

A PROFILE OF LATINO HEALTH IN CONNECTICUT

The Case for Change in Policy & Practice



LATINO POLICY INSTITUTE



Hispanic Health Council

175 Main Street
Hartford, CT 06106
ph 860.527.0856
fax 860.724.0437

December 12, 2006

This report outlines a crisis in Latino Health in Connecticut and calls for statewide changes in policy and practice. Over the following pages, you will read about many critical health issues, including high rates of diabetes, HIV/AIDS, asthma, food insecurity and teen pregnancy in the Latino community in Connecticut. While this report brings to light significant problems, it also identifies a path for addressing these problems. The time has come for a consolidated and strategic approach to achieving systemic solutions.

Through the establishment of a new Latino Policy Institute and the building of a Latino Health Advocacy Coalition, the Hispanic Health Council (HHC) is committing itself to a long-term effort to achieve the goals listed in this report. Critical to this initiative will be the input, support and direct involvement of Latinos and others throughout the state. The time has come for a public outcry against the clear inequities of the health care system in Connecticut.

Connecticut's population is 9.4% Latino and yet Latinos make up 40% of the uninsured in the state. Connecticut ranks 49th out of the 50 states for the percent of the economy spent on state-funded health care, with programs for women and children bearing the brunt of this underfunding. These statistics have serious human consequences. For example, Latinos have a 60% higher mortality rate for diabetes than non-Latino whites and Latino children have asthma hospitalization rates that are five times higher than those of non-Latino white children. This is a crisis that affects all citizens of Connecticut, not only the Latino community. It highlights growing public health issues, educational shortfalls, and healthcare inadequacies the effects of which, while most strongly evident in the Latino population, affect all people, regardless of race.

Each year, the state loses approximately \$1.64 billion as a result of preventable illness among the uninsured. It is critical that individuals and organizations across Connecticut come together as partners in creating an agenda for change in health care policy and practice. We need your help, please join us.

Jeannette DeJesus
President and CEO



TABLE OF CONTENTS

A PROFILE OF LATINO HEALTH IN CONNECTICUT

Executive Summary	1
Introduction: A Conceptual Framework	17
The Latino Population of Connecticut	19
Access to Quality Care	27
Latino Health Through the Life Span	35
Asthma	45
Diabetes	47
Cancer	51
Cardiovascular & Heart Disease	55
Behavioral Health	57
Nutrition	59
Sexually Transmitted Diseases	67
HIV/AIDS & Tuberculosis	71
Oral Health	77
Environmental Health	79
Available Data on Latino Health	83
Conclusion & Recommendations	85
Endnotes & References	89

NOTE: The terms “hispanic” and “latino” are used interchangeably in this report. All racial identifiers such as “white” and “black” refer to non-hispanics.

ACKNOWLEDGEMENTS

This report was a collaborative effort among the staff of the Hispanic Health Council including the following individuals:

Grace Damio, M.S., CD/N
Hispanic Health Council

Megan Samenfeld-Specht
Hispanic Health Council

Jeannette B. DeJesús, M.P. A., M.S.W.
Hispanic Health Council

Merrill Singer, Ph. D.
Hispanic Health Council

John Humphries, M.S.
Hispanic Health Council

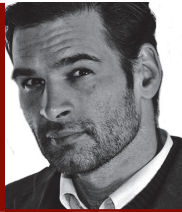
Sofia Segura-Perez, M.S., R.D.
Hispanic Health Council

Madeline McClave
Consultant

This report was made possible by generous financial support from the [Universal Health Care Foundation of Connecticut](#).

Copyright © 2006. The Hispanic Health Council. All rights reserved. Except for short quotes, no part of this report may be reproduced or used in any form or by any means, electronic or mechanical, including photocopying, recording, or by information storage or retrieval system, without written permission from the Hispanic Health Council.

The Hispanic Health Council is a nonprofit, nonpartisan research, direct service, training and advocacy organization with a mission to improve the health and social well-being of Latinos and other underserved communities. The views expressed in this report are those of the authors.



EXECUTIVE SUMMARY

A PROFILE OF LATINO HEALTH IN CONNECTICUT

INTRODUCTION: A CONCEPTUAL FRAMEWORK

The state of Latino health in Connecticut is in crisis. Drastic inequities in health care, health care access, health literacy, socio-economic status and environmental conditions, as well as institutional and interpersonal racism, present major challenges to prevention and successful management of diseases and to achievement of overall well-being. Connecticut's Latinos experience significantly higher rates of many illnesses, and die at an earlier median age than other ethnic groups in the state.¹

The purpose of this document is twofold. First, it presents a profile of the state of Latino health in Connecticut, based on available research from a broad range of sources. Second, the profile is a call to action. The alarming depiction of health disparities that exist in the state calls for concerted policy change toward eliminating these disparities.

Latinos are now the largest minority group in CT — 9% of the state's population.

THE LATINO POPULATION IN CONNECTICUT: AN OVERVIEW

The state's Latino population is growing at a dramatic rate and experiencing increasing inequalities in social conditions resulting in inadequate use of health care and health status. The following statistics provide an overview:

Latinos are now the largest minority group in Connecticut — 9% of the state's population.

Latinos experience the highest poverty rate and the highest unemployment rate of any ethnic group in the state.

The Latino population is young, with a median age of 25 years, and nearly 40% under 20 years of age. Latinos have the highest fertility rates, birth rates and teen birth rates.

People of Puerto Rican origin are the largest subgroup in the state. Health status and behavior vary within different Latino subgroups in the state, and with length of time in the U.S.

Only 42% of Latinos have a high school diploma.

Despite the challenges highlighted above, Latinos are playing and will continue to play an increasingly important role in the economic and social progress of Connecticut. Latino-owned businesses have increased by 43% since 1997. Latinos account for 9% of the state's labor force. Latino purchasing power in Connecticut was estimated to

Latinos experience the highest poverty rate and the highest unemployment rate of any ethnic group in the state.

reach \$7.5 million in 2005. As these statistics demonstrate, the potential for healthy development of Connecticut's future economy is closely tied to the health and well-being of all of its citizens, including its Latino population.

■■■ ACCESS TO QUALITY HEALTH CARE

This segment of the report briefly highlights critical barriers Latinos face in accessing quality health services, resulting in delayed health care utilization and more advanced and more costly health conditions.

■■■ HEALTH INSURANCE COVERAGE

While Connecticut is one of the states with the highest percentage of insured residents, insurance coverage is unequally available among different socio-economic and ethnic groups across the state. It is estimated that between \$584 million and \$1.164 billion are lost annually in the state due to increased morbidity and mortality from preventable diseases among the uninsured. Latinos in Connecticut experience uninsurance at a disproportionate rate compared to the overall population of the state, as follows:

While Latinos represent 9% of Connecticut's residents, they account for a staggering 40% of Connecticut's uninsured population.

Working Latinos are less likely to work for an employer that offers employer-sponsored insurance, and less likely to hold a permanent position that provides insurance even when their employer offers insurance coverage.

As of 2003, Latino children were the most likely to be uninsured (21%) compared to non-Latino white children (7%) and African American children (14%).

In Connecticut, 75% of Latino residents and 90% of Latino leaders reported lack of health insurance to be one of their top ten concerns.

Widespread lack of health insurance is one of the most urgent health problems facing Latinos today, and is a major contributing factor to poor health outcomes and premature death.

■■■ CULTURAL & LANGUAGE-RELATED ISSUES IN ACCESS TO CARE

Some of the most critical barriers to health confronted by Latinos occur during the health care encounter. One is the inequity in quality of care provided to Latinos and certain other groups. Examples of inequities include less complete health histories taken and fewer referrals to specialists when compared to services provided to non-Latino whites. The documentation of stereotyping of patients by health care providers and its attribution as one of the causes of inequities in health, has led to a call for cross cultural training of health providers.

In recent years, some cross cultural trainers have begun to use a training approach involving a broader definition of culture to include “dimensions of diversity” such as: economic class, gender, race, ethnicity, disabilities, sexual orientation, social class, literacy, language, age and spirituality. A challenge to adequate training of Connecticut’s health care professionals and students is the lack of time within busy clinical schedules and packed academic curricula to effectively deliver this content, and to address the fundamental issues causing the inequities.

Another barrier to quality health care experienced by Connecticut’s Latinos is language. Studies, most notably by the Connecticut Health Foundation (2006), have shown that:

44% of Latino adults report that they usually or at least sometimes have a hard time speaking with or understanding a doctor because of language issues.

Patients who see language discordant doctors are more likely to omit medication, miss office appointments and rely on the emergency room for care.

25% of Latino parents surveyed indicate that the inability to communicate in the same language with their doctors was the single largest barrier to getting health care for their children.

In Connecticut, where 8% of residents report speaking Spanish at home, Latino physicians account for only 2% of physicians in the state.

22% of physicians report being unprepared to treat patients with limited English proficiency, a problem that is further exacerbated by the lack of language interpreter services in health settings.

Generally, it is estimated that only half of Latino patients needing interpreter services actually receive them.

Latinos represent 9% of Connecticut’s residents — they account for a staggering 40% of Connecticut’s uninsured population.

HEALTH LITERACY

‘Health Literacy’ is defined by Healthy People 2010 as “the degree to which individuals have the capacity to obtain, process and understand basic health and services needed to make appropriate health decisions”. These are the skills that all people need to, for instance, find their way in a hospital, fill out medical and insurance forms and communicate with medical providers (Health Literacy).

In the years since the first *Current Bibliographies in Medicine* on health literacy was released, national interest has grown on this topic. At the core of this growing interest is the realization that more than 90 million people in the United States struggle to understand basic health information (CBM, 2004). One research study in a public hospital found that one third of English-speaking patients could not read basic health materials, more than a quarter couldn’t read appointment cards and 42% did not understand labels on prescription bottles (Health Literacy).

Evidence of the disproportionate challenges to obtaining adequate health literacy experienced by Connecticut’s Latinos is documented throughout this report. The challenge of improving health literacy among Latinos must be addressed with an approach that takes systemic and individual factors into account.

■■■ LATINO HEALTH THROUGH THE LIFE SPAN

The health inequities experienced during critical stages of the life cycle dramatically reflect the failure of our public health and socioeconomic systems to protect the health of those most vulnerable.

Fertility and Birth Rate

Latinas have the highest fertility and birth rates of any ethnic group and account for 19% of all U.S. births. The percent of families with children is 57% for Latinos, and 31% for non-Latino whites. Nationwide, the rate of Latino children under age 6 is 13% of the Latino population compared to 7% for non-Latino white children. In Connecticut, these rates are 13% and 7% respectively.

The relatively young age of this population group, combined with the relatively greater proportion of families with young children, implies a more intensive need for maternal and child health services.

Prenatal Care

Time of entry into prenatal care and number of prenatal visits are two markers for adequacy of care that have strong implications to birth outcome. In 1998, Latinas gave birth to 6,178 babies in Connecticut. In nearly 20% of these cases, there was late or no prenatal care, compared to only 8% among non-Latino white births. In 2002, Latinas were still the ethnic group most likely to be late in entering prenatal care.

Teen Pregnancy

Adolescent pregnancy is considered a risk factor regarding the health and well-being of the mother, baby and rest of the family, as well as the community and population at large.

The United States has the highest teen pregnancy rate of all developed countries.

Although nationally, the overall teen pregnancy and birth rates have declined, reduction in teen pregnancy rates for Latino teens has lagged behind that of other ethnic groups.

Teen pregnancy rates for Latinos of Mexican descent was 93% while the rate for Latinos of Puerto Rican descent was 60%.

Teen parents are more likely than other mothers to be high school drop-outs and single parents, which could greatly impact their earning potential, household financial health, and support systems.

Research on the consequences of teen pregnancy suggest that teen births are more likely to be premature and low birth weight, and therefore at greater risk of long-term health and developmental problems as well as infant death.

The rapid growth of the Latino population in the U.S. is expected to be even more dramatic among Latino teens. The combination of the growing population of Latino teens, and its relatively high rate of teen pregnancy, illustrates the need for a focused pregnancy prevention effort tailored to this population.

Birth Outcomes

Infant mortality (IM) is the measure of the yearly rate of deaths in children up to one year of age. Infant mortality is considered a sensitive indicator of overall community well-being.

The overall Infant Mortality Rate (IMR) for the U.S. in 2004 was greater than the IMR of 12 other countries.

Among Connecticut's Latinos the IMR is higher than that of the general population in Connecticut.

Many risk factors for infant mortality are lifelong; solutions must be developed at the community level and beyond, not just the individual or clinical level.

The U.S. has the highest teen pregnancy rate of all developed countries.

For many women of child bearing age, pregnancy is the only time they receive regular health care. Preconceptional care is an essential element toward improving birth outcomes, as it provides women with wellness-oriented care with the goal of reducing or eliminating risk factors that could affect pregnancy outcome *before* a conception takes place. In order for preconceptional care to be possible on a broad scale, health care coverage would have to be available to women of reproductive age who are not pregnant. Universal health coverage is an important component to the further improvement of birth outcomes among Latinos.

Child Health

As is reflected in the Infant Mortality Rates, tragic inequities in the health of Connecticut's Latino children are experienced very early in life. Low income Latino children in Connecticut experience a higher rate of low birth weight than low income U.S. children. A national panel of pediatric experts identified the following as the most urgent priorities and unanswered questions in Latino child health: high risk for school dropout, environmental hazards, obesity, diabetes mellitus, asthma, dental cavities, behavioral and developmental disorders, barriers to accessing health care, and impaired quality of care.

Access to Quality Health Care Among Latino Children

In 2004, 58% of Latino children on HUSKY A in Connecticut received well child care, compared to 56% of non-Latino white children and 54% of African American children, an unacceptably low rate for all three groups. That same year, 39% of Latino children had emergency care, compared to 30% of non-Latino white children and 31% of African American children (Connecticut Voices for Children, Child Health and Health Care Disparities in HUSKY A in 2004, 2006).

Latino children are hospitalized at a rate 5 times higher than that of non-Latino white children.

Connecticut pediatric leaders have called for the integration of outreach and care coordination services into the clinical provider sites and the communities that they serve. The proposed system would provide the resources and infrastructure needed to locate hard-to-reach families, and to provide support and services to educate, assist and empower parents in taking health-related action for their children. H.O.M.E. — Health Outreach for Medical Equality — is the pilot program currently being implemented in Hartford to develop the recommended service model.

Adolescent Health

There are many risks in our society to the lives and well-being of adolescents, risks that often have far reaching consequences. Given their comparatively poorer socioeconomic status, it is not surprising that many Latino teens experience multiple threats to their health and engage in risky behaviors such as early involvement in sexual activity and drug use. They are significantly more likely to experience unintentional injuries and behavioral health problems than their (non-Latino) white counterparts. Young Latino men in Connecticut have a higher statistical risk of being murdered than non-Latino white teens, and young Latinas have the highest likelihood of becoming pregnant and bearing children while still teenagers than any other group of adolescents.

Elderly Latinos

One of the most dramatic demographic shifts worldwide is the growing population of older adults. Increases in the elderly proportion of the population are attributed primarily to a decline in birth rates and death rates. The percent of elderly in the overall population has important implications for the economy and for the planning of health and social services.

People over the age of 65 make up approximately 12% of the population in the United States. This figure is projected to become 20% of the population by 2050. The population of elderly Latinos is expected to increase 205% by 2050. Connecticut ranks eighth in the country for percentage of population over age 65 at 14%.

The anticipated 20% of elderly Latinos by 2050 would still be the lowest of any ethnic group. This contrast is reflective of the relatively young age of the current Latino population, relatively high birth rate, and anticipated growth in the number of teens with a high teen pregnancy rate. In light of the high level of poverty and low level of education among the current Latino population, without changes in education and income, the future scenario could be an even lower-income population with disproportionate age concentration at three vulnerable times in the life cycle: young children, adolescent/pregnant adolescent, and elderly.

■ ■ ■ ASTHMA

According to a report by the American Lung Association, in 2005 the number of Americans with asthma was close to 18 million. It is estimated that asthma costs the United States a total of \$16.1 billion a year through a combination of direct medical costs and lost productivity. In Connecticut, adult asthma is higher in urban areas than in rural areas, much more common among families with a household income under \$25,000, and a significant factor in ability to work.

National averages show that overall, Latinos experience lower rates of asthma than other ethnic groups. However, these statistics disguise major differences within Latino subgroups. Studies have suggested that Puerto Ricans may have higher rates of asthma than other Latino subgroups and non-Latino whites. In fact, in Connecticut, where Puerto Ricans are the majority Latino group, pediatric asthma rates are 11% for Latinos, compared to 9% for African Americans and 8% for non-Latino whites. Asthma hospitalization rates are about five times higher among Latino children than for non-Latino white children.

