



Jeanette Ramage. *Apples & Leaves*. Oil on canvas with collage, 39" × 39".  
Courtesy of Longstreth-Goldberg ART, Naples, Florida.

*The development of effective and relevant cancer control programs for Latinas in the southern United States requires recognition of their unique social, cultural, and economic issues.*

# Implications for Breast and Cervical Cancer Control for Latinas in the Rural South: A Review of the Literature

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*The Latino population has more than tripled in six southern US states. Little research exists describing the Latino population in the rural South and the unique cancer control needs of this group. This article reviews existing literature on Latinas with a focus on rural southern settlement processes and applicable breast and cervical cancer control research.*

*Recommendations for effective cancer control programs include developing special outreach efforts conducted with monolingual Latinas, incorporating important cultural components and values related to family, spirituality, and community, and designing programs that incorporate low-literacy materials and messages or that do not require literacy to participate. Understanding the social, cultural, and economic issues that Latinas face is an important first step in designing culturally relevant breast and cervical cancer control.*

## Background

There are currently 35.3 million Hispanics/ Latinos in the United States, comprising 12.5% of the total US population. This figure does not take into

account the 3 to 6 million undocumented workers and the 3.8 million persons in the island of Puerto Rico. Between 1990 and 2000, the total US population grew by 13.2%, while the Latino population grew by 57.9%. It is projected that Latinos will

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*Submitted April 1, 2003; accepted July 14, 2003.*

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*The term "Hispanic" is the most common census group reference for individuals generally grouped as a "race" to include people of Spanish, Mexican, Central American, South American,*

*Cuban, or Puerto Rican descent. The term "Latino" is considered by some social scientists as more ethnically/culturally based for people from Mexico, Central America, and South America (ie, Latin America). The term Mexican American or Chicano indicating citizenship and/or US birthplace applies only to a small proportion of the current immigrants to the rural South. The authors also recognize that some immigrants from these areas are of indigenous backgrounds. For uniformity in describing this group of new immigrants to the United States, the authors use the terms "Latino" to indicate a male, "Latinos" for males and females, and "Latina(s)" for female(s).*

comprise 25% of the total population by 2050.<sup>1,2</sup> Most researchers are now aware of the exploding Latino population in the United States, and there is abundant data on the healthcare needs and cancer control challenges related to Latinos in border areas of the Southwest and large metropolitan areas such as Los Angeles, New York, and Houston.<sup>3-9</sup> With notable exceptions, however,<sup>10-14</sup> little published research exists describing the recent immigration of Latinos in the rural South and the unique health needs this may create. There is also no published research specific to cancer control efforts addressing this new Southern immigrant population.

This article reviews existing literature on the rural Southern settlement processes of Latinos and applicable cancer control research related to breast and cervical cancer. This review is intended to present background literature to assist investigators pursuing research in health care and cancer control as it relates to this unique group of immigrants who are making the South their home. An important first step in designing culturally relevant breast and cervical cancer control research and interventions for Latinas is an understanding of the social, cultural, and economic components that impact their healthcare access and health-seeking behaviors.

## Population Growth: Why the South?

Drawn from Central and South America, the Caribbean and Mexico, the Latino population has more than tripled in 6 Southern states. The current census report<sup>15</sup> indicates 66.9% of Latinos in the United States are of Mexican origin, 14.3% from Central and South American, and the remaining 18.8% are of Puerto Rican, Cuban, or other Hispanic origin. Estimates are that 66% to 70% of Latinos are of Mexican origin in the more recent immigration areas of the South. In Alabama, Arkansas, Georgia, Tennessee, North Carolina, and South Carolina alone, the population has increased by 211% (1990-2000). There are indications that some of this growth is "second-stage" immigration from Mexican Americans moving from California and Texas to improve their lifestyles and work in the growing industry of this area.<sup>13</sup> Erwin<sup>16</sup> reports that over a third of the Latino population sampled in four communities in Arkansas is coming directly from their country of origin, and this is their first experience living within the United States. Moreover, census data indicate that 59% of the Arkansas Latino immigrants are settling into small, rural towns and communities to work at the local poultry plants. Hernandez-Leon and Zuniga<sup>12</sup> present a case study

of an emerging Mexican immigrant community in a small city of the US historic South and suggest that a new array of post-IRCA (Immigration Reform and Control Act of 1996) destinations are arising as a consequence of the secondary migrations of amnestied Mexicans. Permanent settlement is a feature of both of these new destinations as family reunification is taking place in such nontraditional receiving areas.<sup>12,16</sup>

