority issues were not thought about in the way we think about them today. The entire faculty in my school came from a non-minority cultural perspective—as was the case in my clinical internship. I always felt there was something wrong with me, both in graduate school and in my internship, because I was someone who's relationship oriented rather than "me" oriented.

When I came to work in a Hispanic setting, I discovered that I was like everybody else around me. That was a very significant discovery—that I fit better in some contexts than in others. That who I am, without having to change myself, is much more congruent with some cultures. I didn't change, it was the cultural context that changed,

and the way I fit in an Anglo context was dramatically different than in a Hispanic context.

I have always had difficulty with theories that were very individualistic. I fit much better with theories and clinical work that are more collectivist. I sometimes say that my place of work is like a family. But what I really mean to say is that it's collectivist. Collaboration is in the foreground and competition is in the background.

What have your life experiences allowed you to accomplish?

What I'm most proud of is creating a center and a staff with a very, very strong cultural and family orientation. A lot of my work has been in conducting randomized clinical trials of family interventions with minority populations. Our Brief Strategic Family Therapy for troubled adolescents has become widely recognized and recommended by many important national groups. I'm proud of that. But I'm also proud of how I'm using that to launch and promote the careers of others.

Within and outside of that, I think I have made an impact in advancing a family perspective that is of great support to the Hispanic community, in making available an empirically validated, research-proven, science-based family intervention developed for Hispanics. It's been used with other groups as well, but it is definitely very consistent with the Hispanic culture.

What are the most important issues related to health disparities?

My work has been mostly in mental health and drug abuse. However, with regard to health disparities, I have a developing interest in a broad range of areas. One area in which I'm beginning to develop a program of research is the *built environment*. In family therapy, we work with families that have a child or adolescent with drug abuse, delinquency, conduct problems, risky sexual behavior, violence or other behavior problems. At some point I felt I needed to make a bigger impact than can be done one family at a time. I became interested in prevention, in understanding risk and

protection from a cultural perspective. From a broad social, ecological perspective, what are the social systems that influence families and children? Large social systems usually have their greatest negative impact on the poor, because the poor have the least amount of influence on these things.

A very important factor for Hispanics, especially recent immigrants, is social connection in their neighborhoods. About six or seven years ago, I met Elizabeth Plater-Zyberk, dean of the School of Architecture at our university. She has had a big impact on my recent work. She and her husband, Andres Duany, are founders and leaders of the New Urbanism Movement. They believe there is a way of building neighborhoods that promotes social connection.

For example, there should be places to walk in a neighborhood. In the small towns of yesterday, you could walk to the grocery store or to your friend's house. Your kid could walk to school. We've built our modern environments in such a way that you have to drive most of the time. We are socially engineered by the way we build our physical environments. Walking generates social connections. By building neighborhoods for cars and not for walking, we're engineering poor social connectiveness at the local level.

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That's something that interests me a great deal because we know from the work of Felton Earls that social connectiveness at the local level has great implications for many social and health indicators. You can have two communities that have the same ethnicity, race, education and income levels, and one community is going to have poor health and lots of crime and drugs, and the other will have good health and very little crime and drugs. One of the big differences in those two neighborhoods is the amount of informal social connection within the neighborhood. So, building the physical environment in a way that encourages or discourages social connection may have broad implications for health and social factors.

Social connectiveness supports collective parenting, which makes the job easier and is likely to result in better adjusted children. Traditional Hispanic towns in Latin America are high in connection and collectivism. The environment has direct implications for other health behaviors as well. If we drive, we walk less. If we have a long commute, we're likely to have very little time for our families and very little time for physical activity. In Hispanic communities, as well as Native-American and African-American communities, lack of physical activity contributes to obesity, which exacerbates health problems such as diabetes. I'm really interested in the built environment because I think it has implications for a very broad range of health and social problems that afflict poor minority communities.

We need to have greater impact, in a less costly and more efficient way. Having an impact on the built environment can be done by zoning neighborhoods in a way that enhances social connection, allows people to live and work in the same neighborhood, and allows children to walk to school. Zoning is very inexpensive compared to labor-intensive social and behavior interventions. It really doesn't cost anything because the marketplace does the job—it just takes political will.

We need to have greater impact, in a less costly and more efficient way.