The problem, however, is not simply one of the health care system failing to adequately educate Latino parents in asthma management. A study done in Connecticut and Massachusetts found that Latino and African American children were given fewer beta2-agonists (a standard component of asthma management), and Latino children received fewer inhaled steroids than non-Latino white children. Among Latino children in private care, there was a significant association found between Latino ethnicity and low use of inhaled steroids. Clearly, Latinos in Connecticut suffer disproportionate rates of asthma and of inadequate asthma management.

■ ■ ■ DIABETES

Diabetes is a growing problem across the United States and in the Latino population in particular. Generally, the prevalence of diabetes among Latinos is almost twice the rate for non-Latino whites and is likely to increase in the future. Latinos are also more likely to develop complications from diabetes, including heart disease, stroke, kidney disease, blindness, and lower extremity amputation. Despite the high rates of diabetes in the Latino community, Latinos are less likely to use diabetes-related care services.

Latinos in Connecticut have a 60% higher mortality rate for diabetes and 40% higher mortality rate due to diabetes-related causes than non-Latino whites. Moreover, Latinos are 2 times more likely than non-Latino whites to be hospitalized for diabetes or a diabetes-related condition.

Recent research on Latinos in Connecticut with diabetes reflects the extreme nature of the disparities experienced by this population with regard to a variety of factors essential for adequate diabetes management, successful prevention and timely diagnosis of the disease.

Connecticut is estimated to lose between \$584 million and \$1.164 billion annually due to increased morbidity and mortality from preventable diseases among the uninsured.

Cancer incidence rates are lower among Latinas than non-Latino white women, however, Latinas are more likely to die from breast cancer.

■■■ CANCER

Cancer is the second leading cause of death in the United States, accounting for over 500,000 deaths each year. Among Latinos, cancer is the leading cause of death for Latina females ages 25 to 54 and among Latino males ages 45 and over. Despite the fact that Latinos have a lower overall cancer rate than non-Latinos, Latinos do experience higher rates of certain cancers as compared with non-Latino whites: these include cervical, esophageal, gall bladder and stomach cancer.

Even though breast cancer incidence rates are lower among Latinas than non-Latino white women, Latinas are more likely to die from breast cancer. This appears to be due to differences in rates of screening between the two groups. Lack of access to health care, lack of culturally safe care, and lack of awareness of early detection and cancer prevention are the leading barriers to achieving adequate cancer health outcomes.

The ability of Latinos with cancer to receive and to follow through with adequate disease management outside the clinical setting is limited by the lack of health insurance, low levels of health literacy, limited English proficiency and other barriers to quality health care. As the Latino population in Connecticut ages, cancer is likely to become a more significant factor in Latino health.

■■■ CARDIOVASCULAR DISEASE AND STROKE

Cardiovascular Disease (CVD) is the overall leading cause of all deaths among Latinos. Despite the higher prevalence of risk factors for heart disease and stroke, Latinos remain generally unaware of behavioral changes and early intervention strategies that could prevent the onset or progression of heart disease and stroke. Nationally, about one-fourth of deaths among Latinos stem from cardiovascular conditions, and the rate is expected to rise in coming years as the Latino population ages.

The major risk factors for both CVD and stroke include high blood pressure, high blood cholesterol levels, smoking, diabetes, obesity/overweight, physical inactivity and socioeconomic status most of which are prevalent among Latinos. For example, in Connecticut, it is estimated that 57% of Latinos are obese or overweight. In addition, Latinos have the highest rate (22%) of cigarette smoking of any racial or ethnic group.

■■■ BEHAVIORAL HEALTH

In the United States, Latinos face disparities in behavioral health care across areas, including assessment and diagnosis, access to service, quality of care, and training and research. It is estimated that there are only 20 Latino mental health providers available for every 100,000 Latinos in the country.

Although data in this field is limited, the need for increased mental health providers is clear. It has been shown that:

- Twice as many Latinas report depression (11%) as African Americans (6%) or non-Latino white women (5%)
- Twice as many Latina teenagers (21%) attempt suicide as African American (11%) or non-Latino white (10%) teenage girls and
- Latinos are less likely to fill an antidepressant prescription than were non-Latino white patients.

These patterns in behavioral health are also evident in Connecticut. There is no definitive conclusion as to why these disparities exist. Clearly, research is needed that further explores the range of factors from poverty to racism to other psycho-social factors. In addition, there is a critical need for increased behavioral health services that are both bilingual and bicultural.

■■■ NUTRITION

Nutrition related issues are serious health concerns for Latinos in Connecticut, especially because poor nutritional status can cause or exacerbate other serious and growing health problems.

Food Insecurity and Hunger

Rates of food insecurity and hunger among Latinos point out important inequalities. In 2002, the prevalence rates of food insecurity and food insecurity with hunger for the total U.S. population were 1%, and 4% respectively, compared to 22% and 6% for Latinos.

While general rates of food insecurity and hunger in Connecticut are lower than national averages, a Hartford study found that 40% of the households studied were food insecure without hunger and 21% of the children studied experienced periods of hunger.

Basic Nutrition Knowledge

Research within the Hartford Latino community has found low levels of basic knowledge regarding national dietary guidance on healthy food choices and on safe food handling, indicating the need for culturally-tailored nutrition education materials and services. While the HHC's Family Nutrition Program provides thousands of culturally tailored educational contacts each year, they are limited to the Greater Hartford Area. Services such as these need to be available to Latinos throughout the state.

Obesity

Obesity is a problem that is increasing across the United States and in Connecticut. It is estimated that 57% of Latinos in Connecticut are overweight or obese.

Obesity during childhood has many adverse health consequences such as possible persistent high blood pressure, high fasting blood insulin levels, risk of Type 2 diabetes, orthopedic complications, psychosocial effects and stigma.

Latinas have a rate of Pelvic Inflammatory Disease that is 3 times that of their non-Latino white counterparts.

Adults that are overweight/obese are at increased risk for hypertension, Type 2 diabetes, coronary heart disease, stroke, gall bladder disease, osteoarthritis, sleep apnea and respiratory problems, and some types of cancer.

Obesity is associated with poverty, lack of access to high quality food, and lack of opportunities for exercise in low-income communities. Solutions to obesity must address these systemic issues, as well as provide health promotion efforts targeting individuals.

Breastfeeding

Breastfeeding has been continually documented to be the best way to feed infants, with many positive health benefits documented for both mother and child. Nationally, data indicates that 71% of mothers have ever breastfed, 36% breastfed at six months, and 17% breastfed at 12 months, all rates below national goals.

In Connecticut 72% of all mothers initiate breastfeeding, but the rate among Latinos is only 59%. Available duration rates for Connecticut's low-income population are unreliable, but are undoubtedly lower than the national targets. Within the Latino community, breastfeeding initiation and duration are strongly linked to country of origin. Reasons for variation among Latino subgroups needs to be further explored and better understood. Peer counseling has been documented as an effective strategy for supporting breastfeeding among Latinos. Breastfeeding peer counseling efforts need to be expanded in Connecticut.

SEXUALLY TRANSMITTED DISEASES

Every year there are more than 15 million cases of sexually transmitted diseases (STDs) reported in the United States. In Connecticut, chlamydia and gonorrhea are the two most commonly diagnosed STDs.

According to the Connecticut Department of Health, in 2001 Latinas represented 19% of the gonorrhea cases (11 times higher rate than among non-Latino white women) and 30% of chlamydia cases (15 times higher rate than among non-Latino white women). Gonorrhea and chlamydia increase the risk of pelvic inflammatory diseases (PIDs), preterm births, and infertility, and lead to other health complications. Chlamydia also increases the risk of cervical cancer and the likelihood of HIV transmission. Syphilis is another STD that is disproportionately prevalent among Latinos. The syphilis rate of Latinos is twice that of non-Latino whites, and Latinas have a rate of PID that is 3 times that of their non-Latino white counterparts.

Although discussions of STD infection often focus around urban areas, Connecticut's Latino farm worker population is another important high risk population. In a study conducted by the Hispanic Health Council, nearly 30% of farm workers reported having sex within the last 30 days, despite being separated from their spouses; of those who had sex in the past month — over 50% did so with a sex worker. In addition, within this group, condom use was low with only 57% of sexually active respondents reporting condom use.

STDs and high risk behaviors disproportionately affect both urban and rural Latino communities in Connecticut. Among Latinos, lack of knowledge about the nature, symptoms, prevention, and treatment of STDs, and about their routes of transmission is very likely a significant contributor to this serious and growing area of health problems.

■■■ HIV/AIDS AND TUBERCULOSIS

HIV/AIDS

Across the United States, AIDS is the fourth leading cause of death for Latinos. Experts predict that the number of new AIDS cases among Latinos will soon surpass those of non-Latino whites.

In Connecticut, Latinos account for 25% of the cumulative AIDS cases and the epidemic shows no signs of abating. Latino youth are particularly vulnerable. While Latino teenagers comprise 15% of the teenagers in the U.S., they account for more than 20% of new AIDS cases among adolescents.

Although rates of testing for HIV infection between Latinos and the general population are roughly equal, Latinos are much more likely to be tested after the disease has progressed beyond the early stages, reflecting cultural, institutional and economic barriers to care.

AIDS cases in Connecticut are concentrated in the state's three largest cities: Bridgeport, New Haven and Hartford. While cases have been disproportionately concentrated among men, diagnoses among women have continued to climb in recent years. Between 2001 and 2003 the number of new AIDS cases reported among non-Latino whites fell in response to the introduction of new medicines. Strikingly, the rates for Latinos actually increased during this same period. By 2003 there were more new AIDS cases among Connecticut Latinos than among their non-Latino white counterparts, even though the non-Latino white population is more than eight times larger than the Latino population.

The AIDS epidemic has put the Latino population of Connecticut at great health risk. From a public health policy standpoint, AIDS has brought into sharp focus the inequities confronted by Latinos in accessing appropriate health and social services. Of particular note, Latinos have been found to view AIDS as the number one health problem facing their communities and are more likely than non-Latino whites to view AIDS as an urgent health issue.

Tuberculosis

Tuberculosis (TB) has re-emerged as an epidemic condition in the U.S. since the beginning of the AIDS epidemic. Research has shown that co-infection with HIV and TB can reduce the survival time of patients compared to those with just one of these diseases, suggesting a syndemical interaction with deadly consequence for co-infected individuals.

Poor children
had 5 times more
untreated cavities
than their more
affluent counterparts.

Latinos account for 39% of all reported childhood cases of tuberculosis, a rate 13 times higher than for non-Latino whites.

The growing rate of infectious diseases, such as HIV/AIDS, tuberculosis and other diseases, that go untreated until very late stages, or never, among Latinos and other underserved populations in Connecticut, is a serious public health issue for all residents.

ORAL HEALTH

Dental decay is the most common childhood disease, five times more common than asthma. Oral disease has the potential to impact a number of medical conditions, including: cardiovascular disease, diabetes, preterm low birth weight, cancer, HIV/AIDS and smallpox.

Despite the well documented negative effects of dental disease, there is currently little research on Latino dental health in Connecticut. However, several national studies of dental issues facing low-income populations give insight into the barriers facing low income Latinos in Connecticut. A series of national studies conducted between 1984 and 1997 showed that:

Poor children had five times more untreated dental cavities than their more affluent counterparts.

Poor adults were much more likely to have lost six or more teeth due to decay and gum disease than higher income adults.

Non-Latino whites are twice as likely to report that they received a dental exam in the last year as Latinos.

Structural barriers to oral health care must be addressed in order to eliminate the serious inequities in oral health experienced by Latinos and other low-income populations.

ENVIRONMENTAL HEALTH

Environmental threats, including poor air quality, exposure to agricultural chemicals, and lead and mercury poisoning, have serious health effects. The majority of Latinos in Connecticut live in urban areas blighted by polluted air that holds significant risks for respiratory health problems. A study of exposure to diesel exhaust from school buses among Connecticut children found that fine particulate concentrations measured on buses were five to ten times higher than the average levels measured at monitoring stations across the state.

Air Pollution/Chemical Exposure

While many environmental problems are concentrated in cities, rural areas can also pose significant environmental threats. Latino farm workers make up a large percentage of rural Latinos. Farm workers are exposed to pesticides at work, and they and their families are also exposed off the job when these chemicals drift through the air into

nearby labor camps or rural towns. The health effects of exposure to various pesticides and other farm chemicals include skin rashes, burning eyes, cough, nausea, vomiting, diarrhea, difficulty breathing, heightened levels of lymphoma, prostate cancer, and childhood cancers.

Lead Poisoning

Lead poisoning is yet another environmental factor affecting Latinos. Comparatively high blood levels of lead have been found among Latino children, especially among those living in older buildings. Lead can cause neurological problems in children even at very low doses and has been associated with declines in IQ, learning disabilities, hyperactive and violent behavior, and an increase in antisocial behavior. Among adults, it has been linked to neurological problems, high blood pressure and kidney problems.

...high blood levels of lead have been found among Latino children, especially among those living in older buildings.

Mercury

Mercury, now believed to be unsafe at any level in the body, may also constitute a comparatively high risk for Latinos. The two major ways that Latinos are exposed to mercury are by eating mercury-contaminated fish — canned tuna are low-cost and a popular fish among Latinos and by using mercury (sold in some local botanicas in Connecticut in capsule form or melted into candles) in folk healing remedies. The risk of exposure to this highly toxic substance is compounded by a lack of Spanish-language educational materials about the dangers of exposure to even small amounts of mercury.

AVAILABLE DATA ON LATINO HEALTH

We have encountered challenges in providing a complete picture of Latino health in Connecticut due to gaps in available data. Causes of this include:

Variation in health beliefs, status and practices among and within Latino subgroups has been evident in many sections of this document, and in other research.

Data describing Latino health with overall averages often miss important variations reflecting subgroup risk, response to intervention and other critical factors.

The importance of assuring adequate data on health and related issues among Latinos cannot be overemphasized, as it is needed for a clear understanding of the origins of the health inequities experienced by Latinos, their trends, and effective solutions. Evaluation of current research with regard to effective inclusion of Latinos, and expansion of research efforts on Latino health are essential steps toward filling the gaps in available data, and ultimately solving the enormous health inequities described in this profile.

CONCLUSIONS & RECOMMENDATIONS

Throughout this “Profile of Latino Health in Connecticut”, evidence of pervasive health inequities experienced by Latinos in our state represents an urgent call to

action. The magnitude of the problem is enormous, reflective of systemic root causes that must be addressed through decisive policy change. In order to create the political will for such change, a cohesive voice among Latinos and other advocates throughout the state must be as pervasive as the problems at hand and present at every policy table to represent the right to health for our state's fastest growing and drastically underserved population group.

Across the many critical health problems covered in this document are a number of overarching related factors that must be addressed. These include the following.

Lack of Adequate Data on Latino Health

Our ability to sufficiently describe the health status of Latinos in Connecticut is limited by lack of available data.

Poverty

Poverty is at the root of many problems of health care access, health status and health behavior. Latinos experience inequity in income and have the highest poverty rate and highest unemployment rate of any ethnic group in the state. Evident as well is the association between poverty and compromised health status. For real, long-term change in the health status of Latinos to occur, opportunities for a livable wage must be created.

Health Care Coverage

Connecticut Latinos have disproportionately high rates of uninsurance. This has a negative impact on their health care utilization and on the economy of the state. Universal Health Care Coverage is an essential step towards solving the health inequities experienced by Latinos in Connecticut.

Health Literacy

This profile reports a disproportionately low level of educational attainment among Connecticut's Latinos and a related health impact. Related to educational level is the issue of health literacy- "the degree to which individuals have the capacity to obtain, process and understand basic health and services needed to make appropriate health decisions". Health literacy is integrally linked to many of the barriers to health and health care. A focus on health literacy in individual service provision and in the planning of health and education services is critical to elevating the capacity for Latino communities throughout the state to effectively navigate health systems, adhere to health guidance and care for themselves adequately.

Cross Cultural Barriers

To address the impact of cross cultural barriers to health care we recommended a training approach that utilizes a broad definition of culture that includes the issues of class, gender, race, ethnicity, disabilities, sexual orientation, social class, literacy, language, age and spirituality. Such training is process-rich and time consuming. Connecticut must assure that its health

care professionals are skilled in working effectively with diverse populations by committing time and resources to assure training that gets at the fundamental issues and facilitates authentic change.