Most of the information about the rise of atypical locations of Mexican labor and settlement has come from journalistic reports, which have noticed the growing presence of persons of Mexican origin in states like Maine, Utah, Tennessee, Iowa, North Carolina, Nebraska, Georgia, and Alabama and in cities like New York, Atlanta, and Nashville.<sup>12</sup> For instance, some studies have suggested that Mexicans are being driven out of California due to the anti-immigrant environment, which has blamed newcomers for unemployment, overcrowding of schools, and other social ills and has fostered passage of Proposition 187 (a 1994 California initiative cutting off some health and social services to illegal aliens and their children).<sup>17</sup> In nonmetropolitan regions, the restructuring and expansion of meat-packing, poultry, and carpet production have fostered cases of rural industrialization in the Midwest and Southeast, drawing large numbers of newcomers to these regions.<sup>14</sup>

In researching Latino settlement into Alabama, Villatoro<sup>11</sup> documented that "... a community of Latinos is now finding a home in the Deep South." Villatoro disputes the assumption that the United States is inheriting the "poorest of the poor," suggesting that many of the immigrants from Latin America who decide to make this journey are "fairly well educated and sophisticated." Whether second-stage or first-experience living in the United States, these rural, small-town environments and infrastructures may be considerably different for these Latinos than the experiences of the migrating seasonal farm worker, the border town communities, or major metropolitan city settlement patterns.<sup>18-21</sup> As Villatoro points out, "they give up the ethnic connection of populations like those in Los Angeles or Dallas, where "Latino-ness" is intrinsic. Yet they also escape the street riots and organized gangs that have developed in the overpopulated barrios. The small population of immigrants here lives relatively *tranquilo* (peaceful/quietly/tranquil)." In addition, many of the preliminary discussions with Latinos in Arkansas indicate that the small rural community environment is comfortable and appropriate for raising a family and, for many, more closely resembles their home communities in rural Mexico.<sup>16</sup>

## Hay Mucho Trabajo (There Is Much Work)

According to a model of analysis by Lamphere,<sup>22</sup> “economic niches” (specific regional economies) with their specific needs determine the experiences of immigrant workers. Poverty and labor shortages coupled with major growth in the consumption of chicken products influenced by the increase of major fast-food chains has created an environment conducive for poultry growers and manufacturing in nonmetropolitan areas.<sup>14</sup> The lack of labor in these areas means that there is much work (*hay mucho trabajo*) for anyone willing to begin work at \$8.20 per hour. In addition, while Latino immigrant workers have long been an American fixture in metropolitan areas and in the migrant farm stream, circumstances with Latino poultry workers may vary. Workers are bringing their families with them and, more and more, the families are staying.<sup>23</sup> In fact, poultry plants often recruit new workers through ties of family and friendship. According to personnel managers, 85.7% of plants in Georgia and 100% of those in North Carolina recruit new workers through friendship and kinship ties of current workers, recruiting up to 80% to 85% of workers in this way.<sup>14</sup> The carpet industry has also needed more workers, and Mexicans are drawn by the \$10-plus hourly wages and the rural South’s reputation for *tranquilidad* (tranquility). Dalton, Georgia (“Carpet City”), is one such Southern destination for Latinos.<sup>12</sup> The carpet textile industry brought immigration to this area in the mid to late 1990s. Now these rural cities are becoming sites of family reunification.<sup>23,24</sup> Because of size, the social, economic, and educational impact of immigration flows can be greater in these smaller locations than in large metropolitan areas.

With reference to sociocultural factors of the workplace, the rural South has been described as “a racialized division of labor that is a legacy of the Antebellum plantation system,” meaning employers exploit racial/ethnic differences.<sup>10</sup> Nearly half of the poultry processing workers in the United States are located in four low-wage and anti-union states: Alabama, Arkansas, Georgia, and North Carolina. This industry has been described as “large mechanized factories that ... routinely incur high occupational rates of repetitive motion damage, back injury, and debilitating lacerations.”<sup>10</sup> This model of work and housing is identical to that found in the farm labor market in the seasonal labor regions of Georgia and North Carolina.<sup>14</sup>

Latino immigrant workers have in effect become a new category of labor “sharecroppers” among the Southern poor. The social and working conditions of this new source of cheap labor are characterized by an increase in the number of families with dependent

children, intensive and sometimes hazardous work conditions, the exploitation of ethnicity and possible lack of citizenship, and marginal housing opportunities. These conditions often combine to have a significant and often negative impact on immigrant health care.