What recommendations do you have for clinical practitioners?

My recommendation is that we make the family our public health focus rather than the individual. Take a family in which the father is an alcoholic, the mother is depressed, and the adolescent is engaging in delinquent behavior, drug use, risky sexual behavior and violent activities. The way we design our public health system right now, the father gets treated one way, the mother gets treated another way and the kid gets treated yet a different way. There is no understanding of the interdependence among these three people. It's equivalent to a physician treating a liver as if the liver didn't reside within the human body. It wouldn't make sense. You have to treat the medical condition with the knowledge that it resides within the system of the

human body, with all that occurs in the human body. It has physical, emotional and spiritual components.

I think that's one of the major revolutions in the teaching of medicine in recent years—the movement away from treating the organ toward treating the whole person. But, in social services, we are still at the level of treating the individual. We don't recognize that if a father is an alcoholic, a mother is depressed and their adolescent is delinquent, the three need to be treated as a single, interactive whole. In public health, there is still this individual view of the world, as if individuals live in a vacuum. Thinking in terms of systems—this is the next step in public health.

Thinking in terms of systems—this is the next step in public health.

Most of us have gone to schools that built behavior and social theories on the notion of the individual. Surely in my field of psychology, in mental health and psychiatry, we do a lot of that. We as practitioners need to think more about the immediate social context and the influence of the family. Some professionals, such as social workers, are trained to think of the social context, the family systems. But the places where they work don't always allow them to focus on the family because reimbursement systems are often symptom and individual oriented.

Practitioners should advocate within their organizations for a family orientation. Mental health systems, for example, are likely to treat the child's conduct disorder in one program, the father's alcoholism in a substance abuse program and the mother's depression in an affective disorders program. But why treat them separately if they are members of the same family system? One practitioner could treat the whole family, rather than three practitioners treating three individuals as if they were not connected to each other. Practitioners must understand and treat the family behaviors that are maintaining these individual symptoms in order to help families help themselves.

Who has mentored you and what do you do to mentor others?

There are at least two different ways of mentoring. The most common way is a one-to-one relationship in which the mentor passes on technical knowledge as well as wisdom about the profession and about life within the context of a trusting relationship. Another way is to create an environment in which individuals learn from each other. At the Center for Family Studies, I've worked to create such an environment. I've set it up in such a way that, rather than learning just from me, faculty develop different areas of expertise and then learn from each other. There's a lot of one-to-one mentoring work, but there is also a lot of learning that occurs laterally. After all, I'm a systems person. I believe in the family as a model for a collectivist organization. So I'm creating a network of interdependent individuals in which the whole is more than the sum of the parts because its members can contribute to each other.

What is your passion, your vision, your hope for the future?

When the social environment is hostile to families, the most vulnerable communities—poor, minority communities—are affected the most.

If I had a magic wand and could do anything, I would want to see a multilevel effort to support families. Families are particularly important in minority communities. Actually, most minority groups have some kind of small “family” network that is important within that group, whether it's a kinship network or extended network, a tribe or a nuclear family. When the social environment is hostile to families, the most vulnerable communities—poor, minority communities—are affected the most.

In a multilevel movement, we would build physical environments that support families; we would teach health professionals to work with families rather than with individuals; and we would teach teachers to be the teachers of families. When the child goes home having learned something new, that something new needs to be supported

by the parents and not be in conflict with them. So the teacher must help all the family members in the development of any one of the family members.

I would like to see national efforts to support collectivism, with families at the center of the effort. There are examples of successful collectivist movements in this county. As we've come to understand the role of the physical environment in our lives, we've made major changes at many levels in society, government and business to collaborate in protecting the environment. Society litters less, the government created the Environmental Protection Agency, and certain businesses make money out of good environmental policies such as recycling, building fuel-efficient, low-pollution cars, and integrating water conservation into new homes and equipment. Our awareness of environmental impact has caused major changes at multiple levels.

A similar multilevel movement is needed and will eventually happen around the protection of our natural social networks, particularly families. But we will have to develop scientific evidence to propel such a national movement. Changes in the physical environment were mobilized initially through scientific evidence.