Language Barriers

Thousands of Connecticut Latinos need Spanish-language health care. The capacity of the state's health care system to address the need, with Spanish-speaking providers or medical interpretation, is inadequate, and this service gap impacts health literacy and health care utilization. The federal government requires Language Access Services in health care settings and payment for such services is feasible in Connecticut through Medicaid reimbursement. Medical interpretation is a necessary and affordable step towards solving this urgent problem.

Health Care Access

Throughout this profile, difficulties in accessing health care services, managing chronic disease and changing health behavior, are common across the series of health issues discussed. One (partial) solution to these problems is the utilization of peer health educators/peer counselors/care coordinators as a strategy towards facilitating access to care, reinforcing clinical guidance and supporting health behavior changes. The public health literature has affirmed the effectiveness and cost-effectiveness of this approach. The potential for utilizing peer health support as a strategy toward facilitating access to care and adherence to clinical guidance should be rigorously explored with carefully planned and evaluated pilot studies focused on the critical health areas in which health inequities are experienced. Effective models should be supported as one of a number of necessary solutions to health inequities.

The breadth of these recommendations reflects the seriousness and complexity of the work that lies ahead. Achieving long-term improvements in the quality of health among Connecticut's growing Latino population will require building a broad coalition of community organizations, service providers, research and advocacy organizations and others concerned with Latino health as a unified and powerful force for change. As part of that broader effort, the Hispanic Health Council is launching the Latino Policy Institute to bring these stakeholders together as partners in an agenda for change in health care policy and practice throughout the state.

While the enormity of the issues at hand may appear overwhelming, hope and persistence must prevail as we move forward. When Puerto Ricans are asked, "Cómo estás?" (how are you?), a common answer is "En la lucha..." (in the struggle). The struggle of attaining good health for Connecticut's Latinos is an essential one towards assuring the well-being of the entire state. The Hispanic Health Council looks forward to working with you as part of our Latino Policy Institute. In the struggle for the health of our communities in Connecticut, Venceremos! (We shall overcome!)



INTRODUCTION

A CONCEPTUAL FRAMEWORK

According to the Constitution of the World Health Organization, health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”

This document provides an overview of the state of Latino health in Connecticut, and portrays a reality that is in sharp contrast with the state of well-being described by the WHO. The health status of Connecticut’s Latinos also contrasts with that of the general population, and particularly with that of non-Latino whites, reflecting what have commonly been termed “racial and ethnic health disparities.”

Since the landmark report produced by the Institute of Medicine “Unequal Treatment”, there has been increased awareness and concern about health disparities in the U.S. “Unequal Treatment” describes health disparities in the U.S. as follows:

“A long-standing and well-documented pattern of health disparities exists in the United States. This pattern is apparent in health care outcomes and utilization, and is evidenced by the disproportionate incidence of disease, disability and death among specific racial and ethnic groups.”

Institute of Medicine
Unequal Treatment, 2002

Current thought on health disparities involves the more precise term of health “inequities”, described as products of a society’s political and economic systems and the illness-generating social conditions that they create (Waitzkin, 2006). Current understanding also involves the growing evidence of the impact of both institutional and interpersonal racism on health, stemming from the following potential pathways:

- Economic and social deprivation
- Toxic substances and hazardous conditions
- Socially inflicted trauma
- Targeted marketing of legal and illegal substances
- Inadequate health care
- Stress-mediated biological dysregulation (Bennett, 2005).

The six health areas originally targeted by the federal government for addressing health disparities include: cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations (National Center for Cultural Competence, 2001). This report covers these topics, but also addresses a number of additional health and related areas critical to the well being of Latinos in Connecticut. These include:

Current thought on health disparities involves the more precise term of health “inequities”, described as products of a society’s political and economic systems and the illness-generating social conditions that they create.

Health Care Coverage, Health Care Access — highlighting the critical issue of medical interpretation among others, Latino Health Through the Life Cycle, Asthma, Diabetes, Behavioral Health, Nutrition, Oral Health and Environmental Health.

Each chapter of this report portrays inequities in specific health areas experienced by many thousands of people in our state, due to a complex web of causal and relational factors that must be addressed systemically. In some cases, the available data is limited, providing an incomplete picture. The need for more complete data is addressed at the end of the document.



AN OVERVIEW

THE LATINO POPULATION OF CONNECTICUT

■■■ CURRENT AND PROJECTED GROWTH

From 1990 to 2000, the Latino population in Connecticut grew by more than 50%, compared to an overall growth in the state's population of only 4%.

In 1990, Latinos comprised 6% of the state's total population. By 2000, that percentage had risen to 9%. This represents an increase of more than 100,000 Latinos in the state over that ten-year period for a total of 320,323 as of 2000 (U.S. Census Bureau, 2000). Latinos are now the single largest minority group in the state of Connecticut.

The median age of Latinos in the United States is 25 years and nearly 40% of Latinos are under 20 years of age. Moreover, the proportion of Latino children to the total number of children in the U.S. has increased at a faster pace than that of any other ethnic group, growing from nine percent of the child population in 1980 to 19% by 2003 (Interagency Forum on Child and Family Statistics, 2005). Census projections indicate that Connecticut's Latino population will continue to grow at an accelerated pace reaching 574,000 or 13% of the State's population by the year 2025. Refer to Tables 1 and 2 for more detail about the population make-up of key Connecticut urban cities.

Census projections indicate that CT's Latino population will continue to grow at an accelerated pace reaching 574,000 or 13% of the State's population by the year 2025.

In key cities throughout Connecticut, Latinos account for a significantly larger percentage of the population including:

Hartford – 41%	Bridgeport – 32%	New Britain – 27%
Windham – 27%	Waterbury – 22%	New Haven – 21%
Meriden – 21%	New London – 20%	

U.S. Census Bureau 2000a and 2000b

■■■ LATINO SUBGROUPS

Connecticut's Latino population is made up of subgroups from diverse points of origin throughout Latin America. People of Puerto Rican origin account for 61% of all Latinos in the state, with 7% being Mexican, 2% Cuban, 3% Dominican, 4% Central American, 10% South American, and 12% other Hispanic of Latino origin. The proportions of Latino subgroups vary in different regions of the state.

Health statistics vary among different Latino subgroups, and with length of time in the U.S. Therefore, generalizations about Latino health that are based on overall averages

among all Latinos miss important distinctions between subgroups. For example, the rate of asthma among Puerto Ricans is more than double that of Mexicans or Cubans, and the frequency of AIDS-related mortality among Puerto Ricans is more than three times the rate among Mexicans (National Centers for Health Statistics, 2002). Notably, among Latino subgroups, Cubans have the best health status and Puerto Ricans, the worst. This appears to stem from the higher socio-economic status of Cubans.

The great majority of Latinos in the U.S. are Mexican, and the majority of Latinos in Connecticut are Puerto Rican. For many health issues affecting Latinos in the U.S., there are no national data. The local studies that have been conducted have often been focused on the Mexican populations in other states and regions of the country. Where national health data do exist, they are based on averages that are more reflective of the (majority) Mexican population than of the experience of Puerto Ricans. Therefore, the data often does not reflect the experience of Connecticut's Latino population.

■■■ EDUCATION/SCHOOL DROP-OUT

Comparing Latinos and non-Latino whites in Connecticut by level of educational attainment, findings from the 1990 Census, displayed in Figure 1, reveals significant gaps between these two populations. Among Connecticut residents 25 years of age and older, Latinos were the least likely to have earned a high school diploma. While 13%

Table 1 | CT Cities with the Largest Latino Population by Selected Characteristics, 2000*

City	Population	Hispanic	Hispanic	White	Black	AI/AN ^a	Asian	Other ^b
Hartford	121,578	49,847	47%	28%	38%	0.5%	2%	32%
Bridgeport	139,529	44,649	44%	45%	31%	0.5%	3%	20.5%
New Britain	71,538	19,315	43%	69%	11%	0.4%	2%	17%
Windham	22,857	6,324	28%	74%	5%	0.6%	1%	19%
Waterbury	107,271	23,600	30%	67%	16%	0.4%	2%	15%
New Haven	123,626	25,961	28%	43%	37%	0.4%	4%	15%
Meriden	58,244	12,231	24%	80%	6%	0.4%	1%	12%
New London	25,671	5,134	24%	63%	19%	0.9%	2%	15%

Source: U.S. Census, 2000). Race columns include both Hispanics and non-Hispanics.

^a Includes American Indians (AI) and Alaskan Natives (AN).

^b Includes persons of two or more races, native Hawaiians and Pacific Islanders.

^{c,d,e,f} Figures include all city residents.

of non-Latino whites and 26% of African Americans over 25 had not completed high school, among Latinos the rate was 42% (U.S. Census Bureau, 2000b). Nationally, the adolescent school drop-out rate in 1999 was almost 29% among Latino youth compared to 13% for African American youth and about seven percent among non-Latino white teens.

Education is an important health-related variable because people with more education tend to be healthier than those with lower levels of education (Pappas et al., 1993). Education both directly and indirectly affects health outcomes, such as through greater ability to access health information, and through the association with standards of living and working conditions.

LANGUAGE

In Connecticut 8% of the state's Latino residents report speaking Spanish at home (U.S. Census Bureau, 2000b). Twenty-two percent (22%) of physicians report being unprepared to treat patients with limited English proficiency, a problem that is further exacerbated by the lack of trained language interpreter services in health settings. Generally, it is estimated that only half of Latino patients needing interpreter services actually receive them.

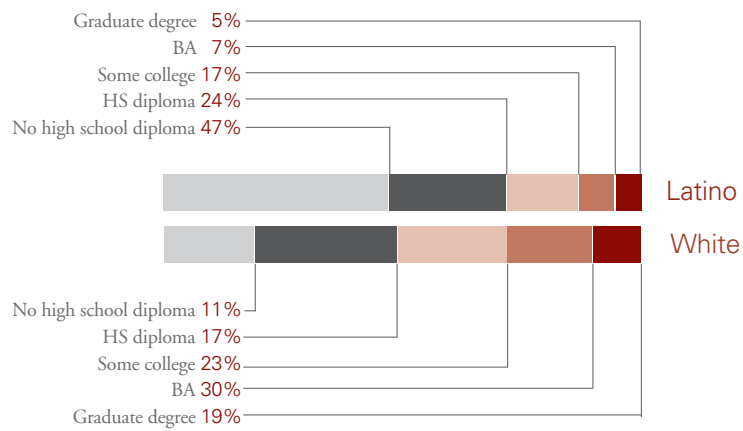
Table 2 | CT Cities with the Largest Latino Population by Selected Characteristics, 2000*

City	Population	Hispanic	Hispanic	Other than English at home ^a	High School or More ^b	Below Poverty Line ^c	Per Capita Income
Hartford	121,578	49,847	47%	47%	61%	31%	\$13,428
Bridgeport	139,529	44,649	44%	44%	65%	18%	\$16,306
New Britain	71,538	19,315	43%	43%	69%	16%	\$18,404
Windham	22,857	6,324	28%	28%	18%	0.6%	\$16,978
Waterbury	107,271	23,600	30%	30%	16%	0.4%	\$17,701
New Haven	123,626	25,961	28%	28%	24%	0.4%	\$16,393
Meriden	58,244	12,231	24%	24%	11%	0.4%	\$20,597
New London	25,671	5,134	24%	24%	16%	0.9%	\$18,437

Source: U.S. Census, 2000. Race columns include both Hispanics and non-Hispanics.

^a ^b ^c Figures include all city residents.

Figure 1 | Educational Attainment among Connecticut Residents 25 years of Age & Older*



*Source: Hynes et al. 1999

LOW INCOME LEVELS AMONG LATINOS

While Latinos are experiencing robust population growth, socioeconomic indicators suggest that Latinos in Connecticut are enduring severe hardships. Nearly one-third (32%) of this group live in poverty, representing the highest poverty rate of any racial/ethnic group in the State. Notably, the 2000 Census also found that Latinos have the lowest per capita income of all ethnic groups in Connecticut. While the per capita income of non-Latino whites grew to \$32,330 in 2000, it was only \$13,123 for Latinos.²

There is a strong relationship between poverty and health disparities. But researchers also note that these disparities are greatest among poor people who live in communities with high rates of poverty. Thus, poor people in cities with lower overall rates of poverty are at lower risk of dying than those living in cities with higher rates of poverty (Budrys, 2003) such as Hartford. Moreover, studies of differences by location among the poor show that the sociophysical environment in which people live — that is, their experience of their surrounding community including issues of danger, stress, comfort, and appeal — is a critical determinant of their health (Budrys, 2003).

GANGS & VIOLENCE AMONG LATINO YOUTH

Gang involvement, a powerful force on the streets of many Latino neighborhoods, represents another threat to the health of Latino youth. Gang activity is an important factor contributing to the fact that the rate of firearm deaths among Latino males between the ages of 15 and 19 is more than double the rate among non-Latino white youth, as reflected in Figure 2.

Table 3 | CT Poverty Rate by Race and Hispanic Origin, 2002–2003

	Number	Poverty Rate **
White	191,720	7%
Black	86,650	28%
Hispanic	102,890	32%
Other	21,880	16%

* Source: Kaiser Family Foundation, 2002.

** Represents percentage of the total population for each racial or ethnic group living below the federal poverty line.

In Connecticut, more than one-third of homicide deaths are among victims between 15 and 24 years old and homicide is the leading cause of death among Latinos in this age group. As seen in Table 4 below, the homicide rate for Latinos between the ages of 15 and 24 is more than four times that among non-Latino whites (Hynes et al., 1999).

■■■ SUBSTANCE USE AMONG LATINO YOUTH

As Bourgois (1995) found in his study of crack dealers in New York City, lack of access to respectable jobs in the mainstream economy and the emotional costs of prejudicial attitudes in the job market tempt many Latino youth into involvement in the drug trade. A statewide survey of seventh- to tenth-graders in 27 school districts across Connecticut asked students to report on substance use via confidential, anonymous, self-administered questionnaires (Cook et al., 2001). The results showed that Hispanic

Figure 2 | National Firearm Death Rate Per 100,000 Population Among 15-19 Year Old Males*



*Source: Interagency Forum on Child and Family Statistics, 2005.

Latino's comprised 27% of Connecticut's incarcerated individuals though they made up only 9% of the general population of the state in 2000.

Table 4 | Age-Adjusted Death Rate For Homicide In CT, 1993-1997*

Ethnicity	Deaths	Age-adjusted Death Rate**	Relative Risk***	Excess Deaths***
White	121,578	49,847	47%	28%
Latino	139,529	44,649	44%	45%
African American	71,538	19,315	43%	69%

* Source: Hynes et al., 1999

** Includes American Indians (AI) and Alaskan Natives (AN).

*** Includes persons of two or more races, native Hawaiians, Pacific Islanders.

students were more likely than non-Latino whites or African Americans to have recently used alcohol, tobacco and other drugs, especially in districts that were classified as 'homogeneous' or predominantly Caucasian. They conclude that 'Patterns of use (among students) mirrored those of the dominant racial/ethnic group in the district and Hispanics appear to be strongly influenced by the behaviors of their non-Latino white peers (Cook et al., 2001).'³

The authors of the Connecticut study suggest: "Given the large Puerto Rican constituency in the state, the prevalence of substance use among the Hispanic population is not surprising. Studies have shown that the Mexican-American and Puerto Rican substance use levels mirror and often exceed those of non-Latino whites. In light of the racial and ethnic differences in (substance) use, it is imperative that prevention and treatment programming be culturally appropriate (Cook et al., 2001)".

■■■ INCARCERATION & CONNECTICUT LATINOS

Latinos are overrepresented in Connecticut's prison and jail population. In 2000, they comprised 27% of Connecticut's incarcerated individuals though they made up only 9% of the general population of the state (Wagner, 2004). In 2001, Connecticut's prison population increased at three times the rate of the national average, the third greatest prison population jump in the country. This is most likely due to the growing number of people serving prison sentences for drug-related crimes: from 1990 to 2002, the percentage of those behind bars for drug offenses increased by 135% (CT Alcohol & Drug Policy Council, 2005; Harrison and Beck, 2003).

Notwithstanding their high poverty rate and other difficult conditions, Latinos will play an increasingly important role in the economic and social progress of Connecticut. Presently, Latinos account for 9% of the state's labor force (Hall and Geballe, 2004); Latino-owned businesses have increased by 43% since 1997 (U.S. SBA, 2005); and Latino purchasing power in Connecticut was estimated to reach \$7.5 million in 2005 (Selig Center for Economic Growth, 2000). Coupled with the projected Latino population growth rates, these factors indicate that ignoring the important

contributions Latinos make to Connecticut's labor market will have serious negative consequences for Connecticut's economy.