## Health Care and Health-Seeking Behaviors

Sociocultural factors, compounded by lack of access to care and lack of health insurance, may make Latinos less likely to receive preventive and screening services. As noted by Brown et al,<sup>25</sup> although many factors affect health status, the lack of health insurance and other barriers to obtaining health services effectively diminish racial and ethnic minorities’ utilization of preventive services and medical treatments that could reduce their burdens of disease and contribute to improved health status.

A multitude of sociocultural variables may influence health-seeking behaviors. Solis et al<sup>26</sup> report two general hypotheses to account for Latinos’ underutilization of preventive health services: the first hypothesis attributes lower use of preventive health services to lack of access to care, and the second hypothesis argues that level of acculturation (integration or accommodation in a new culture) of Latinos influences their utilization patterns.

## Access to Care

Access can be defined in terms of factors that influence the ease with which medical care can be obtained. For Latinos, such factors include the availability of health insurance, access to a routine place of care and a regular provider, type of healthcare facility, and its proximity to residence.<sup>26</sup> According to *Healthy People 2010*, no more than 66% of those individuals who meet the poverty criteria had insurance, while only 60% of the Mexican Americans had health insurance.<sup>27</sup> This does not include the number of Latinos who live in the United States without immigration papers. Several studies funded by the Robert Wood Johnson Foundation report that Latinos are less likely to be insured than other groups and that they have poorer access to health services.<sup>25</sup>

Latinos in urban areas are more likely to rely on public health facilities, hospital outpatient clinics, and emergency rooms. Working poor are especially vulnerable to access barriers and are often not eligible for assistance through governmental programs.<sup>26,28</sup> Insurance and service availability varies widely depending on work status, immigration status, time in

the United States, and age. In a study by Chavez and colleagues,<sup>28</sup> 7 out of 10 Mexican interviewees in Dallas were covered by private medical insurance despite their undocumented immigration status. This compares favorably with that of the general US population. (These respondents were interviewed prior to the enactment of the Immigration Reform and Control Act in 1986, which controlled unauthorized immigration to the United States.) Latino immigrants from Mexico have been in the United States the longest of the four subgroups included in this study. Due to the shared border between Mexico and the United States, Mexican immigrants have had easier access to the United States than their Central and South American counterparts and thus have had a longer period to settle and acquire jobs that provide insurance. Only 41.4% of their more recently arrived counterparts in Dallas, the Central Americans, were covered by private insurance. Of course, these data do not indicate the level of inadequate medical insurance, which includes high deductibles, limited coverage, and difficult notification procedures.<sup>28</sup> It is unclear from this study how insurance was obtained; immigrants may have either paid for some less expensive private insurance on their own or subscribed under the “papers” that allow them to work. Following this pattern, the new immigrant population from Latin America living in Southern states might be expected to have a significantly lower percentage of insured individuals. A recent needs assessment conducted in South Carolina found that Latinos had an average age of 30 years with an average residency in the United States of 3 years; 93% were of Mexican origin, 75% were employed but had limited English proficiency, and 87% of the population was uninsured.<sup>29</sup>

Mueller and colleagues<sup>30</sup> found that insurance status is the most significant determinant of healthcare utilization and that an uninsured person is twice as likely as an insured person to forgo medical care. Minorities were less likely than whites to use physician services, and the use was even lower for rural residents. The most striking differences were found among rural Latinos. When ethnicity and insurance status were combined, rural uninsured Latinos were the least likely to receive health care (70% less likely).

## Language, Culture, and Access to Care

While lack of health insurance is extremely significant, it is not the only reason for limited access to care. Place of residence and cultural differences between residents and healthcare providers also create access problems. Nearly 27 million Latinos in the United States speak Spanish, and 12.4 million report

that they speak English less than “very well.”<sup>2</sup> A survey released in December 2001 conducted by the Robert Wood Johnson Foundation found that 19% of Latino patients did not seek medical treatment because of language barriers. These language barriers lead to difficulties in understanding symptoms, in asking questions, and in trusting their physician’s ability to comprehend their medical needs. In the same survey, 94% of healthcare providers stated that communication is a top priority in delivering quality care, and they agreed that language barriers were a major challenge.<sup>31</sup>

Also complicating the conceptual framework is the issue of how language influences healthcare use, particularly preventive services such as cancer screening. Although there is no published research regarding screening utilization in the rural South, studies of new Latino immigrants in metropolitan areas may predict potential issues for other newly arrived groups. Woloshin et al<sup>32</sup> discuss language as a communication barrier between the healthcare provider and the patient, while others emphasize the effect on screening practices of language as an access factor.<sup>26</sup> Viewing language acquisition as merely an “access factor” may be an oversimplification. Language influences perceptions, cognitive structure, and self-expression, which may affect how Latinas interact with providers.<sup>33</sup> Thus, it is likely that language as well as literacy operates on many levels in combination with more intrinsic cultural factors that contribute to the likelihood that a woman will obtain recommended screening.