At this stage, when we address health disparities the major attention is on the symptoms—it's diabetes, it's drug abuse, it's violence. But really the epidemic is about the processes that cause the symptoms. Symptoms are merely the surface of an underlying process. So I want to move the discussion on health disparities beyond the level of talking about symptoms. What are the processes that bring about health disparities in minority communities?

Symptoms are merely the surface of an underlying process.

One important process is the lack of social connectivity. We have engineered a breakdown of connectivity by the way we build our neighborhoods—for cars, not for people. If we do what it takes to rebuild walking neighborhoods, obesity will decrease, which will have an impact on several health problems. Also, social connectivity will increase, which will reduce social problems, including drug use, delinquency, risky sexual behavior and unwanted pregnancies, poor prenatal health care and others.

An Academic Activist

FERNANDO M. TREVIÑO



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He was one of the founders of the national Medicine and Public Health Initiative and served as its cochair for two years. As a social science analyst at the National Center for Health Statistics, he was the principal consultant on the design, implementation and analysis of the Hispanic Health and Nutrition Examination Survey. He has served on numerous national committees and panels, including the National Committee on Vital and Health Statistics and was the founding chair of that committee's Subcommittee on Minority Health Statistics. He has published and lectured extensively on national statistical data policy, and Mexican American and minority health issues. In honor of his service, the APHA established the annual Fernando M. Treviño Award for Excellence.



Who has inspired your work?

I was fortunate enough to have two parents who sacrificed their whole lives to try to give us what they could. My mother, in particular, had one mission in life—that all of her children go to college. Being the oldest, I received a fair share of maternal pressure. There was just no doubt that I was going to get a degree. She really didn't expect me to get graduate degrees, that wasn't something she was aware of or familiar with. But I really got excited by the academic world. I realized that the kinds of things I wanted to do professionally required I go to graduate school. So the inspiration at that point became my own. It became internalized. My initial inspiration was my mother pushing me toward college, and, after that, there were other people who really inspired the kind of research I ended up doing and the career path I took.

The person who inspired me initially to go into research was Bob Roberts. When I was seeking my master's of public health degree at the University of Texas, I'd made it through my course work and learned a fair amount, I thought, regarding the health needs of the general population. I'd read quite a bit about the health needs of the white, non-Hispanic population, and about the health needs of the African-American population. But I hadn't really learned anything about the health needs of the population I was hoping to go back and serve—the Mexican-American population.

So toward the end of my degree program, I had an opportunity to take an elective and started seeking a faculty member who would take me on for an independent study to look at the health status of the Hispanic or Mexican-American population. I ran into professors who said they didn't know anything about the subject or really weren't very interested in it. Finally someone steered me to a young assistant professor, Bob Roberts, a sociologist who became a social epidemiologist. I told him I was interested in spending a semester studying the health needs of the Hispanic population. He said, "Great. Go to the library. Come back in two weeks and report to me what you've found." Two weeks later I returned to his office rather chagrined and he said, "What's the matter?" I said, "Well, I think I did something wrong. All I found were four articles

and they weren't even very good articles." He smiled and said, "I could have told you that two weeks ago, but I wanted you to experience it for yourself. That's the extent of our knowledge on the health needs of the Hispanic population in the United States."

I was dumbfounded. In this country we had the fifth-largest Hispanic population in the entire world, and we didn't know anything about what their health needs were. We, therefore, didn't have any systematic way to go about trying to meet those health needs. So that really turned me on to research. I'd wanted to be a hospital administrator initially, but I realized there was such a dearth of knowledge that we had to systematically study this population, as we have other groups, so that our policy makers and leaders could direct dollars in the right direction to have an impact on their health needs. Bob Roberts taught me a very valuable lesson.

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We decided to spend the semester looking at a large body of data on the mental health of Mexican Americans. We had many mental health studies because, in the 1950s, E. Gartly Jaco, a sociologist in Texas, had conducted a statewide epidemiologic study. He looked at all the people who had sought psychiatric care at either a public or a private facility, and learned that Hispanics were severely underrepresented in the state's psychiatric population. He wrote some articles stating that the reason Mexican Americans were underrepresented was they had better mental health status than whites or blacks. That started a furor of controversy.

Some people thought he was right and sought to do research to identify the protective elements of the culture. Others thought he was wrong, and that the reason Mexican Americans didn't show up was that they were using *curanderos* (folk healers) or Catholic priests; they were going to other sources of care. And then there was a third group who said that the reason they aren't showing up is that we've got barriers in our health care system. That group made the most sense to me.