Latinos will play an increasingly important role in the economic and social progress of Connecticut. Presently, Latinos account for 9% of the state's labor force; Latino-owned businesses have increased by 43% since 1997; and Latino purchasing power in Connecticut was estimated to reach \$7.5 million in 2005.



ACCESS

TO QUALITY CARE

Latinos in Connecticut face a number of significant impediments to accessing health care. Lack of health insurance coverage has been widely documented as one major barrier. However, insurance coverage does not guarantee access to quality care.

Latinos in Connecticut experience a web of barriers to accessing and utilizing care and barriers to receiving quality care within the health care setting, that result in:

- Delayed health care utilization until health conditions are more advanced and more costly — to them, their communities and the state as a whole and
- Incorrect follow-through on health instructions and referrals, stemming from misunderstandings and resulting in inadequate self care and disease management.

This chapter presents an overview of the factors affecting access to care. Subsequent chapters describe critical barriers to accessing and utilizing health care in the context of the health conditions that are either caused and/or exacerbated by those barriers.

The World Health Organization ranks the U.S. 37th in the world in overall health care quality.

HEALTH INSURANCE COVERAGE

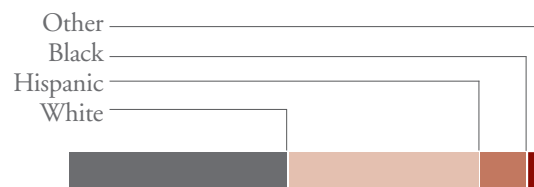
Universal Health Care is a system of health care that provides high quality care at an affordable cost and leaves no one out (www.universalhealthct.org). While the United States is the wealthiest country in the world and spends more per capita on health care than any other country, it lacks a universal health care system, and is far from meeting the terms of its definition. In fact, the World Health Organization ranks the U.S. 37th in the world in overall health care quality (Conyers, J., 2003). In 2004, nearly 16% of the U.S. civilian, non-institutionalized population, lacked health insurance and it is estimated that an additional 8% are underinsured — that is, insured but failing to see a doctor because of insufficient coverage and additional cost. In fact, in the U.S., 3/4 of those who have difficulty paying their medical bills have some form of insurance (Centers for Disease Control and Prevention, 1998).

Widespread lack of health insurance is arguably one the most urgent health problems facing Latinos today, contributing to poor health outcomes and premature death. Connecticut has one of the lowest ‘un-insurance levels’ in the country, the eighth lowest in the nation and the sixth lowest among the employed, with about ten percent of the adult population lacking health insurance (Robert Wood Johnson Foundation/RWJF, 2005). However, as shown in Figure 3, lack of health insurance coverage is higher for Latinos than for any other major ethnic population in the state.

Widespread lack of health insurance is arguably one of the most urgent health problems facing Latinos today, contributing to poor health outcomes and premature death. Connecticut has one of the lowest ‘uninsurance levels’ in the country, the eighth lowest in the nation, and sixth lowest among the employed.

While Latinos represent 9% of Connecticut’s residents, they account for a staggering 40% of Connecticut’s uninsured population. In addition, the uninsured rate among Latinos shows no signs of abating. In fact, the percentage of Latinos who are insured in Connecticut actually declined from 87% in 1997 to 76% in 2000. The proportion of Latinos participating in Medicaid plans also declined from 18% in 1997 to 14% in 2000 (Center for Research and Public Policy/CRP, 2002).

Figure 3 | Uninsured in Connecticut by Race and Hispanic Origin, 2005*



*Source: Connecticut Office of Health Care Access, 2005

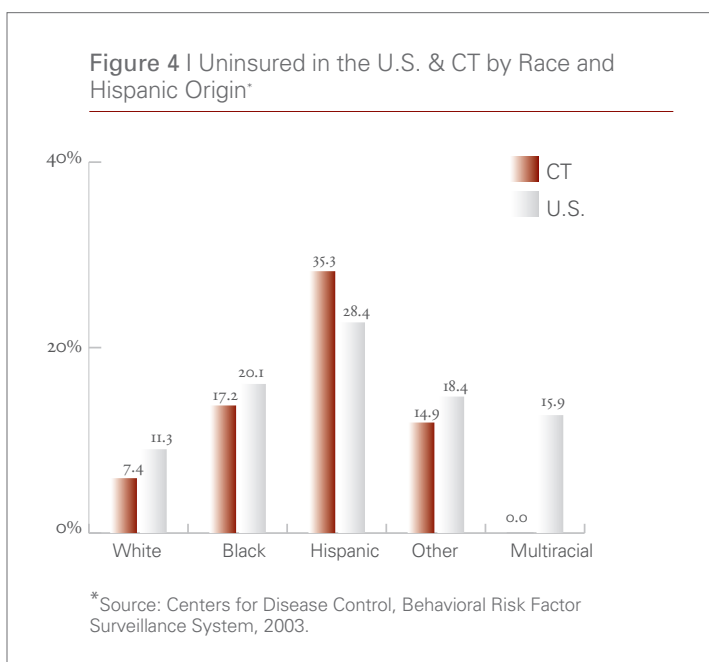
Almost one in four individuals earning under \$25,000 does not have health insurance in the state. This figure includes many working poor, self-employed, and unemployed. People who do not finish high school are more than five times less likely to have health insurance than individuals who graduate from college (McMillen et al., 2004).

Lack of Employer-Sponsored Insurance (ESI) programs and permanent employment opportunities are two of the factors fueling the number of uninsured Latinos. Even when ESI was available, 40% of employed Latinos did not hold a permanent, full-time position, and therefore were less likely to qualify for ESI (OHCA, 2005A, 12). A report prepared for the Commonwealth Fund (Ditsler et al., 2005) goes on to describe that this situation has particularly grave implications for nonstandard workers (“those in part-time, temporary, or contract positions”):

“After slowing briefly in the mid-1990’s, health costs have risen sharply... The foundation of employment-based health insurance has continued to crumble as fewer employers offer coverage and those who do have shifted more costs to their workers. In addition, even as the ranks of uninsured continue to grow, a persistent fiscal crisis has pressed many states to constrain public coverage. Circumstances are particularly dire for nonstandard workers, who often lack job security and a stable employer-employee relationship. Indeed the characteristics of nonstandard work, like low wages and a hands-off employment relationship, make it inherently difficult for these workers to either take advantage of group-based solutions or buy into non-group options.”

In Connecticut, Latinos earn a per capita income of only \$13,123 (U.S. Census Bureau, 2000a) and represent the highest poverty rate of any racial/ethnic group (32%). In this context, when health care is not employer-sponsored, it is simply unaffordable to many Latino families (KFF, 2002c). In 2004, the average health insurance premium for a family of four was \$8,788 per year, representing 23% of the Latino median family income in Connecticut (McMillen et al., 2004).

The effects of ‘uninsurance’ on the quality of life of Latinos are profound. National indicators show that uninsured Latinos are two to three times more likely to go without needed health care, resulting in higher rates of preventable disease and premature death (Rios, 2001). Figure 4 indicates a correlation between lower rates of insurance coverage and lower rates of health care service utilization among Connecticut’s Latinos.



A survey conducted by the Center for Research and Public Policy showed that 25% of Latinos were unable to afford a doctor’s visit when they needed one in the past year (CRP 2000, 15). More recently, the Robert Wood Johnson Foundation (2005) reported that: nationally, 37.7% of uninsured Latinos are unable to see a physician at a time of need compared to about 10% of insured Latinos. The Connecticut Office of Health Care Access (CT OHCA, 2002) household survey on health care access found that 9% of people who lacked health insurance did not receive emergency care when they needed it during 2000.

The costs of lack of insurance coverage are significant. It is estimated that Connecticut loses between \$584 million and \$1.164 billion annually due to increased morbidity and mortality from preventable diseases among the uninsured (McMillen et al., 2004). Such preventable disease is not evenly distributed but tends to cluster among the poor and ethnic minorities. Disparate rates and experiences with a number of health conditions are highlighted later in this document.

Not surprisingly, survey findings indicate that lack of health insurance is a major concern for Connecticut's Latino residents and leaders alike; 75% of Latino residents and 90% of Latino leaders reported lack of health insurance to be one of their top ten concerns (CRP 2000, 13). This critical issue, lack of insurance coverage, is disproportionately experienced by Latinos in Connecticut, who subsequently experience disproportionate impact on their access to health services and their health outcomes.

■■■ CULTURAL AND LINGUISTIC ISSUES IN ACCESS TO CARE

Growing awareness of the impact of cultural and linguistic barriers to health care has resulted in federal requirements for culturally and linguistically appropriate care, and initiatives in many parts of the country intended to address these issues. There is still much work to be done for Connecticut's health care system to fully meet these mandates.

The landmark Unequal Treatment report of the Institute of Medicine report includes among sources of health disparities: “cultural and linguistic barriers in health care settings” and “disparities arising from the clinical encounter, possibly due to bias, uncertainty or stereotyping.”

The Office of Minority Health (OMH) of the U.S. Department of Health and Human Services has established National Standards on Culturally and Linguistically Appropriate Services (CLAS). CLAS Standards regarding Culturally Appropriate Care are not mandated, but are recommended by OMH for adoption as federal mandates. They include the assurance that health care staff from all disciplines receive ongoing training in culturally and linguistically appropriate service delivery.

Culture is a broad term with multiple interpretations; thus the education and training provided to staff of health care institutions is varied in its content. In recent years, there has been growing awareness that limiting training to what has commonly thought of as ‘culture’ runs the risk of ignoring some of the most important sources of the stereotyping referred to in the Institute of Medicine (IOM) report.

Training approaches have begun to use a broader definition of culture, one that includes economic class, gender, race, ethnicity, disabilities, sexual orientation, social class, literacy, language, age and spirituality.

Such training requires profound conceptual exploration and personal reflection, and is therefore process-rich and time consuming. A challenge to the adequate training of Connecticut's health care professionals and students is the lack of time within busy clinical work days and packed academic curricula to effectively deliver this content.

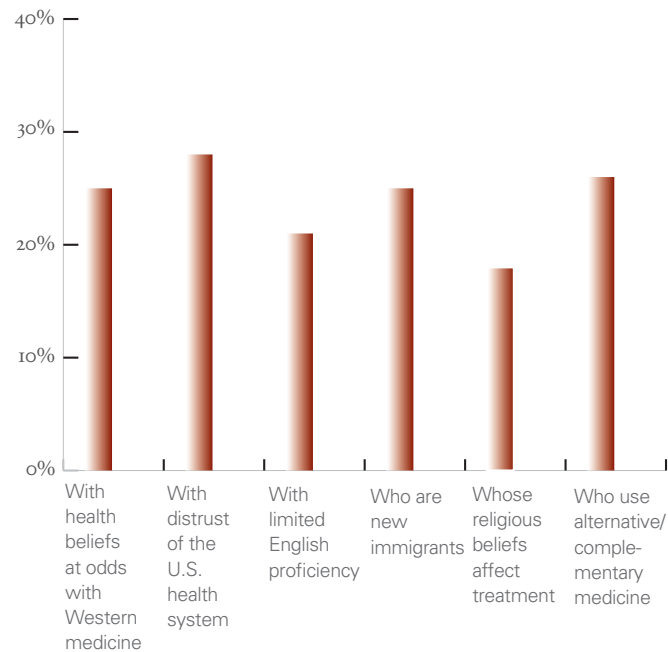
Among the barriers to quality health care experienced by Connecticut's Latinos, language is one of the most serious. The Commonwealth Fund (Doty, 2003) found that 44% of Latino adults report that they usually or at least sometimes have a hard time speaking with or understanding a doctor because of language issues. Indeed, of all ethnic groups, Latinos, especially Spanish-speaking Latinos, are the most likely to report problems understanding and communicating with a physician. A study on access barriers to health care for Latino children indicated that 25% of parents surveyed indicated that the inability to communicate in the same language with their doctors was the single largest barrier to getting health care for their children (Flores et al., 1998).

Poor health outcomes often result when Latino patients see language discordant doctors. These patients are more likely to omit medication, miss office appointments and rely on the emergency room for care (Carillo et al., 2001). Conversely, language concordance between physician and patient has a positive impact on health behaviors.

A study conducted at the General Medical Practice of the University of California, San Francisco, found that Spanish monolingual patients whose physicians spoke Spanish had better recall of their physician's recommendations and asked more questions during their visit than their counterparts seen by non-Spanish speaking clinicians (Perez-Stable et al., 1997).

As noted in Figure 5, 22% of physicians report being unprepared to treat patients with limited English proficiency, a problem that is further exacerbated by the lack of language interpreter services in health settings. Generally, it is estimated that only half of Latino patients needing interpreter services actually receive them (Latino Commission on AIDS, 2001), although cost estimates by the U.S. Office of Management and Budget (OMB) indicate that language services would only add \$4.04 to the average cost of a health care visit (U.S. OMB, 2002). Especially rare is the availability of a trained medical interpreter, even though when such an interpreter is available Latinos report that their ability to understand a doctor's instruction goes up by 70%. Undoubtedly, health care institutions limit opportunities for patient education and treatment compliance when they fail to recognize and address the needs of their limited English proficiency patients. This is particularly important in Connecticut where 268,045 Latinos (over five years of age) or 8% of residents report speaking Spanish at home (U.S. Census Bureau, 2000b).

Figure 5 | Percent of Resident Physicians Very Or Somewhat Unprepared to Treat Patients... 2005*



*Source: Connecticut Office of Health Care Access, 2005

Unfortunately, as Hofmann and Hooper (2001,17) note, “The ability of Connecticut’s health care providers to communicate with non-English speaking people is very limited.” The lack of Latino physicians in Connecticut poses an especially difficult challenge; 2002 estimates indicate that there are only 235 nonfederal* Latino physicians in the entire state of Connecticut accounting for 2% of the state’s physicians (12,742) (KFF 2002e).

OMH Culturally and Linguistically Appropriate Services Standards mandate Language Access Services, including requirements for free language assistance services, including bilingual staff and interpreter services, at all points of contact, in a timely manner during all hours of operation, and the provision of competent language assistance by trained interpreters and bilingual staff. (OMH, 2000). According to the Connecticut Health Foundation report, *Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients*:

Approximately 5% of Connecticut’s residents are of limited English proficiency (LEP).

About 49% of low-income Spanish-speaking Connecticut residents have LEP.

More than 22,000 people with LEP were enrolled in the state’s Medicaid program in 2003, and used about 5% of the program’s health services.

- About half of these low-income, LEP Connecticut residents speak Spanish.
- Health care providers are not aware of those medical interpretation services available to their patients.
- It is feasible for the medical interpretation to be funded through the state’s Medicaid Program.
- A work group is needed to raise awareness of the need for and availability of interpreters, and to create an effective system for implementing an interpretation system across provider types.

In summary, the growing number of uninsured Latinos and the persistent lack of access to culturally and linguistically appropriate health care services are fueling a health crisis within Connecticut’s Latino population that is likely to worsen without substantial reforms in provider recruitment/training and health policy and practice.

HEALTH LITERACY

Health Literacy is defined by Healthy People 2010 as “the degree to which individuals have the capacity to obtain, process and understand basic health and services needed to make appropriate health decisions”. Health literacy skills are needed by all people to, for instance, find their way in a hospital, fill out insurance medical and insurance forms and communicate with medical providers (Health Literacy).

In the years since the first *Current Bibliographies in Medicine* on health literacy was released, national interest has grown on this topic.

At the core of this growing interest is the realization that more than 90 million people in the United States struggle to understand basic health information (CBM, 2004-1).

Examples of this are illustrated in a public hospital research study that found one third of English-speaking patients could not read basic health materials, more than a quarter couldn’t read appointment slips and 42% did not understand labels on prescription bottles (Health Literacy).

Evidence of the disproportionate challenges to obtaining adequate health literacy experienced by Connecticut’s Latinos is documented throughout this report. The challenge of improving health literacy among Latinos must be addressed with an approach that takes systemic and individual factors into account.



LATINO HEALTH

THROUGH THE LIFE SPAN

The health inequities experienced during critical stages of the life cycle dramatically reflect the failure of our public health, and socio-economic systems to protect the health of those most vulnerable. This chapter describes inequities experienced by Latinos in Connecticut during those critical times in the life cycle.