As an example of language’s complex role, O’Malley and colleagues<sup>33</sup> found that among Latinas in New York City, the subset of women who chose to be interviewed in Spanish and were the least acculturated, having someone in the clinic who spoke Spanish was not predictive of screening use. One implication of this finding is that simply introducing interpreters or Spanish speakers into the clinic, without addressing patients’ level of acculturation, may not be sufficient to change behavior. It might be necessary, for example, to involve trained lay health workers from cultural backgrounds similar to those of the target population.<sup>34</sup>

## Family Issues Related to Health

The factors that draw Latina immigrants to the United States and encourage them to stay once they have immigrated revolve around preexisting familial ties to those already in the United States and the social networks the Latinas develop once they are in the United States. Women make crucial contributions to the family in the key roles of subsidy, subsistence, and healthcare providers.<sup>35</sup> Although securing access to

health care for their family members is important to Latinas, this is not the primary motivation for their immigration to the United States. In a telephone survey of Latinas and Anglo women in California, Chavez et al<sup>17</sup> determined that access to and utilization of medical services was not a reason women migrated or intended to remain in the United States. Despite their immigration status, undocumented Latina immigrants often viewed themselves as part of a community in the United States and that having family and community ties there significantly influenced their intentions to stay.

Farr and Wilson-Figueroa<sup>36</sup> conducted focus groups with a group of Mexican women in a rural Oregon community. These women had access to a local family clinic, which was designed for them. When asked about illnesses that were frequently experienced, the women reported diabetes, high blood pressure, tuberculosis, and chronic colds and coughs to be ongoing problems, but they were hesitant to talk about sexually transmitted diseases. This could have a major impact on efforts to increase use of Papanicolaou testing and decrease cervical cancer incidence in this population.

Chavira-Prado<sup>35</sup> reports that in most cases, women are in charge of all matters pertaining to their families' health. In their health roles within the home, women recommend, administer, monitor, and modify medications and home care prescribed by health care professionals. They accompany or refer family members to consultations with doctors, dentists, and other healthcare facilities and providers, and they have up-to-date knowledge of healthcare resources.<sup>35</sup> If a family member became ill, it was common to wait to see if the illness would resolve on its own or with home remedies or over-the-counter medications. If the illness did not go away, then they would visit the clinic or hospital. Women agreed that friends or extended family members were helpful during times of illness. Women stated that their husbands typically helped very little and that they were normally responsible for obtaining health care and care of the children.<sup>36</sup> The women in these studies contributed to their families' survival by functioning as brokers between the family and service institutions. Their domestic responsibilities facilitated the broker function. For instance, childcare responsibilities provide them opportunities to interact with institutions and key personnel and to learn about available services and eligibility criteria. As women enroll their children in school or daycare, they are referred to healthcare facilities for vaccinations and they learn about lunch programs for school children. As women broker encounters between their children and families and the practitioners of traditional Western medicine, their interactions with healthcare providers are

shaped by cultural differences in perspectives on health, the nature of "hot" and "cold" bodily states, the contrast between traditional folk remedies and modern medicine, and the role of emotion and religion in the manifestation and treatment of disease. As Latino immigrants arrive from a variety of ethnic subcultures with a mixture of religious and folk beliefs concerning health and illness, it is important to be aware of the potential barriers posed by these beliefs to the practice of traditional Western medicine among Latino immigrants.<sup>37-40</sup>

## Breast and Cervical Cancer

As there is no research on cancer control issues specific to rural Latinas in the South, a brief review of comparable research on other Latina populations in the United States are summarized as possible predictors of behavior in the new immigrant population. Breast cancer is the most commonly diagnosed cancer among Latina women in the United States.<sup>41</sup> Although the incidence rates of breast cancer are somewhat lower for Latinas than Anglo women, Latinas have traditionally been more likely to have larger tumors or metastatic disease or both at the time of diagnosis.<sup>42,43</sup> Moreover, although mammography use among Latinas in the southwestern United States is increasing,<sup>44</sup> Latina screening rates are still significantly lower than those of white non-Hispanic women.<sup>45</sup> One study<sup>46</sup> based on the 1990 National Health Interview Survey showed that Hispanic women living in the South had the highest likelihood of not intending to have a mammogram in the next 1 to 3 years. Therefore, Latinas are still less likely to receive appropriate breast cancer screening.