So I ended up doing my master's thesis on what happens when you reduce the hypothesized barriers. When you have bilingual therapists, when you use paraprofessionals who are indigenous to the lower-income population, when you reduce the financial barrier, would you then achieve the expected utilization of services? And that's basically what I found. If you reduce the barriers to care, people will come, because, in fact, we are not more mentally healthy. We may even be at greater risk, since most low-income populations with low levels of education usually are under greater stress than the general population.

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That's how I initially got into mental health research. My master's thesis and my doctoral dissertation looked at mental health in Mexican Americans. In the course of my literature review, I came across a fantastic book that really made sense. It was written by someone who understood the culture, someone who was something I had never seen before—a Mexican-American faculty member, Amado Padilla. Padilla, at that time a psychology professor at UCLA, was really the guru of Mexican-American mental health. He did some primary studies. He later headed up a major mental-health research center at UCLA. So, even though I had not met him, he was in many ways my idol and my model. Coincidentally, many years later, we both competed for the funding for that mental health center and I ended up becoming the director. It's something I never would have expected—to be in competition with him. He was inspiring because he showed me that a Mexican American could get a PhD and do research.

Another person who inspired my work was my mentor during my doctoral program, John Bruhn. He's now retired in Arizona, but he went on to have numerous posts, including vice president for academic affairs at the University of Texas at El Paso and provost at Penn State, Harrisburg. When he headed up the doctoral program at the University of Texas Medical Branch, Galveston, and I was working for him, he approached me and said, "Have you ever considered going for a doctorate?" I truly had

not. I really didn't think I was smart enough to get a PhD. He encouraged me to apply. He became my mentor and taught me how to write grants and articles.

What lessons do you have to share with others?

Especially to the student who may be the first person in the family to go to college, as many of us were, the first lesson is perseverance. Once, when I was a master's student working in the library on some project late at night, I was tired and thinking maybe I really wasn't capable of doing all the work. I remember the librarian asked how it was going and I said I was really frustrated. She said, "You've got to remember

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that the whole trick to graduating is perseverance. It has nothing to do with brilliance, it's perseverance. Many bright people just quit." And, I thought, that's very true. If you persevere, you will eventually accomplish your task. You may not be the first one to finish or graduate, but you can do it. So I think it's important to never give up.

The second thing is to push yourself to try something even if you think it's not something you can achieve. Most of the time, you will surprise yourself and find you are perfectly capable of achieving whatever it is you take on, as long as you take it on in a serious fashion. It's also important that you give back once you achieve something, however you choose to do that, whether it's by mentoring or teaching the next generation or giving back directly to the community.

I've always thought of myself as an academic activist. In graduate school, they teach you that if you get too intimately involved you lose your objectivity, that you're not really a scientist unless you remain detached. I've seen too many of my colleagues do that. They study something, they write about it, and once the article appears in a journal, they leave it alone. I think that if you study something, and you really care enough about it, you don't just publish it. Based on your findings, you should see how you can influence legislation or policy or direct services.

In the course of my career, I've had an opportunity to do that. Early on, I was fascinated by the whole concept of utilization behavior—why people use or don't use services. I started looking at health insurance coverage among different groups, particularly the Hispanic populations, and found that Mexican Americans had the lowest utilization of any group in the country. In terms of going to the doctor, to hospitals, to the dentist, you name it, whichever provider you want to look at, we go the least of anybody and we're also the most likely to be uninsured. So I've had the opportunity to try to influence lawmakers to redesign the way we provide public health-insurance programs in this country.

Another lesson is to take advantage of the opportunities that come your way. It's amazing what you can do if you just take advantage of the opportunities that present themselves.

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What have your life experiences allowed you to accomplish?

I like the model of being an academic activist. There are things I've been able to accomplish as a result of that blend of science and the effort to shape policy. For example, in the 1980s, I wrote an article for the *American Journal of Public Health* that reiterated that even though the United States has the fifth-largest Hispanic population in the world, we didn't even have crude mortality rates—the most basic health indicator—for this population. We didn't know how many Hispanics were dying in this country each year, let alone how many had heart disease, cancer or nutritional deficiencies. I became quite concerned about that. Years later when I was appointed by the Secretary of Health and Human Services to the National Committee on Vital and Health Statistics, which is the national advisory group to the Department of Health and Human Services on statistical issues and policy issues, I

argued for the creation of a subcommittee on minority health statistics and became the first chair of that committee.