Fertility and Birth Rate

Latinas have the highest fertility and birth rates of any group and account for nearly 19% of all U.S. births. This results in a comparatively young Latino population with nearly 40% under the age of 20. The median age for Latinos is 25 years, compared to the median of 36 years for the U.S. population as a whole (Mosaic and EDC Report, 2004). Subsequently, the percent of families with children is 57% for Latinos, and 31% for non-Latino whites. Nationwide, the number of Latino children under age six is 13% of the Latino population compared to 7% for non-Latino whites. In Connecticut, these rates are 13% and 7% respectively (AECF Pocket Guide, 2003). The relatively young age of this population group, combined with the relatively greater proportion of families with young children, implies a more intensive need for maternal and child health services.

Latinas have the highest fertility and birth rates of any group and account for nearly 19% of all U.S. births.

Prenatal Care

In 1998, Latinas gave birth to 6,178 babies in Connecticut. In nearly 20% of these cases, there was late or no prenatal care, compared to only 8% among non-Latino births (Mueller and Hynes, 2005). Notably, in 2002, Latinas were still the ethnic group most likely to be late in entering prenatal care — a rate that climbed to almost four times that of non-Latino white women. While in 2004, 84% of pregnant women in Connecticut received adequate prenatal care, pregnant Latinas in Connecticut were least likely to receive prenatal care during their first trimester (77%) as compared to African American (82%) and non-Latina white women (92%), thereby increasing the risk of infant mortality and low birth weight infants (United Health Foundation, 2005; KFF, 2004a).

Teen Pregnancy

Adolescent pregnancy is considered a risk factor for the health and well-being of the mother, baby and rest of the family, as well as the community and population at large.

The United States has the highest teen pregnancy rate of all developed countries, approximately five times that of Germany and France and double that of the United Kingdom. Latinos currently have the highest teen birth rate.

In the U.S., about one million teens become pregnant each year; 95% are unintended and almost $\frac{1}{3}$ end in abortion (CT DPH, 2002). The overall teen pregnancy and birth rates have declined dramatically in recent years, from 62 births per 1,000 females age 15-19 in 1991, to 41 per 1,000 in 2004 (Child Trends, 2006).

The reduction in teen pregnancy rates for Latino teens has lagged behind that of other ethnic groups. Although historically it has not always been the case, Latinos currently have the highest teen birth rate. In 2004, for every 1,000 female teens between the ages of 15 and 19 there was the following number of pregnancies: Asians – 17.3, Non-Latino whites – 26.7, American Indians – 52.5, Non-Latino African Americans – 63.1, and Latino teens – 82.6. Teen pregnancy rates for Latinos of Mexican descent vs. Puerto Rican descent were 93.2; and 60.8 respectively (Child Trends, 2006). In 2004 in Hartford:

There were 428 births to teens, down from a high of 747 in 1990, but up from 406 in 2003.

20% of all births were teen births, down from a high of 29% in 1994, but up from a low of 19% in 2003.

The rate of births to mothers under the age of 15 was 7%, down from 15% in 1994, but up from a low of 7% in 2003 (Breaking the Cycle, www.teen-pregnancyhartford.org).

■■■ CONSEQUENCES OF TEEN PREGNANCY

Teen parents are generally more disadvantaged than other teens, both before and after becoming parents, and are generally unprepared for the financial, psychological and social responsibilities of becoming parents. Teen parents are also more likely than other mothers to be high school drop-outs and single parents, which could greatly impact their earning potential, household financial health, and support systems. Research on the consequences of teen pregnancy suggest that teen births are more likely to be premature and low birth weight, and therefore at greater risk of long-term health and developmental problems as well as infant death. These children generally have a less stimulating home environment, poorer academic outcomes and higher likelihood of becoming teen parents themselves. One study indicated that children of teen mothers did worse on math and reading scores, language and communication skills, social skills, and physical and emotional well-being than children of older mothers. (Child Trends, 2006).

The rapid growth of the Latino population in the U.S. is expected to be even more dramatic among Latino teens, with a projected 50% increase by 2025, compared to 6% for the overall teen population. Latino teens now make up about 17% of the U.S. teen population, and are expected to make up 24% in 2025.

Due to the combination of the growing population of Hispanic teens and its relatively high rate of teen pregnancy, a focused effort towards addressing the specific needs of this population regarding pregnancy prevention is needed (Ryan, et. al., 2005).

Birth Outcomes

Infant mortality (IM) is the measure of the yearly rate of deaths in children up to one year of age (Hazelwood, 2003). The overall Infant Mortality Rate (IMR) for the U.S. in 2004 was 7, greater than the IMR of 12 other countries, including: Hong Kong, Japan, Sweden, France, Germany, Spain, Czech Republic, Italy, Canada, Australia, United Kingdom and Cuba. The U.S. goal for reduction of IMR is 5 deaths per 1,000 live births. (United Health Foundation, 2005).

For many women of child bearing age, pregnancy is the only time they receive regular health care. Pre-conceptional Care is an essential element toward improving birth outcomes, as it provides women with wellness oriented care and a focus on reducing or eliminating risk factors that could affect pregnancy outcome before a conception takes place.

These figures indicate the following important contrast: nationwide, the IMR for Latinos is lower than the rate for the U.S. population; in Connecticut, the IMR for Latinos is higher than the IMR for the general population in the state and nationwide. More specific data is available in Tables 5 and 6 (on the next page) on the 2001 Infant Mortality Rates (Matthews, Menacker, MadDorman, 2003).

This apparent contradiction is in fact a reflection of the differences between Latino subgroups in the United States, and points out the danger of generalizing about the health of Latinos based on nationwide figures that disproportionately represent Latinos of Mexican descent. The majority of Latinos in Connecticut are Puerto Rican, and health indicators of the Puerto Rican population tend to indicate worse health status than that of other Latino groups.

Infant mortality is considered a sensitive indicator of overall community well-being. The majority of infant deaths are related to the life circumstances and health status of the mother before conception and throughout her life. Factors related to many infant deaths include: lifelong health care access, nutritional status, exposure to trauma and racism, addiction, socio-economic status and others (Matthews, Menacker, MadDorman, 2003). Therefore, solutions must be developed at the community level and beyond, not just the individual or clinical level. In order for preconceptional care to be possible on a broad scale, health care coverage would have to be available to women of reproductive age, who are not pregnant. Universal health coverage is an important component to the further improvement of birth outcomes among Latinos.

Table 5 | 1998 IMRs for the U.S. and CT, by ethnic group*

Ethnicity	U.S.	Connecticut
Total	7.2	7.0
African Americans	13.8	16.7
Latino	5.8	9.6
Asian/Pacific Islander	5.5	NOT REPORTED
American Indian	9.3	NOT REPORTED
Non-Latino White	6.0	5.7

*<http://www.cga.ct.gov/aaac/Documents/Health%20Disparity.pdf>, Healthy People 2010: Selected Health Disparity Areas.

Child Health

As is reflected in the Infant Mortality Rates reported in the previous section, tragic inequities in the health of Connecticut's Latino children are experienced very early in life. Other inequities affecting Latino children reflect conditions that were in place long before they were conceived, and will impact their well-being long into their futures.

In 2001, the Latino Consortium of the American Academy of Pediatrics Center for Child Health Research, assembled 13 expert panelists to identify the most urgent priorities and unanswered questions in Latino child health (Flores et al., 2002). The panels reviewed available studies and drew the following conclusions.

Latino children are at high risk for school dropout, environmental hazards, obesity, diabetes mellitus, asthma, lack of health insurance, non-financial barriers to accessing health care, and impaired quality of care.

Latino children are at high risk for behavioral and developmental disorders, although much remains unclear about the mental health needs of Latino children.

The prevalence of dental cavities is disproportionately greater for Latino children than other children, although the causes for this disparity remain unclear.

Culture and language profoundly affect Latino children's health, and there is inadequate cultural competency training provided to health care professionals.

Latinos are underrepresented at every level in the health care professions, including pediatrics, further lowering the likelihood of culturally and linguistically appropriate care for this population (Flores et al., 2002).

In Connecticut, the following data are available on the health of the state's Latino children. Only 71% of Latino children are fully vaccinated by two years of age as compared to 80% of non-Latino white children and 78% of African American children (Flores and Zambrana, 2001). Latinos also account for 39% of all reported childhood

Table 6 | National IMRs of 2001 by subgroup*

	IMRs
U.S.	6.8
Latinos	5.4
Puerto Ricans	8.5
Mexicans	5.2
Cubans	4.2

*Matthews, Menacker, MadDorman, 2003.

cases of tuberculosis, a rate 13 times higher than for non-Latino whites (Flores and Zambrana, 2001). In a study of preschool children hospitalized for asthma, Latino children were found to be seventeen times less likely to receive a nebulizer at the time of discharge as compared to non-Latino white children (Flores and Zambrana, 2001). Latino children are five times more likely to experience unintentional injury than non-Latino white children. In fact, the leading causes of morbidity and mortality for Latino children are: pedestrian injury, motor vehicle accidents, drowning and poisoning. The death rate due to motor vehicle accidents was 72% higher for Latino children than for non-Latino white children (Flores and Zambrana, 2001).

A national survey (National Pediatric Surveillance System, 2002) conducted annually to monitor the health of low-income children found the following. The rate of low birth weight among low-income Latino children in Connecticut was lower than the rate for the overall population of low-income children in the state, but higher than the rate for low-income Latinos nationwide, low-income children nationwide and the overall U.S. rate. The rate of overweight for low-income Latino children in the state was higher than for all other groups, and more than doubles the rate for all U.S. children.

Access to Quality Health Care Among Latino Children

Child health experts recommend that all children receive periodic well child visits, with specific protocols for provision of services designed to detect and treat health and developmental problems before they become serious. For low-income children insured by HUSKY A, these well child care/preventive services are provided in a comprehensive benefit package known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT). States receiving federal funds for Medicaid are required to demonstrate that 80% of their enrolled children receive health care according to EPSDT protocols. Despite these professional recommendations and federal requirements, annual well child care usage rates for young children have declined steadily to less than 50% of children enrolled in HUSKY A by six years of age (CT Voices Children Report, 2006). In response to this situation, and to dissatisfaction with its impact on the quality

of care that they were able to provide to their patients, pediatric leaders in the state initiated a year-long assessment process that revealed a number of system-wide concerns. One of the recommendations resulting from this process was for a systemic solution that would integrate outreach and care coordination services into the clinical provider sites and the communities that they serve. The recommended system would provide the resources and infrastructure needed to locate hard-to-reach families, and to provide support and services to educate, assist and empower parents in taking health-related action for their children. H.O.M.E. — Health Outreach for Medical Equality — is the pilot program currently being implemented in Hartford to develop the recommended service model.

Table 7 | Comparison Of Key Indicators Of Child Well-being In Hartford*

Key indicators presented as percent of total births	Hartford	Connecticut	Average of 50 cities with highest levels
Births to teens	19	7	13
Births to girls who were already mothers	21	16	22
Births to unmarried women	77	29	43
Birth to mothers with less than 12 years of education	37	12	27
Mothers receiving late or no prenatal care	5	2	5
Births to mothers who smoked during pregnancy	8	7	9
Low-birth weights (<5.5 lbs.)	12	8	9
Preterm births (<37 completed weeks of gestation)	13	10	13

Source: Annie E. Casey Foundation, 2005.

Adolescent Health

For most in Connecticut, the teen years tend to be healthy ones, at least compared to later years in life. Yet there are many risks in our society to the lives and well-being of adolescents, risks that often have far reaching consequences. Indeed, as Connecticut Voices for Children points out, “Half of all adult deaths are attributable to behavior that has its origins in youth” (Canny et al. 2002, 12). Given their comparatively poorer socioeconomic status and life prospects, it is not surprising that many Latino teens experience multiple threats to their health and engage in risky behaviors including early involvement in sexual activity and drug use. They are significantly more likely to

experience unintentional injuries and behavioral health problems than their non-Latino white counterparts. Young Latino men in Connecticut have a higher statistical risk of being murdered than non-Latino white teens, and young Latinas have the highest likelihood of becoming pregnant and bearing children while still teenagers than any other group of adolescents (Hynes et al., 1999). See Table 8 for teen birth data.

Elderly Latinos

One of the most dramatic changes worldwide is the growing population of older adults. Increases in the elderly proportion of the population are attributed primarily to decline in birth rate and death rate. Percent of elderly in the overall population has important implications for the economy and for health planning.

People over the age of 65 make up approximately 13% of the population in the United States. This figure is projected to increase to 20% of the population by 2050. Similarly, the percentage of persons over age 85 is anticipated to grow from 1% of the population in 1990 to 5% of the population in 2050 (Shippensburg Univ., 2005).

Connecticut ranks eighth in the country for percentage (14%) of population over age 65. This translates to 439,935 individuals, 162,931, or 37%, of them with a disability. In Connecticut, there are 18,898 grandparents responsible for care of grandchildren (U.S. Census, 2000). Growth in the elderly population is anticipated among all ethnic groups, but at varied levels, as noted in Table 8.

Table 8 | Projected Increase in Percent of Population 65 Years & Over (nationwide)

Ethnicity	1990	2050	% Change
All races	13	23	83%
Non-Latino White	13	24	77%
African American	8	20	147%
Asian Pacific Islander	6	19	227%
Latino	5	16	205%

Source: *An Aging Society*, On-line <http://www.ship.edu/~sfmade/ebook/agingsociety/chap1.html>

Based on the above data, the anticipated increase in the percent of elderly in the Latino population is one of the highest — second to only Asian/Pacific Islanders. However, the anticipated 2050 percent of elderly Latinos (to overall Latino population) would still be the lowest of any ethnic group. This contrast is reflective of the relatively young current Latino population, relatively high birth rate, anticipated growth in the number of teens with a high teen pregnancy rate.

Despite recognition of the aging of American society in general, there is comparatively little research on the health and health care needs of elderly ethnic minority populations, including Latinos. Nationally, studies have shown that Latino elderly, on average, experience earlier and more functional declines compared to the overall elderly population in the U.S. (Randall, 1999).

Latinos age 60 and older have a greater prevalence of difficulties in daily living, and they are also less likely to fully recover from health problems that limit physical functioning compared to non-Latino whites. Some researchers have argued that among Latinos, physical aging tends to precede chronological aging, leading to a situation in which Latinos in their late 40's have health profiles that are similar to non-Latino whites older than 60 years of age (Randall, 1999).

As a result of these factors, as well as traditional Latino cultural beliefs about the responsibilities of the young to care for the old, Latino elderly may be more dependent on their children, both physically and emotionally, than non-Latino white seniors (Lopez and Yzaguirre, 1992). The Pew Hispanic Center (2002) study of experiences and attitudes in the U.S. Latino population, for example, found that across all country-of-origin Latino subgroups people were much more likely to agree than disagree with the following sentence: "Elderly parents should live with their adult children." Notably, acculturation had an important impact on this attitude, with Spanish-dominant individuals being more likely to strongly agree with this sentence than bilingual individuals, who, in turn, were more likely to strongly agree than English-dominant Latinos.

According to the National Hispanic Council on Aging (NHCoA), a national agenda for action on issues concerning Latino elders is urgently needed. NHCoA convened a leadership roundtable to identify strategies and solutions for critical issues affecting the Latino elder population. Based on the roundtable proceedings, 10 resolutions were submitted to the White House Conference on Aging in December, 2005. These include the following:

- Remove disincentives in Supplemental Security Income (SSI) that discourage cohabitation with family members.
- Amend the National Family Caregiver Support Program (NFCSP) so that more Latino families providing care giving will benefit from the program.
- Modify Medicare policies to meet the needs of the older Latino community.
- Provide funding for community based programs that provide respite services for elderly Latino populations.
- Review current Area Agencies on Aging and SHIP programs for orientation and outreach to Latino populations.
- Develop a federal research agenda for aging Latino populations as a priority.

In light of the high level of poverty and low level of education among Connecticut's Latino population, without changes in educational and income opportunities, the future scenario could be an even lower-income population with disproportionate age concentration at three vulnerable times in the life cycle: young children, adolescent/pregnant adolescent, and elderly. Furthermore, as Connecticut's Latino population ages, the prevalence of health issues associated with aging is likely to increase. The time is now for planning regarding needed services targeting this population.



ASTHMA

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

According to a report by the American Lung Association, in 2005 the number of Americans with asthma was close to 18 million. It is estimated that asthma costs the United States a total of \$16.1 billion a year through a combination of direct medical costs and lost productivity (American Lung Association, 2006).