The Centers for Disease Control and Prevention (CDC) recently reported data on new cases of cervical cancer among Hispanic and non-Hispanic women diagnosed during 1992-1999 in 11 geographic areas covered by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program.<sup>47</sup> Analyses indicate that despite an overall decrease in the rate of new cases of invasive cervical cancer among women who are at least 30 years old, rates for Hispanic women are approximately twice as high as those for non-Hispanic women. They suggest that Hispanic women in the United States may underutilize screening services for cervical cancer. Despite the evidence that invasive cervical cancer is highly preventable through regular screening, Hispanic women and women 50 years of age or older represent population groups disproportionately affected by this disease. The report also suggests that culturally sensitive outreach should be directed to these groups of women to encourage screening and that health inter-

ventions and appropriate diagnostic and treatment services should be available for women with an abnormal screening result.<sup>47</sup>

Similarly, there are recent complementary reports from the CDC regarding lowered screening rates for breast and cervical cancer in Latinas. Latinas, particularly those who live in counties along the US-Mexico border, are less likely than non-Hispanic women to undergo routine screenings such as mammography or Papanicolaou testing for breast and cervical cancers.<sup>48</sup> This study used data from the Behavioral Risk Factor Surveillance System surveys conducted in 1999 and 2000 to examine screening rates for breast and cervical cancers among this population. Hispanic women were less likely to have had a recent mammogram or Papanicolaou test compared with non-Hispanic women in border counties, compared with Hispanic and non-Hispanic women in nonborder counties in Texas, New Mexico, Arizona, and California combined, and compared with other women in the United States. Although these data are based on border communities in the Southwest and metropolitan areas, many of the barriers affecting recent immigrant women in these areas may apply to Latinas in rural Southern communities as well, where the barriers may be even greater due to the meager number of Spanish-speaking health professionals in the rural South. Likewise, these higher rates of cervical cancer and lower screening rates may be predictive of expected rates in new immigrant Latinas in the South.

## Perspectives on Cancer

The research literature contains numerous articles on Latino attitudes and perspectives toward health and illness.<sup>49-59</sup> The literature suggests that Latinos are more likely than Anglos to have what are termed *fatalistic beliefs*.<sup>58,59</sup> A “general outlook on life founded on the belief that life events are inevitable and that one’s destiny is not in one’s own hands”<sup>56</sup> is a suggested cause of screening noncompliance for Latinos.<sup>57-59</sup> However, Hubbell and colleagues<sup>4</sup> confirmed earlier findings by Chavez<sup>7</sup> that health beliefs in traditional Mexican culture and belief in folk illnesses and folk practitioners did not have a significant influence on the behavior of Latinos seeking conventional medical care in the United States.

Latinas were nearly twice as likely as Anglo women to believe that they needed a mammogram only when they had a breast lump and often believe that cancer is God’s punishment for improper or immoral behavior.<sup>54</sup> In a telephone study of 803 Latinas and 422 Anglo women, Latinas were more likely than Anglo women to believe that factors such

as breast trauma (71% vs 39%) and breast fondling (27% vs 6%) increased the risk of breast cancer; they were less likely to know that symptoms such as breast lumps (89% vs 98%) and bloody breast discharge (69% vs 88%) could indicate breast cancer; and they were more likely to believe that mammograms were necessary only to evaluate breast lumps (35% vs 11%) ( $P < .01$  for each). Latino ethnicity and acculturation levels were significant predictors of these beliefs.<sup>17</sup> These findings imply that breast cancer control programs should address these differences to provide more culturally sensitive and individualized interventions.

## Interventions for Latinas

A review of interventions developed for other Latina populations may provide insight into the possibilities for reaching Latinas in the rural South. Several cancer control colleagues have incorporated Latino role models,<sup>6</sup> churches,<sup>5</sup> and lay health advisors, *promotoras*, or *consejeras*.<sup>6,7,9</sup> into successful interventions for reaching Latinas and positively increasing screening behaviors. The *Por La Vida* model in southern California demonstrated the need to work within and for local networks of Latinas.<sup>8,9</sup> Similarly, Ramirez and colleagues<sup>6</sup> demonstrated the replicability of *A Su Salud/En Accion* project for reaching Latinos in multiple urban communities across the United States. Particularly pertinent to the rural south, Mishra et al<sup>60</sup> demonstrated that cancer control programs designed for less acculturated women should use informal and interactive educational methods that incorporate skill-enhancing and empowering techniques. These authors suggest a breast cancer control program called the *Empowerment Model* based on a theory of self-efficacy by Bandura,<sup>61</sup> with the addition of an empowerment pedagogy by Freire.<sup>62</sup> Their findings suggest that educational programs should be interactive and not didactic, should be conducted at an educational level that is comprehensible and appropriate for the literacy level of the women, should address the women’s personal beliefs, and should provide skill-building exercises such as breast self-examination.