My first order of business as chair was to have hearings on whether or not we should add a Hispanic identifier to the nation's birth and death records. A blue-ribbon panel appointed by the National Committee on Vital and Health Statistics had recommended against including a Hispanic identifier (a little box that indicates if you are of Hispanic origin and, if so, which group). The National Center for Health Statistics issues the standard certificates of birth and death every ten years, then states are free to adopt or not adopt the standard certificate. But there was a good chance the states would not adopt that particular parameter if it weren't on the standard certificate. So we held hearings and I got the Committee to recommend to the secretary that we add the Hispanic identifier. Now we can do mortality studies with Hispanics.

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Years later I was in Washington, D.C., at George Washington University Hospital, getting ready to discharge my wife and newborn daughter. It was really satisfying to fill out the birth certificate saying the father is of Hispanic origin, the mother is of Hispanic origin, so here is a Hispanic child, born in Washington, D.C. We were able to capture the fact that there was a Hispanic birth at that particular hospital, even though that's an unlikely place for a Mexican American to be born. That is one example of how you can influence what happens. I'm proud of the fact that I helped to change the situation so we would have the data we need.

Here's another thing I'm very proud of: as soon as I finished my PhD, I was selected by the National Center for Health Statistics to work with them to design the nation's first large-scale study to assess the health status of the Hispanic population in the

United States. For four years I worked as their chief consultant on the design and implementation of the Hispanic Health and Nutrition Examination Survey, which is, to date, the most successful study they've ever conducted. We interviewed and examined over 12,000 Mexican Americans, Puerto Ricans and Cuban Americans between the ages of 6 months and 74 years. We collected valuable data that allowed us, for the first time ever, to compare the health status of those populations to the other populations for whom we had data.

When I became executive director of the American Public Health Association (APHA), I pushed to hold meetings between the APHA and the American Medical Association (AMA). I'd worked with both organizations, and they are very different. I kept pushing even though I encountered a lot of resistance. In the course of 121 years of coexistence, those two groups had never sat down at the table to talk to each other about the health issues of this country. In 1994, we held the first meeting and out of that grew the National Medicine and Public Health Initiative, which I cochaired with Roy Schwarz, senior vice president of the AMA at that time. Eventually we brought together 65 major health leaders and national organizations to talk about how we get medicine and public health to interact and collaborate more closely with one another.

This initiative was based on my own life experiences. I'd trained at a school of public health with two medical schools directly across the street, and they never had anything to do with each other. Years later, when I went to teach at the University of Texas Medical Branch at Galveston, I realized what a different mindset and perception of the whole system the medical community had relative to the public health community. I thought, "We can no longer continue this estrangement." In every society, we need both the medical system—to care for us if we're injured or get sick—and a public health system—to keep us healthy for as long as possible. In an ideal world, those two systems work together and cooperate with each other because, all too often, you've got to trade

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people back and forth between the two systems. I'm very proud of the fact that we finally got the medical and public health communities talking together. The first national congress on medicine and public health got 400 of the top leaders in the country to address this issue.

I was fortunate enough to be named executive director of the APHA, only the seventh person in its history to serve in that capacity. It was a pleasure especially because when I came on as executive director Helen Rodriguez-Trias was the president of the association. I remember at the opening session of the annual meeting in San Francisco she and I were up on the platform and I whispered to her, "Helen, who would have ever guessed that the American Public Health Association would have a Hispanic woman president and a Hispanic male executive director? And here it is, happening at the same time." That, to me, was a great opportunity—to lead the American Public Health Association during the critical years of the Clinton health care reform movement.

I later got to experience leadership at the world level when I was elected president of the World Federation of Public Health Associations, which is based in Geneva. It gave me the opportunity to work with about 68 national public-health associations and deal with some very tough issues that existed throughout the world.

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What are the most important issues related to health disparities?