Although the national asthma prevalence rate for Latinos is lower than that for non-Latino whites or African-Americans, this varies within Latino subgroups. Studies have suggested that Puerto Ricans may have higher rates of asthma than other Latino subgroups and non-Latino whites (American Lung Association, 2006). Asthma is so prevalent among Puerto Ricans in Hartford that a variety of folk treatments have developed, including breathing exercises and rubbing the child's chest to promote relaxation (Pachter et. al., 1995; Guarnaccia et. al., 1985).

The Connecticut Department of Public Health regularly conducts the telephone-based Behavioral Risk Factor Surveillance System (BFRSS) to assess health issues in the state. Overall, asthma is much more common among children than adults. Findings on adult asthma for 2001 (Miskell et al., 2003), show that adult asthma is higher in urban areas than in rural areas, much more common among families with a household income under \$25,000 compared to those with higher income, and a significant factor in ability to work.

Frequency of asthma varies by location in Connecticut. Rates have been found to be particularly high in Hartford, leading the Hartford City Council to declare an "asthma emergency" in the city. The Hartford Health Survey from the year 2000 (Hartford Health Dept., 2000) found the citywide average of self-reported asthma in adults to be 15%. An examination of this rate by ethnic group shows that rates were 22% among Latinos compared to 13% among African Americans, 12% among non-Latino whites, and 1% among West Indians. In the Hartford Health Survey of 2003 (Hartford Health Dept., 2003), the Latino rate stayed the same while the non-Latino white rate dropped to 10%.

Notably, a city-wide, door-to-door survey of 413 households that was designed to collect data on both physician-diagnosed asthma and respondent-reported signs and symptoms of asthma (Mitchell and Lipsett, 2001), found even more striking asthma rates in Hartford.

In a study of preschool children hospitalized for asthma, Latino children were found to be 17 times less likely to receive a nebulizer at the time of discharge as compared to non-Latino white children.

These researchers reported that 41% of Latino households had at least one household member suffering from asthma or asthma symptoms, compared to 36% of African American households, 15% of non-Latino white households, and eight percent of West Indian households. Similarly, a comprehensive physician screening of 11,000 children living in Hartford found alarming high percentage of children screened have asthma. Low-income Latino families that have young children with asthma lack the necessary information, training in asthma management, and medical resources for good asthma control (Berg et al., 2004).

The disparities in asthma rates and treatment for children of different ethnic groups in Connecticut provide compelling examples of the disproportionately high rates among Latino children. A study by Connecticut Voices for Children of children ages 21 and under showed asthma rates of 11% for Latinos, compared to 9% for African Americans and 8% for non-Latino whites (CT Voices Children Report, 2006).

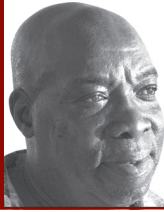
In a study of hospitalization rates between 1992 and 2000, hospitalization rates for Latino children in Connecticut were consistently about 5 times higher than for non-Latino white children.

Data on hospitalization and emergency room visits for asthma, collected from all acute-care hospitals in Connecticut (Miskell et al., 2003), indicate that the asthma hospitalization rate for children in Connecticut's five largest cities — the places Latinos tend to be most concentrated in the state — is higher than for the state as a whole and for the nation.

The problem, however, is not simply one of inadequate education by the Health Care system of Latino parents in asthma management. The Childhood Asthma Severity Study, which surveyed 1,002 children and their families in Connecticut and Massachusetts, found that Latino and African American children were given fewer beta2-agonists (a standard component of asthma management), and Latino children received fewer inhaled steroids than non-Latino white children (Ortega et al., 2002).⁴

Even among Latino children in private care, there was a significant association found between Latino ethnicity and low use of inhaled steroids. The researchers concluded that programs at the site of care and at home are urgently needed to eliminate disparities in asthma treatment among Latino children.

Clearly, Latinos in Connecticut suffer disproportionate rates of asthma and of inadequate asthma management. A full understanding of the reasons behind these inequities, and development of solutions based within the health care system, and in the community, are urgently needed.



DIABETES

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

Type 2 diabetes is the sixth leading cause of death in the United States. The prevalence of diagnosed diabetes increased 49% from 1990 to 2000, and is expected to increase 165% from 2000 to 2050. The health and economic impact of diabetes is extensive.

In the U.S., Type 2 diabetes is the leading cause of blindness, kidney failure, foot amputation and complications in pregnancy. People with diabetes are likely to have two to four times higher rates of heart disease and stroke. Overall the risk of death for people with diabetes is about twice that of those without diabetes (CDC, 2004b). The annual economic cost of diabetes in the U.S. is estimated at \$98 billion.

Compared with non-Latino whites, Latinos are 2 times as likely to develop diabetes, it has been found that four out of every ten Latinos are at risk for developing diabetes (Luchsinger, 2001; Thackeray, et al., 2004). Despite the higher prevalence of diabetes among Latinos, use of diabetes-related healthcare services such as annual dilated eye exams, glycosylated hemoglobin tests, self-monitoring blood glucose, doctor visits for diabetes, foot exams, and attendance at diabetes self-management classes are all lower in this population than among non-Latino whites (CDC, 2005).

A key problem facing the growing number of Latinos with diabetes is that health insurers generally do not pay the complete cost of diabetes education and counseling (Urbina, 2006). This is due to the structure of risk-based insurance businesses that do not want to attract costs by offering these services. Experts say

“... the lone hope on the horizon is a restructured reimbursement system that puts the business of chronic care on a more competitive footing with acute care. . . this restructuring could start if government insurance programs like Medicaid began paying more for preventive efforts like education, a move that the private sector would be likely to follow (Urbina, 2006).”

In Connecticut, an estimated 6% or 157,580 Connecticut adults 18 years and older reported having been diagnosed with diabetes, and an additional 63,032 are estimated to have undiagnosed diabetes. Connecticut adults with diabetes are one and one-half times as likely to be overweight, twice as likely to have high cholesterol levels and three times as likely to have high blood pressure as residents without diabetes.

A key problem is that health insurers generally do not pay the complete cost of diabetes education and counseling.

On average, 6 people are hospitalized every hour in Connecticut for complications related to diabetes. Their average stay in the hospital is four days (CT DPH, 2005a and b).

Diabetes and its complications are much more common among Latinos than in the general population in Connecticut. Compared with non-Latino whites, Connecticut's Latinos have 60% higher mortality rates due to diabetes, more than twice the risk of being hospitalized due to diabetes and diabetes-related causes, and nearly two and one-half times the risk of hospitalization for lower extremity amputation (CT DPH, 2005a and b). During the years 1999-2001, there were approximately 18 deaths related to diabetes for every 100,000 non-Latino whites compared to 26 such deaths for every 100,000 Latinos (Wilson, 2004).

The University of Connecticut's Department of Nutritional Sciences, the Cooperative Extension System, and the Hispanic Health Council collaborated to examine the characteristics of Puerto Ricans with diabetes and the barriers they confront in attempting to successfully manage this disease through the 'Diabetes Prevention Among Latinos (DIPAL)' case-controlled study of 200 Puerto Rican women (Pérez-Escamilla et al., 2004). Half of the women in the study had been diagnosed with diabetes while the control group had not. The results of the study (shown in Table 9) reflect the extreme nature of the disparities experienced by this population with regard to a variety of factors essential for adequate diabetes management, successful prevention and timely diagnosis of the disease.

Clearly, the population studied lacks some of the basic elements necessary for general good health and essential for management of a complex and potentially life threatening disease. The study indicates:

- The need for a more systematic approach to diagnosis of diabetes
- The need for access to the elements necessary for diabetes prevention, including access to high quality, low-cost food and exercise (addressed in the Nutrition section of this document)
- The need for access to comprehensive health care including primary and subspecialty providers and
- The complexity of effective diabetes management, the many gaps in the system of care, and the perceived lack of support on the part of those diagnosed with diabetes indicate the need for peer counselors to facilitate their navigation of the health care system and to reinforce clinical teaching regarding disease management and self-care between clinical visits.

The Hispanic Health Council, University of Connecticut and Hartford Hospital, as part of their partnership in the NIH EXPORT Center for the Elimination of Health Disparities Among Latinos (CEHDL), are conducting a random sample study to develop, implement and evaluate a diabetes peer counseling intervention. The peer counselors will reinforce clinical teaching in the home, with close supervision and coordination with the study's health care team. It is anticipated that the study will result in best practices recommendations and recommendations for model replication.

Table 9 | Results of the Diabetes Prevention Among Latinos (DIPAL) Study

Health Symptoms	Those diagnosed with diabetes experienced a high level of health symptoms commonly associated with inadequate management of the disease such as: excessive urination (68%), excessive thirst (54%), increased fatigue (52%) or blurred vision (61%). All control group members (those not diagnosed with diabetes) experienced many of the same symptoms (a possible indication of having diabetes).
Specialist Care	The percentages of diabetics in the study who responded that they had never seen health specialists considered important for effective disease management were as follows: dietitian (46%), podiatrist (52%), and diabetes educator (50%).
Health Insurance	Those diagnosed with diabetes were less likely than the control group to have been without medical insurance during the year preceding the survey (14% vs. 28%). Among those who had insurance, 72% were covered by Medicaid and 9% by Medicare.
Obesity	The overwhelming majority of diagnosed diabetics were overweight or obese (90%), as was true for controls (83%). Obesity is a risk factor for Type 2 diabetes, and makes diabetes management more difficult.
Food Insecurity/Hunger	Among diagnosed diabetics, 58% were food insecure with 26% living in households experiencing hunger; compared to 55% and 14% of the undiagnosed controls. Lack of adequate nutritious food compromises the ability of a person with diabetes to adequately manage the disease and to avoid major complications.
Basic Knowledge	Both diagnosed diabetics and undiagnosed controls lacked basic knowledge about nutrition that is necessary to successfully prevent or manage the disease.
Exercise	Only 35% of the total study sample reported exercising regularly.
Depression	Nearly 50% of the total sample reported symptoms of depression.
Support	Many of those with diagnosed diabetes reported that they had little family support in managing the disease.

Source: Pérez-Escamilla et al., 2004.



CANCER

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

Cancer is the second leading cause of death in the U.S., with just under half a million new cancer diagnoses each year. Notably, about half of all new cases of cancer are diagnosed among people 65 years of age and over, a group that, while growing among Latinos, is still comparatively smaller than in the general population.

National and Connecticut data on Latinos and cancer are not sufficient for an adequate description of current prevalence and mortality across types of cancer and Latino subgroups (Modiano, 1995; O'Brian et. al., 2003). Therefore, comparisons between Latinos and non-Latinos are not always possible. Comparative rates that are available vary with specific kinds of cancer and among different Latino subgroups.

National data indicate that Latinos have a lower overall cancer rate than non-Latinos. However, they do experience higher rates of certain cancers as compared with non-Latino whites: these include cervical, esophageal, gall bladder and stomach cancer (U.S. DHS, 2003). Additionally the incidence of breast and lung cancer among Latinos is rising (ACS, 2003; ALA, 2005).

Nationally, cancer is the leading cause of death for Latina females ages 25 to 54, and among Latino males ages 45 and over (Collins et al., 1999). More specific statistics regarding Latinas and breast cancer reveal their experience with inequities related to this disease:

National indicators show that Latinas have a lower rate of breast cancer (70 per 100,000) as compared to non-Latina white women (112 per 100, 000) (American Lung Association, 2005).

However, uninsured Latinas are 2 times more likely than non-Latina whites to be diagnosed with cancer at a later stage (Breast Cancer Fund).

In addition, only 38% of Latinas age 40 and older have regular mammograms that could detect cancer at its earliest stage (before clinical symptoms develop) (ICC, 2001).

The five-year survival rate for Latinas with breast cancer is only 76% as compared to 85% for non-Latino white women (ICC, 2001).

Consequently, even though overall breast cancer incidence rates are lower among Latinas than non-Latino white women, Latinas are more likely to die from breast cancer.

Even though overall breast cancer incidence rates are lower among Latinas than non-Latino white women, Latinas are more likely to die from breast cancer.

Data on cervical cancer and Latinas are only available through 1999. However, those data reveal some critically important patterns, as follows:

During 1992-1999, the incidence rate for invasive cervical cancer was 17 per 100,000 for Latinas nationally, compared to 8.9 per 100,000 for non-Latina women (Morbidity and Mortality Weekly Report, 2002).

The mortality rate for invasive cervical cancer was 4 per 100,000 for Latinas compared with 2.6 per 100,000 for non-Latino whites (Morbidity and Mortality Weekly Report, 2002).

Among Latinas, death from cervical cancer accounted for 300 cases per year, a disturbing 23% increase over the last decade (American Cancer Society, 2003).

In Connecticut, data on cervical cancer reveal the following: cervical cancer accounts for approximately two percent of invasive cancers every year and about one percent of cancer deaths (CT DPH, 1999). The age-adjusted incidence rate for Latinas was 18 per 100,000 compared to eight per 100,000 for non-Latino whites and 15 per 100,000 for African Americans (Connecticut Tumor Registry, 1999; CT DPH, 2001d).

Screening-related behavior appears to be a major factor that differentiates the cancer survival rate of Latinas from the women of other ethnic minority populations. These screening rates are generally lower among Latinas as well as lesbians, women with low income or education, and women who live in rural areas (Brownson et. al., 1998; Connecticut Tumor Registry, 1999).

In Connecticut, Latinas are less likely to have had a Pap test recently or ever than African American or non-Latina white women (Adams, 2000). In 2000, a survey was conducted in Connecticut and neighboring states among women older than 18 years of age and with intact cervix to determine how many had never had a Pap smear test and how many had not been tested within the last three years.⁵ The fact that women in Connecticut are less likely to have ever or recently been screened than women in nearby states may be tied to the higher percentage of Latinas in Connecticut and their comparatively low screening levels.

Research indicates a variety of reasons for lower cancer screening rates among Latinos. Lack of access to health care, lack of culturally safe care, and lack of awareness of early detection and cancer prevention are the leading barriers to achieving adequate cancer health outcomes (Harmon et al., 1996). Specific examples include:

Screening rates for prostate cancer among Latino men is also very low. Studies have suggested that acculturation is a mediating factor in terms of fear and lack of knowledge of cancer and cancer screening (Elder et al., 1991).

First-generation Latina migrants have higher rates of cancer, suggesting limited opportunities for appropriate health care and health care information and fragile health care infrastructures in their home countries. They also have lower awareness of health care services available to them (Huerta, 2003).

Compared to women from other ethnic groups, Latinas exhibit less knowledge about cervical cancer and cancer screening techniques, report greater levels of embarrassment during the screening procedure and exhibit great fear of cancer (Harlan et al., 1991).

Lack of health insurance, low levels of health literacy, limited English proficiency and other barriers to quality health care limit the ability of Latinos with cancer to receive and to follow through with adequate disease management outside the clinical setting. The Hispanic Health Council's DIVAS Spanish-Language women's cancer support group consistently finds that members: 1) don't understand (or follow) their medication regime and 2) address cancer after a number of other life circumstances considered more urgent to them.

As the Latino population in Connecticut ages, cancer is likely to become a more significant factor in Latino health. Higher rates of late stage diagnosis of cancer and cancer-related morbidity among Latinos in Connecticut are a direct product of health inequities suffered by the Latino population of the state.



CVD

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

Cardiovascular disease, including coronary heart disease, hypertension, and stroke, is the number one cause of death among Latinos and in the United States as a whole. These diseases, especially coronary heart disease and stroke, kill almost as many people, nationally, as all other diseases combined and they are among the leading causes of disability in the country (OMH, 2005a).

A national focus on lowering the rates of such diseases has contributed to a recent decline in heart disease in the overall population of the country. Similarly, the number of people dying from stroke has been cut by half in recent years because of improved control of high blood pressure and a decrease in smoking among adults.

Like cancer, cardiovascular and pulmonary diseases are important causes of morbidity and mortality among Latinos in Connecticut. However, because of the younger age of the Latino population compared to the general population of the state, rates of these diseases tend to be lower among Latinos. This may mask disparities, especially in particular subgroups of Latinos (e.g. by gender, or primary language). Lack of data on the treatment experiences of Latinos suffering from cardiovascular and pulmonary diseases precludes a full assessment of how Latinos experience these health conditions compared to other groups.

Comparing rates of coronary heart disease across ethnic groups at the state and national levels, the Centers for Disease Control and Prevention’s Healthy People DATA2010 database records statistics for death rates from heart disease and stroke (CDC, 2001) as noted in Tables 10 and 11.

The major risk factors for cardiovascular disease and stroke include high blood pressure, high blood cholesterol, smoking, diabetes, obesity/overweight, physical inactivity and socioeconomic status.