## Implications for Health Care and Cancer Control

These findings imply that breast and cervical cancer control programs should examine local variations in language, culture, social, and economic factors to provide more culturally sensitive interventions. A better understanding of culture and world view is important in patient education and disease detection, and it is

essential to study local conditions when planning health policies or programs.<sup>4</sup> In univariate analyses, the following factors were each statistically significantly associated with greater receipt of ever and recent clinical breast examination and mammography: having higher acculturation levels, a usual source of care, higher income, and health insurance; immigrating to the United States before the age of 16 years; spending a greater proportion of one's life in the United States; and using English for the interview.<sup>17</sup> With rural Latina residents having some of the lowest insurance rates in the nation, as well as meeting few of these conditions that are associated with screening, special attention is needed to provide adequate outreach messages for recent Latina immigrants in the South. Many low-income Latinos place priority on survival activities such as paying the rent or having enough food to eat. For them, preventive health measures are a secondary consideration. This pattern of "pragmatic poverty" has been found among other poor minorities in the rural South.<sup>63</sup> Therefore, programs must be designed that will fit into the framework of their lifestyle. Limited time and resources to devote to health are major concerns for Latino immigrants. They need a program that demonstrates how to implement these preventive health measures into the course of their normal day.<sup>64</sup>

Latino immigrants are limited in their ability to secure health and insurance benefits through their employment. Fear of deportation or losing their jobs keeps them from asking for safety at the workplace or

#### Recommendations for Creating Effective Cancer Control Programs

- Develop special outreach efforts conducted with Latinos who are monolingual
- Incorporate screening into the settings that are used by Latinas or establish effective referral mechanisms
- Incorporate important cultural components and values related to Latina family, spirituality, and community
- Design programs that incorporate low-literacy materials, messages, and graphics and do not require literacy to participate in or to market the program or service
- Increase availability of low-cost or no-cost screenings and broaden insurance or eligibility criteria for Medicaid
- Provide and incorporate bilingual signage in healthcare institutions and clinics
- Provide trained medical interpreters
- Work toward increasing available bilingual professional staff through focused education, training, and hiring programs, since providers report the lack of available bilingual staff and funding for health care as key barriers to meeting the needs of this population
- Work to raise awareness on the part of policy makers and service agencies of the need for culturally competent and linguistically accessible health care
- Provide training to healthcare providers and staff in cultural competency and medical Spanish for an ever-growing segment of the population in the South

other needed employee benefits. As shown by Moore,<sup>65</sup> undocumented workers have a real or imagined political inability to gain occupationally related security. Because women are quite often the primary caregivers for the children, they bear a major burden for maintaining family security and welfare. They must deal with bureaucratic agencies associated with healthcare services and insensitive and prejudiced personnel, and they must find the means to overcome transportation, cost, and language barriers.<sup>65</sup> Undocumented Latinas tended to be younger and employed in menial jobs. Their use of public assistance was low even though they were likely to have young children.<sup>17</sup>

The current literature on the multiple factors and variables that may impact health and health-seeking behavior patterns among recent Latino immigrant populations supports several recommendations for creating effective cancer control programs. These are presented in the Table.

## Conclusions

Recent Latino immigrants face personal, social, political, cultural, and economic barriers in their access to health services. Access to health services is limited for all populations in poor, rural areas, but the clustering of Latinos in these rural areas makes them more vulnerable to the unique challenges of acculturation and the acquisition of language and social skills that permit the use of the healthcare system. Effective screening and treatment programs among these rural Latino populations require the development of culturally sensitive interventions that acknowledge the need for a population health approach. This approach recognizes the impact of the economic, social, cultural, and political context within which recent Latino immigrants live and work on their patterns of health service usage and their ability to monitor and control patterns of disease and illness within their families and their community.

*Appreciation is expressed to Nicole Seiler for her assistance with the preparation of this manuscript.*

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