The number one issue we face is low education levels. Numerous studies worldwide show that if you want to have an impact on a population's health status, the best way is to put money into educational systems. When you get educated, all kinds of things happen. You know how to take care of yourself better. You get a better, safer job. You eat better because you have a better income. You have safer housing. Education provides benefits which correlate very highly with health status.

Regrettably, the one thing that's all too common among all the Hispanic groups is that we're challenged to make sure our young people pursue education and prepare themselves for a competitive role in this society. We're down at the bottom in terms of our educational levels. This is the number one thing we need to address for the Hispanic population.

With lack of education almost always comes poverty. Also, Mexican Americans and other Hispanic groups frequently work in occupations that place them at higher risk for injury or exposure to dangerous substances, such as pesticides. Occupational risk is another area that we've got to address in terms of Hispanics. And access to care, which I mentioned earlier. We've really got to do something about the fact that our people can't see a doctor as often as they need to. Because the Hispanic population has lower educational levels and higher rates of poverty, all too often we're operating in survival mode rather than upgrading to the self-actualization level. If we can begin to address educational needs, we can begin to move our people away from the survival mentality.

Occupational risk is another area that we've got to address in terms of Hispanics.

Are there other issues that come to mind?

There are certain diseases that we have to attack, such as diabetes, that are more prevalent in Hispanics. Not only do Hispanics have lower access to health care but we also have lower access to preventive health services. I believe, in general, we have not benefitted from health education efforts as much as other populations. We need to target more health education programs toward the bilingual or monolingual communities, especially if they're not getting care from other places. Here in Fort Worth our school of public health started organizing a Hispanic wellness fair. A lot of times you hear that Hispanics aren't sufficiently interested in their health, but we've not found that to be the case here.

Every year about 400 volunteers from all the hospitals, area agencies and schools come together on a Saturday to provide free services. This past year, we had 6,000 Hispanics show up for these free services. The doors weren't going to open until 10 A.M. but people started lining up at 8 in the morning. I heard people say, "I'm going to go down and get a mammogram. I'm going to take the kids to get vaccinated." They are desperately hungry for some of these services. I hope that health education professionals can begin to target the Hispanic population to a greater degree.

What advice do you have for clinical practitioners?

At one time my mother was a teller at a bank, and a lesson she taught me was, "Be nice, especially to the poor people." She said that the rich people walked into the bank and everyone fell all over themselves trying to be nice, but it was the poor person with the \$10 deposit who really needed the kind words. I thought that was a very important message.

It's very, very important that you treat people with respect and dignity.

It's hard being a clinician, especially these days. With managed care and everything else going on, you're under great pressure and a lot of times you've got to get people in and out in 10 minutes. But, it's very, very important—especially when working with Hispanics—that you treat people with respect and dignity.

Clinicians have to educate without being intimidating or condescending. It's important to say, "As you well know..." then go ahead and tell them exactly what you think they need to know, because they probably don't know it, but you don't want to put them in a situation where they have to admit that. If you educate them and treat them with dignity and respect, you will have somebody very loyal, who will keep coming back to you and comply with whatever it is you are prescribing.

Who has mentored you and what do you do to mentor others?

I'll mention John Bruhn again. I learned a lot from the way he operated. When I mentor my students or people I work with, I provide them with challenges. I give them some work to do and allow them to make mistakes. That's something John was great at. He probably knew you were headed toward a mistake but he didn't stop you; he let you make the mistake and was very kind about it. He simply said, "Well, you know what you learned from that. Now how do we go forward?"

It's important to let people make mistakes, and to reinforce them and give them some confidence. I try to provide opportunities. Now that I'm at a more senior level, I get to create opportunities. I give people tasks and let them do it the way they think is appropriate. A lot of times I've found they do it in ways that never would have occurred to me. I just guide them and am there to support them when they need it.

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What is your passion, your vision, your hope for the future?

My number one hope is to see the educational level of the Hispanic population rise. It's a critical issue for the whole nation. I'd love to see more Hispanics prepare themselves for leadership positions. We have too few Hispanics in leadership roles in the health sector, and we are definitely in need of people who are familiar with the needs of the population. I would love to see policy makers begin to truly address the needs that exist and the realities of the Hispanic population. Hispanics are hard workers. They are very dedicated, creative and loyal. We need to prepare them to meet challenges and give them an opportunity to contribute to the betterment of our society.