Table 10 | Age-Adjusted Death Rates for Coronary Heart Disease for the US and CT*

Ethnicity	National**	Connecticut**
White	201	176
African Americans	250	204
Latino	144	120
All ethnic groups	204	177

*Per 100,000 persons for all ages. Age-adjusted 1999 baseline data.

**CDC, DATA2010, 2001.

Table 11 | Age-Adjusted Death Rates for Stroke for the US and CT*

Ethnicity	National**	Connecticut**
White	60	50
African Americans	82	55
Latino	40	29
All ethnic groups	62	50

*Per 100,000 persons for all ages. Age-adjusted 1999 baseline data.

**CDC, DATA2010, 2001.

Among Latinos, the drop in the frequency of heart disease has lagged behind the rate of decrease within other groups. Nationally, about one-fourth of deaths among Latinos stem from cardiovascular conditions, and the rate is expected to rise in coming years as the Latino population ages. Latinas, in particular, are overrepresented among heart disease cases in the country (NCLR, 2001). The major risk factors for cardiovascular disease and stroke include high blood pressure, high blood cholesterol, smoking, diabetes, obesity/overweight, physical inactivity, and socioeconomic status. Most of these factors are prevalent among Latinos. For example, in Connecticut, it is estimated that 57% of Latinos are obese or overweight (KFF, 2002a). In addition, Latinos have the highest rate of cigarette smoking of any racial or ethnic group (KFF, 2002b).

It is important to note that the prevalence of heart disease and stroke and their related risk factors increases with age. As the relatively young Latino population matures over the next few decades, it is expected that heart disease and stroke will significantly increase unless Latino prevention and risk reduction health initiatives are implemented (NCLR, 2001).



BEHAVIORAL HEALTH

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

Nationally, in terms of mental health and Latinos, disparities have been identified in the areas of assessment and diagnosis, access to services, quality of care, and training and research. Less than one percent of the licensed psychologists in the U.S. report that they are Spanish-speaking and it is estimated that there are only 20 Latino mental health providers available for every 100,000 Latinos in the country (Latino Mental Health Summit, 2005).

As a result, there may be significant language and cultural barriers between Latinos and mental health care providers. For example, the 2000 Medical Expenditure Panel Survey found that Latinos were significantly less likely to fill an antidepressant prescription than were Caucasian patients (Harman et al., 2004). Poverty, generally, is known to be associated with both dropping out of mental health services as well as shorter lengths of stay in treatment (Hoberman, 1992). This relationship is especially significant for Latino children and families. (Canino et al., 1986; Sue et al., 1991). A number of mental health experts have urged that Latino mental health intervention is most effective if it is culturally appropriate (Rosado and Elias, 1993).

The need for increased attention to Latino mental health in the United States is clear. Nationally:

Twice as many Latinas (11%) report depression as African American (6%) or non-Latino white women (5%) (Rouse, 1995).

Between 1992 and 1997, Latinas nationally had a significantly greater rate of hospitalization (98 per 100,000 population, age adjusted) due to self-inflicted injuries than did non-Latino white women (72) (Hofmann and Hooper, 2001).

Twice as many Latina teenagers (21%) attempt suicide as African American (11%) or non-Latino white (10%) teenage girls.

These patterns can also be seen in Connecticut. It is not completely clear why these disparities exist, but the stresses of poverty, single parenting, and lack of health insurance may play important roles (Office of Research on Women's Health, 1998).

The disparities Latinos in Connecticut face in accessing mental health services are exemplified by the Connecticut Voices for Children's report on the state of children's mental health in the state (Geballe, 2002). While noting that data are limited, the report notes that in the state-funded HUSKY behavioral health services, for example, ethnic minorities are disproportionately underrepresented. Thus, the report points out

Twice as many Latinas report depression (11%) as African Americans (6%) or non-Latino white women (5%).

Latinos are less likely to fill an antidepressant prescription than were non-Latino white patients.

that while 62% of the children enrolled in HUSKY were Latino or African American, only 46% of the residential placements by the Connecticut Department of Children and Families in 1995 were for Latino or African American children. In contrast, about 70% of youth sent to juvenile detention were ethnic minorities (many of whom suffered from behavioral health problems). The report concludes that research is needed to identify whether these data are a consequence of disparities and what can be done to remedy the differing treatment patterns. This point applies generally: research is needed to assess the issue of disparity in Latino mental health access in Connecticut.

Information on Latino mental health in Connecticut is particularly sparse. Ana Lazu, who has since won national recognition for her work on Latino mental health issues in Connecticut, discovered this problem when she sought help for her own slide into depression.

"Like other Latinos living with mental illness, I faced a double stigma — one imposed by society, and one imposed by my culture. My language, religion and traditions are an important part of my identity, and I wanted to find services that would enable me to preserve my heritage while becoming well."

Ana Lazu

National Latino Behavioral Health Association, 2005.

Not finding such services, Lazu created Latinos Unidos Siempre, a non-profit organization that has developed expertise in providing culturally-sensitive and appropriate care to the Latino population in eastern Connecticut.

Despite the lack of statewide data, local data from various studies provide evidence of significant behavioral health illness among Connecticut's Latinos, as follows:

Among the 200 Latinas between age 35 and 60 studied by the HHC/UConn Diabetes Prevention Among Latinas study, 55% reported symptoms indicative of clinical depression, based on the results of a depression scaled administered with each of them.

The Hartford Department of Health and Human Services regularly conducts a telephone-based Hartford Health Survey on health issues affecting Hartford residents. The survey had consistently shown that area Latinos, who comprise the largest ethnic group in the city, suffered from high levels of depression, significantly higher than any other ethnic group. The rate in the 2003 study was 35%. Since the Hartford Health Survey depends on telephone access, it is likely that those without telephones were unreachable and not included in the study, would likely suffer at least as high a rate of depression, if not higher.



NUTRITION

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

Nutrition-related issues among Latinos represents a major public health concern, especially because poor nutritional status can cause or exacerbate other serious and growing health problems. The key findings summarized in this section point to serious concerns about this group's nutritional status as well as underlying issues of access to food and knowledge about nutrition that are essential to good health.

The Hispanic Health Council's Family Nutrition Program (FNP), delivered through a ten-year partnership with the University of Connecticut, has produced a significant body of data on nutrition, food security, obesity, breastfeeding and food safety among Latinos in Hartford.

■■■ FOOD INSECURITY & HUNGER

Food security has been defined as “having access to enough food at all times for active, healthy living” (Nord et al., 2003) and is considered a necessary condition for adequate nutritional status. It implies that a family has confidence in its ability to have enough nutritious food for all family members, at all times. Food insecurity involves a continuum from the point at which a family experiences fear of running out of food, or not having enough food for the entire household until obtaining money to purchase more.

At further points along the continuum of food insecurity, families consume less food by: skipping meals, reducing portion sizes to make what is available last longer, eating fewer varieties of foods and/or buying cheaper foods that are often laden with calories, fat and sodium. The most severe condition of food insecurity is hunger.

Unfortunately, rates of food insecurity and hunger have been increasing in the United States, alongside income disparities. In 2002, the prevalence rates of food insecurity and food insecurity with hunger for the total U.S. population were 11%, and 4% respectively, compared to 22% and 6% for Latinos (Nord et al., 2003, Children's Defense Fund/CDF, 2005).

Food security has been defined as “having access to enough food at all times for active, healthy living.”

An assessment conducted with Latino caretakers of Hartford preschool children found that 40% of the households studied were food insecure without hunger and 21% of the children studied experienced periods of hunger.

Latino households in the U.S. were almost three times more likely to suffer food insecurity (22%) when compared with non-Latino white households (8%), and more than twice as likely to experience hunger (6% vs. 2.6%) (CDF, 2005).

In Connecticut, generally, prevalence rates of food insecurity and hunger were lower than the national level at 8% and 3% respectively (Food Research and Action Center, 2005). In startling contrast, a nutrition needs assessment conducted with Latino caretakers of preschool children in Hartford by the FNP found that 40% of the households studied were food insecure without hunger, and 21% of the children studied experienced periods of hunger (Pérez-Escamilla et al., 1997; Himmelgreen et al. 2000). Short stature, a reflection of socioeconomic deprivation in childhood (Gunnell et al., 1998), was identified in 11% of the toddlers in the study sample (Perez-Escamilla et al., 1997).

Lack of adequate nutrition during a period of growth can affect many aspects of nutritional health, including reduced iron status leading to anemia. Researchers tested the iron status of a sub-sample of preschool children from the same assessment, and found that one-third had iron-deficiency anemia (Pérez-Escamilla et al., 1997). Follow-up FNP studies have also documented high levels of food insecurity among survey respondents from the program's needs assessment on Latinas in Hartford and diabetes (DIPAL), which found that 58% of respondents were food insecure with 26% living in households experiencing hunger (Pérez-Escamilla et al., 2004).

Food insecurity, hunger, poor nutritional status and obesity are serious issues for Latinos in Connecticut. These conditions correlate with poverty at the individual level and at the community level. A 2005 report ranks towns statewide based on four basic elements and 38 indicators of community food security. Among the 20 municipalities ranked the least food secure are seven of the eight municipalities in the state with populations that are 20% or more Latino. The eighth ranks number 141 of 169. Of the 20 municipalities ranked the most food secure, none has a Latino population of more than 2.8% (Connecticut Food Policy Council, University of Connecticut and Hartford Food System 2005; U.S. Census 2000). Hartford, with the highest percentage of Latinos in the state, ranked 166 overall.

Community food security is a relatively new concept that supports the development and enhancement of sustainable, community-based strategies to improve access of low-income households to healthful, nutritious food, to increase the self-reliance of communities in providing for their own food needs and to promote comprehensive responses to local food, farm and nutrition issues (Connecticut Food Policy Council, University of Connecticut and Hartford Food System, 2005).

Clearly, Latinos in Connecticut experience hunger and food insecurity at the individual and family levels in communities that also suffer from community-wide

food insecurity. Long-term solutions must address problems at the neighborhood and systems level as well as through culturally effective interventions targeted to children and families.

■■■ NUTRITION KNOWLEDGE

Research shows that low-income caretakers and their children are likely to have poorer dietary practices than their wealthier counterparts. While food security is an influential factor in food choices, it is hypothesized that differences in food choices are at least partially determined by levels of knowledge about nutrition and health (Pérez-Escamilla et al., 2000). For families that have few resources with which to buy food, it can be difficult to find nutritious food among the thousands of possible selections in a typical supermarket. The wide selection at supermarkets can be confusing at best, particularly when language is a barrier to communication.

The HHC conducted a study of 426 Latino households with at least one child 12 years of age or younger to better understand food and nutrition knowledge, attitudes and behavior among Latinos in Hartford (Pérez-Escamilla et al., 2000). Key findings indicated that:

The vast majority (93%) of respondents were familiar with the USDA Food Guide Pyramid (FGP), yet there was wide variation regarding their knowledge about numbers of portions recommended by the FGP.

94% were familiar with food labels, yet 24% of those who were familiar never used them and only 18% used them consistently when food shopping.

Less than half of respondents were familiar with the term “saturated fat”, and while the majority of respondents were familiar with the term “cholesterol”, there were many misconceptions about food sources for both saturated fat and cholesterol.

Respondents who spoke only Spanish were less likely to be familiar with certain basic nutrition concepts/terms (i.e. food label knowledge and use, number of portions recommended by FGP, etc.).

Other FNP studies have indicated similar findings regarding lack of nutrition knowledge among Hartford’s Latino population (Pérez-Escamilla et al., 1999 and 2004). The Family Nutrition Program has focused its culturally tailored nutrition education interventions to address the gaps in knowledge identified by the research. Latinos across the state need access to bilingual materials and education that will give them accurate information and the skills needed to apply that information when shopping and preparing food.

■■■ OVERWEIGHT AND OBESITY

Results from the 1999-2000 National Health and Nutrition Examination Survey (NHANES) indicate that an estimated 64% of U.S. adults were either overweight or obese, up from 56% ten years earlier and 47% twenty years before that. Among

children, the prevalence of being overweight has tripled between 1999-2000. One of the national health objectives for the year 2010 is to reduce the prevalence of obesity among adults to less than 15%.⁶ National prevalence data also indicate that a greater percentage of Mexican-American adults were overweight/obese (73%) when compared with non-Latino whites (62%) (American Obesity Association, 2002). It also shows that Latino children have higher rates of overweight/obesity within each age group than non-Latino white children: ages 6 to 11 (35% vs. 26%); and, ages 12 to 19 (44% vs. 27%).

According to the Centers for Disease Control, (CDC), obesity rates have been rising steadily in Connecticut, from 11% in 1991 to 18% in 2002 (CDC, 2003a). More than half (52%) of the state's residents are obese or overweight, and 3,000 people die annually from obesity and its complications.

The annual cost to the state from obesity-related health problems is \$856 million. In Connecticut, approximately 9% of the state's children are overweight and in some communities 25% of the children are overweight (State of Connecticut, 2006). Comparative obesity rates among ethnic groups in the state are as follows: 36% for Asian/Pacific Islanders; 49% among Latinos; 52% for non-Latino whites; and, 61% among African Americans (KFF, 2002a).

Obesity during childhood has many adverse health consequences such as persistent high blood pressure, high fasting blood insulin levels, risk of type 2 diabetes, orthopedic complications, and psychosocial effects and stigma. Adolescents who are obese will also be more likely to stay obese into adulthood (American Obesity Association, 2002). Adults who are overweight/obese are at increased risk for hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some types of cancer (American Obesity Association, 2002).

The FNP nutritional needs assessment found that 17% of the Latino preschool children studied were classified as obese (Pérez-Escamilla et al., 2004). A study of 2,509 Hartford public school students also illustrated the magnitude of the city's epidemic of childhood weight problems and obesity. Results indicated that the percent of children who were either overweight (with a body mass index higher than the 95th percentile) or at risk of being overweight (with a body mass index between the 85th and 95th percentile) was 23% in kindergarten, 42% in 6th grade, and 40% in 10th grade. The likelihood of being overweight was similar among both African American and Latino children (Burke et al., 2001). The Hartford public school population is more than 50% Latino.

The HHC/UConn DIPAL study found that, of the 200 women studied, 90% of those with diabetes were obese or overweight, and 83% of those diagnosed with diabetes were obese or overweight (Pérez-Escamilla et al., 2004).

■■■ BREASTFEEDING

Breastfeeding has been extensively documented as the best way to feed infants. There is strong evidence that breastfeeding protects infants from several types of infection, including ear infection, diarrhea, and respiratory illnesses. In addition, breastfeeding is now associated with preventing the onset of obesity and with improved cognitive scores. Breastfed infants are less likely to become sick, and they also display less severe symptoms when they do become ill. The American Academy of Pediatrics (2005) recommends that infants be breastfed exclusively for the first six months of life, followed by the introduction of complementary foods at six months with continued breastfeeding at least through the first year. Nationally, representative data from the 2003 National Immunization survey indicate that 71% of mothers have ever breastfed, 36% breastfed at six months, and 17% breastfed at 12 months (CDC, 2003c).

These numbers are markedly different among low-income families. According to the 2003 report of the Pediatric Nutrition Surveillance System (PedNSS) that monitors the nutritional health of low-income children in federally funded maternal and child health programs, 53% of the low-income infants surveyed were ever breastfed, 22% were breastfed for at least 6 months and 14% were breastfed for at least 12 months. While significantly lower than for the general population, these rates represent a dramatic increase since 1994, when the PedNSS rate for low-income infants ever breastfed was 39%. This increase was evident across all racial and ethnic groups. The rate among low-income Hispanics increased from 45% to 65% and among African Americans from 25% to 40% (U.S. DHS, 2004).

In Connecticut, 72% of mothers initiate breastfeeding, though at six months, only 36% are still breastfeeding. The 2003 Connecticut PedNSS data indicates an increase in breastfeeding rates among low-income infants from 1% in 1994 to 54% in 2003, with a similar increase among Latinos at 35% and 59% respectively. However, these rates are still considerably below the national objectives. Furthermore, the rates given represent infants “ever breastfed”. Available duration rates for Connecticut’s low-income population are unreliable, but are undoubtedly lower than the national targets (U.S. DHS, 2004).