Besides leaders, we need more Hispanic health professionals. In the 1970s, we had one Anglo physician for every 538 Anglos, one African-American physician for every 4,100 African Americans, one Native-American physician for every 13,800 Native Americans, and one Mexican-American physician for every 25,000 Mexican

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Americans. The situation has gotten better for all groups, and we now have Hispanic physicians, nurses and dentists, but we don't have enough. It would be great to see larger numbers of Hispanics in public health, medicine and all the other health fields for two reasons. First, they are likely to go back and serve the Hispanic population, and can sometimes do it better because of their innate knowledge of that culture. Second, they serve as role models and inspiration to other Hispanics to secure the same level of training. When you see someone else do it, you start to believe that maybe you can achieve as well.

You and Helen worked together at APHA. Any thoughts about her that you would like to share?

She was an incredibly gracious lady, the epitome of diplomacy, the ultimate elder statesperson. She had been through so many difficult situations to achieve what she did as a Puerto Rican woman, yet she was not at all bitter. She was the most positive, supportive, warm individual one could hope for. She never lost her cool. She was always able to resolve a difficult situation and make everybody feel good about the solution.

She was near the end of her presidency at APHA when I came on board, but I did work with her the subsequent year when she remained on the board as the immediate past president and then a couple of years later when the Women's Health Congress meeting was held in China. I asked Helen to represent the APHA at the meeting in Beijing and to talk about the public health needs of American women. She was the first person, the only person, I considered asking to chair the delegation, and of course she did that beautifully, as she did everything else that she took on. She was very supportive of those who were younger and very patient with our mistakes. She was a great inspiration to many of us.

Recommendations

THE ELIMINATION OF HEALTH DISPARITIES will require a concerted effort by individuals and institutions in the public health community and beyond. Reliable data about the health status of specific populations is essential to this endeavor. There are excellent data sets being developed by the Federal Government, state and regional entities, and various health care organizations. Some of that data is included in the introduction to this publication. Using this data and other information, different recommendations have been developed to guide the effort to eliminate disparities.*

One thing becoming evident is that data alone will not be enough to accomplish the task. To effectively reach populations affected by disparities, providers need to have a personal understanding of the communities and people within those populations—who they are, what matters to them and how they can be supported in building a stronger foundation for health. To achieve meaningful change in American health care, data about disparities must be linked to experience and wisdom about people, and power must be shared. This bringing together of science and wisdom, data and heart, has been one of our primary goals in offering these interviews.

The leaders who have shared their ideas, experiences and inspiration with us here have articulated a set of recommendations critical to success in eliminating health disparities among Latinos.

*See, for example, *Revised CLAS Standards from the Office of Minority Health*, outlining 14 recommendations for culturally and linguistically appropriate services, at www.omhrc.gov/CLAS; and *Healthy People 2010*, 2d ed., U.S. Department of Health and Human Services, Washington DC.

General Recommendations

- ✘ Keep yourself in the work. Objectivity is not always the appropriate course. Your dreams, values, principles and vision empower you as an advocate and a provider.
- ✘ Develop programs and policies that support the integrity of families, recognize their assets and help them stay together.
- ✘ Give people the means and power to carry out advocacy and change on their own behalf. Effective programs can only endure with genuine community involvement.
- ✘ Improve education for Latinos at primary and secondary levels to increase opportunity, decrease poverty and improve health outcomes.
- ✘ Develop comprehensive interventions that address the root causes of poor health and health disparities, including poverty, racism and lack of opportunity.
- ✘ Encourage Latinos to enter the health field in many different arenas—health education, research, policy, administration and provision of care.
- ✘ Give students and young professionals in the health field opportunities to work directly with Latino communities during their training.
- ✘ Create programs that establish better access to health care, including preventive care, and that address the high number of uninsured and underinsured Latinos.
- ✘ Establish initiatives that address specific conditions and diseases prevalent among Latinos, including diabetes, health disease, sexually transmitted disease (STD) and HIV, substance abuse and mental health problems.
- ✘ Promote programs and policies that support immigrants and help them learn to function within the basic structure of American society.
- ✘ Challenge established norms in your discipline that do not take culture into account, and question the assumptions of power that go along with being a health professional.

- ✘ Take steps to ensure that programs, policies and institutions recognize and respect the heterogeneity of Latinos.
- ✘ Recognize cultural qualities common in Latino communities, such as collectivism, respect and loyalty.
- ✘ Understand and accept responsibility for mentoring others, especially Latino youth, health students and young professionals.

Isabel M. Martinez

- ✘ Offer opportunities for Latino students who enter the health field to prepare themselves for leadership positions, work on formal research projects and build trust with the people they will serve through work in communities.

Helen Rodriguez-Trias

- ✘ Listen carefully to others and hear their points of view. You can get people moving around a collaborative answer if they feel it's their answer as well.
- ✘ Build a sense of the interrelatedness of physical and social environments and quality of life, to help people see that our collective and personal health is at stake.
- ✘ Take steps to help society become less selfish and less violent, in our homes as well as in every other place we set foot.

America Bracho

- ✘ Remember that there is power in small steps. People can move from supporting a friend, to supporting a community, to advocating for a cause, to building a stake in democracy.
- ✘ Include community members as community workers among the staff of your organization.

- ✘ Evaluate community programs. Be accountable about time, money and your vision to demonstrate credibility and help sustain your program.

Rosa Maria Gil

- ✘ Understand and value your own cultural heritage as an essential part of your self-identify.
- ✘ Compromise in the effort to bring about change, but be very clear about your personal values and identify the line beyond which compromise is unacceptable.
- ✘ Don't continue to fund research studies that reiterate things we already know. Instead, fund programs to bring about structural change in education, poverty or health practices in the Latino community.

Henry Montes

- ✘ To do public service, you must put personal ego concerns aside and focus on the public's common good.
- ✘ Emphasize Latinos' role as major contributors to our society and a valuable population in the United States.
- ✘ Strive for justice and mercy in every decision and action you undertake. Develop a vision of a peace-filled life, both for yourself and the people you serve.

José Szapocznik

- ✘ Make the family, rather than the individual, the focus in public health.
- ✘ Develop interventions derived from Latino cultural experience that are scientifically sound.
- ✘ Encourage a multilevel movement to strengthen social connectivity.

Fernando M. Treviño

- ✘ Remember the power of perseverance. It allows people to get things done.
- ✘ Practice “academic activism” by bringing science to the effort to shape policy.
- ✘ Address occupational health as an important area of risk for Latinos, especially poor and undereducated workers.

Resources

Information and Support

- ✧ The National Alliance for Hispanic Health
www.hispanichealth.org
- ✧ Hispanic Dental Association
www.hdassoc.org
- ✧ National Association of Hispanic Nurses
www.thehispanicnurses.org
- ✧ National Hispanic-Serving Health Professions Schools
www.hshps.com
- ✧ National Hispanic Council on Aging
www.nhcoa.org
- ✧ Congressional Hispanic Caucus Institute, Inc.
www.chci.org

Talking About Health

- ✧ Purnell, L. D., and B. J. Paulanka. 1998. *Transcultural health care: A culturally competent approach*. Philadelphia: F. A. Davis Company.
- ✧ Diversity Rx
www.diversityrx.org
- ✧ Resources for Cross Cultural Health Care
www.diversityrx.org/html/wercch.htm

Ideas

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Health Issues and Demographics

- ✘ Centers for Disease Control and Prevention
www.cdc.gov
- ✘ U.S. Census Bureau
www.census.gov
- ✘ National Center for Health Statistics
www.cdc.gov/nchs
- ✘ Office of Minority Health
www.omhrc.gov
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- ✘ U.S. Department of Health and Human Services. 2001. *Mental health: Culture, race and ethnicity—a supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

Eliminating Health Disparities

Conversations with Latinos

is one of a series of *Public Health Profiles* published by ETR ASSOCIATES, a private, nonprofit agency committed to providing health education/promotion resources for underserved populations. Each book in the series focuses on a cultural group that has traditionally experienced health disparities, profiling leaders working to promote health and prevent disease. The content includes background information on existing disparities and recommendations to improve practice and outcomes in the future.

ELIMINATING HEALTH DISPARITIES is for:

- ✕ Health care providers and prevention specialists
- ✕ Health educators
- ✕ Teachers and students in health promotion
- ✕ Community health workers
- ✕ Public health policy makers
- ✕ Funders