The FNP nutrition assessment (Pérez-Escamilla et al., 1997) found that half of the 248 respondents had not breastfed. This and subsequent studies conducted by the same group indicated that the primary barriers among Latino mothers in Hartford for not choosing breastfeeding were: the perception that breastfeeding is embarrassing, particularly in a public setting; fear that breastfeeding would be painful; and the perception that they would have insufficient milk. (Pérez-Escamilla et al., 1997; Anderson et al. 2004). Furthermore, they found that social support is a key determinant in the decision to breastfeed infants. Within the Puerto Rican community in Hartford, mothers younger than 30 were less likely to initiate breastfeeding and mothers who were not the head of household were more likely to initiate breastfeeding.

Breastfeeding has been extensively documented as the best way to feed infants.

Within the Latino community, breastfeeding initiation and duration are strongly linked to country of origin. In contrast to studies among Mexican groups that found positive associations between breastfeeding and certain cultural beliefs and practices, the opposite was found among Puerto Ricans. This may, in part, reflect differences in breastfeeding practices and levels of breastfeeding support in the countries of origin, in this case Mexico where 90% of mothers initiate breastfeeding vs. Puerto Rico where breastfeeding rates lag behind those in the U.S. and Latin American countries (Anderson et al., 2004).

Within the Latino community, breastfeeding initiation and duration are strongly linked to country of origin. The identified relationship between breastfeeding and social support and the lack of comfort with the idea of breastfeeding indicates the need for breastfeeding role modeling and support.

The CDC's *Guide to Breastfeeding Interventions* states that multi-faceted interventions with peer support as one of the main components have been effective in supporting breastfeeding initiation and duration. The evaluation of the Breastfeeding: Heritage and Pride Peer Counseling Program, which has been operating for more than ten years as a collaboration between the Hispanic Health Council, Hartford Hospital and the University of Connecticut, found that women receiving individual peer counseling were more likely to be breastfeeding at one and three months post partum than those receiving only routine support, and were significantly more likely to initiate breastfeeding (Chapman et al., 2004).

FOOD SAFETY

Across the United States, food borne illnesses cause 76 million illnesses and 5,000 deaths per year. The need for food safety education to minimize the risk of food borne illnesses is now one of the Dietary Guidelines for Americans and the subject of a major national education campaign (Bermúdez-Millán, 2004). However, until recently, little had been done to understand and address food safety behavior risks among Latinos, the largest and fastest growing minority group in the country.

In 2001, Bermudez-Millan et al. conducted a study of food safety knowledge, attitudes, and behavior among 100 Puerto Rican Caretakers in Hartford. They found that:

Although 97% of respondents reported washing hands before cooking, only one in the ten directly observed in their homes actually did it.

While 89% reported washing cutting boards with soap and water, only six of the ten observed actually did so.

Only five percent (5%) of the 100 respondents reported knowing what cross contamination is and 80% used the same cutting board for meats and vegetables.

Only four percent (4%) used a thermometer to check if meats were thoroughly cooked and only 10% defrosted meat in the refrigerator as is recommended.

People who speak English are much more likely to understand the meaning of cross contamination.

Clearly, there is a need for a comprehensive, sustained, bilingual public education campaign focusing on the nutrition, fitness and food health issues discussed above. These efforts must target Latinos of different age groups and in specific subgroups. However, the many serious issues described in this section call for a number of system changes needed to assure that Latinos in Connecticut have the means to obtain healthy food, and the support needed for dietary behavior change.



STDS

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

Sexually transmitted diseases are infections that can be passed from one person to another through sexual contact. In the United States, there are more than 15 million cases reported annually (CDC, 2004). Adolescents between the ages of 15 and 24 are at greatest risk for acquiring an STD.

Of the five sexually transmitted diseases (STD's) that physicians in Connecticut are required to report to the Connecticut Department of Public Health (new cases only), chlamydia and gonorrhea are the most commonly diagnosed and have reached nearly epidemic proportions in some communities. In a 2001 study, Latinas represented 19% of the gonorrhea cases (11 times higher rate than among non-Latino white women) and 30% of chlamydia cases (15 times higher rate than among non-Latino white women) (CT DPH, 2001d). The incidence of syphilis diagnoses is rising, while there have been no new cases of either chancroid or neonatal herpes.

Chlamydia and gonorrhea are bacterial infections that cause pelvic inflammatory disease, preterm birth and infertility. They also contribute to the development of cervical cancer. The rate of new chlamydia infections began to rise during the 1980s and continued to do so until 1992. The incidence rate then declined through the end of 1997, but began to rise again in 1998. By 1999 there were over 6,000 new cases of the disease among women in Connecticut (at the rate of 359 per 100,000 population). Every year since then, 5,000 to 7,000 new cases have been reported in the state, primarily among women.

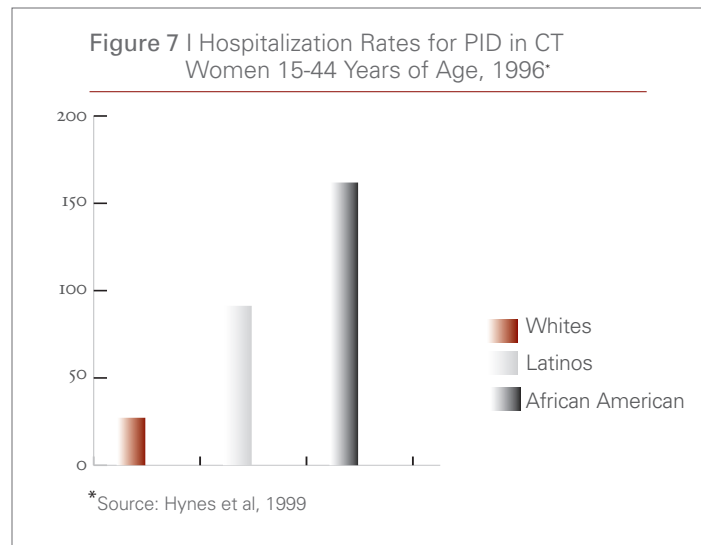
The rate of chlamydia infection among Latinos and African Americans is drastically higher than among non-Latino whites. Chlamydia is the most common of STD's and often goes undetected because infected persons may not exhibit symptoms. An important side effect of Chlamydia is that it increases the risk of cervical cancer and the likelihood of HIV transmission (CT DPH, 2001d). Between 1999 and 2003, there were approximately 200 cases per 100,000 non-Latino whites compared with approximately 2,500 per 100,000 Latinos (Wilson, 2004). In 2003, for example, 17% of chlamydia cases diagnosed in the state were among Latinos, with a 5:1 female to male ratio. (CT DPH, 2004b; U.S. Preventive Services Task Force, 2001). The case rate in 2000 for chlamydia among Connecticut Latinos was 765 compared to 438 (per 100,000 population) among Latinos, nationally.

Chlamydia and gonorrhea have reached nearly epidemic proportions in some CT communities.

Similarly, between 1999 and 2003, the incidence rate of new gonorrhea cases in Connecticut was over 500 (per 100,000 population) for Latinos compared to less than 100 (per 100,000 population) among non-Latino whites. In 2003, there were approximately 3,000 cases of gonorrhea reported in Connecticut; 12.5% were among Latinos (CT DPH, 2004b). The case rate (per 100,000 population) for gonorrhea among Latinos in Connecticut is 170 compared to 78 for Latinos nationally (Wilson, 2004). Further, gonorrhea is probably even more common in Connecticut than these statistics suggest. Experts estimate that at least half of all cases go unreported, and that as many as one in every 150 people is infected, especially in inner-city areas.

Until recently, there had been fewer new cases of syphilis (although the rate among Latinos has been double that of non-Latino whites) compared with past periods when syphilis rates spiraled as a result of the emergent crack cocaine epidemic (Farley et al., 1990). However, current, new increases in the number of syphilis cases in Connecticut appear to be linked to the growing, illicit use of crystal methamphetamine among men who have sex with men (GayHealth, 2005).

Another disease related to sexual behavior is pelvic inflammatory disease (PID) among women. In 1996, as seen in Figure 7 below, the relative risk for PID hospitalization among Latinas was 3 times the rate among non-Latino white women, with a rate per 100,000 of 91 among Latinas compared to 27 among their non-Latino white counterparts (Hynes et al., 1999)



Most of the concern about STD infection in the Latino population of Connecticut has been focused on urban populations. Connecticut, however, also has a significant migrant farm worker population and most are Latino. With funding from the National Institute on Alcohol Abuse and Alcoholism, the Hispanic Health Council has been studying the effects of alcohol consumption on risky sexual behavior in this population. Nearly 29% of farm workers interviewed in the study reported having sex during the past 30 days, despite being separated from their spouses or primary partners (n=177).

Many of their sexual partners were sex workers and nearly 45% of study participants reported that they had paid for sex during their lifetime, and 35% (n=75) during the past 30 days. Of those who had sex in the last month, 53% (n=26) did so with a sex worker. In this group, condom use with sexual partners was relatively low: just 57% (n=28) of those who were sexually active during the last 30 days reported always using a condom during that time (Duke, 2003).

In summary, in both urban and rural Latino populations of Connecticut, STDs and behaviors that place individuals at risk for STDs are extremely prevalent. Among Latinos, lack of knowledge about the nature, symptoms, prevention, and treatment of STDs, and about their routes of transmission is very likely a significant contributor to this serious and growing area of health problems.

■■■ CULTURAL INFLUENCES ON SEXUALITY

There are data that indicate that higher rates of acculturation, generally measured by duration in the U.S., results in younger Latina women having a more ‘Americanized’ view of sex and sexuality. A 1999 study of youth in New York supports the idea that second-generation Puerto Ricans have different definitions of gender roles, particularly around women’s sexual behavior (Asencio, 2002). This shift is particularly pronounced in mainland, inner-city Puerto Rican communities like Hartford (Weeks et al., 1998). The low rate of condom use found among younger Latinos in Hartford may be attributable to Latinas not wanting to commit two immoral acts in one behavior: to have sex is immoral, to have sex without a condom may seem less immoral in that having condoms on hand means that the sex was planned. This is especially true if the Latina considers her partner her life love.

Most significantly, the number of young Latinos engaging in potentially dangerous, early sexual activity is burgeoning. Landale and Hauan (1996) report that the percentage of first-generation Puerto Rican immigrants to the U.S. mainland who have had intercourse by age 17 is almost three times greater than their counterparts who did not migrate. The same figure for second-generation immigrants is almost four times greater than for non-migrant Puerto Ricans.



HIV/AIDS & TUBERCULOSIS

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

Latinos view AIDS as the number one health problem facing their communities and they are more likely than non-Latino whites to view AIDS as an urgent health issue. The AIDS epidemic has put the Latino population of Connecticut at great health risk. From a public health policy standpoint, AIDS has brought into sharp focus the disparities Latinos face in accessing appropriate health and social services. It has also helped to illuminate the role of various barriers to risk reduction (e.g. poverty) on the health status of the Latino population of Connecticut.

AIDS is now the fourth leading cause of death in the Latino population across the United States; Latino AIDS cases have been reported in every state, as well as in Puerto Rico. About 20% of all people living with HIV in the U.S. are Latino. However, there are marked regional differences in the distribution of AIDS cases within the Latino population. AIDS prevalence is notably greater among Latinos in the Northeast, including Connecticut, than in the rest of the country.

Latinos account for 25% of the cumulative AIDS cases in Connecticut and the epidemic shows no signs of abating. For example, in 2002, Latinos accounted for almost one-third of the AIDS cases reported (32%) (CT DPH, 2002). Among Connecticut Latinos, AIDS is the second leading cause of death ranked by premature mortality under age 75 (CT OHCA, 2004b).

Despite the life-threatening nature of this disease, HIV prevention and education initiatives remain woefully inadequate. Latino youth and women are particularly vulnerable. While Latino teens comprise 15% of the teenagers in the U.S., they account for over 20% of new AIDS cases among adolescents. (Singer, 2005) A recent survey among sexually active teenagers indicated that Latinos continued to have the lowest rate of condom use (48%) compared to African Americans (64%) and non-Latino whites (56%) (Giachello, 1996). The AIDS case rate per 100,000 population (i.e. HIV prevalence) reached 1.5 for non-Latinos between the ages of 11 and 19 years by 1998. Among Latino youth in this age bracket, the comparable rate was six, or about four times the non-Latino white rate (Singer 2005). Additionally, the rate of infection among Hispanic women is growing rapidly. "The rate of Latinas as a proportion of all Latino AIDS cases climbed from 15% in 1990 to 23% in 2002" (Rios, 2004).

About 20% of all people living with HIV in the U.S. are Latino. AIDS prevalence is notably greater among Latinos in the Northeast, including Connecticut, than in the rest of the country.

Experts predict that the number of new AIDS cases among Latinos in the U.S. will soon surpass that of non-Latino whites, raising critical questions about the adequacy and appropriateness of AIDS prevention and care available to Latinos. This concern is heightened by the recognition that, while improved prevention and treatment methods contributed to a general decline in AIDS cases for all ages, genders, and ethnicities during the 1990's, the decline was not distributed evenly, resulting in a widening gap between Latinos and both African Americans and non-Latino whites.

While, nationally, new AIDS cases among non-Latino whites declined by 73% between 1993 and 2001 compared to previous years, among Latinos this figure was only 56%. Similarly, the number of deaths attributed to AIDS during this period fell by 80% among non-Latino whites but only by 63% among Latinos (Singer, 2005).

Also during this period, the estimated AIDS prevalence (that is, number of accumulated cases) among non-Latino whites rose by 68% (Singer, 2005). In striking contrast, prevalence among Latinos jumped by 130% in the same timeframe. These numbers confirm significant disparities between Latinos and the majority population regarding HIV prevention, infection, and early detection and care.

While rates of testing for HIV infection nationally are roughly similar between Latinos and the general population (about 45%), Latinos are much more likely to be tested after the infection has already progressed beyond the early stages of the disease. This reflects cultural, institutional and economic barriers to HIV services and care.

In one study, 60% of Latinos did not receive HIV testing until they were already experiencing symptoms of HIV infection or were ordered to be tested by a physician (Singer, 2005).

Connecticut, a comparatively small state, ranks 18th among other states in the total number of reported new AIDS cases and eighth in the rate of AIDS cases per 100,000 population. The annual rate of reported AIDS cases per 100,000 population in Connecticut is 20 compared to 16 for the total U.S. population (CT DPH, 2002). AIDS cases are concentrated in the state's three largest cities: Bridgeport, New Haven, and Hartford. In 1999, they were disproportionately concentrated among men (69%). However, the diagnosis of AIDS among women continues to climb rapidly: from 26% of cases reported in 1995 to almost 38% of cases reported in 2000. AIDS prevalence among Latinos in Connecticut is highest among 40 to 49 year olds, but among 30 to 39 year olds the number of AIDS cases per 100,000 surpasses that of all other ethnic groups in the state (CT DPH, 2003b). It is also in this age group that AIDS rates among Latinas come closest to those of Latino men in the state.

While heterosexual transmission contributed to 15% of AIDS cases nationally in 1998-99, in Connecticut heterosexual transmission accounted for 19% of cases. From

1997 to 2002, intravenous drug use (IDU)-caused AIDS cases among all U.S. women declined from 45% to 38%. However, among Latinas, IDU and sex with injection drug users (IDUs) accounted for 58% of the total AIDS cases among U.S. Latinas through 2002 (Rios, 2004).

In response to the introduction of new medicines, between 2001 and 2003 the number of new AIDS cases reported in Connecticut dropped each year for the non-Latino white population, whereas for Latinos the rate actually increased each year.

By 2003 there were more new cases of AIDS being reported among Latinos than among non-Latino whites despite the fact that the non-Latino white population is more than eight times larger than the Latino population.

Indeed, the incidence of AIDS cases among Latinos has been rising steadily since 1990. Similarly, while Latinos in Connecticut in the past had lower rates of AIDS-related deaths per year than non-Latino whites and African Americans, by 2002 all three groups had roughly equal numbers of AIDS-related deaths despite the greater overall size of the non-Latino white population (Wilson 2004).

Of the three principal routes of HIV transmission— injection drug use, men having sex with men, and heterosexual sex— injection drug use has consistently been the most prevalent reported route of infection among Hartford’s AIDS cases, especially among Latinos.

Latino men who have sex with men (MSM) are a subpopulation of concern with regard to the AIDS epidemic. Beginning in 1998, a majority of the newly diagnosed AIDS cases nationally were among ethnic minority men (CDC, 2000). A recent seven-city study found that 15% of young Latino MSM are infected with HIV (Valleroy et al., 2000). Other national studies estimate that the HIV prevalence rate among Latino MSM is now over 20% (Diaz et al., 2000). In addition, recent research suggests that HIV sexual risk behavior within this population may be increasing (Mansergh et al., 2004).

It has been found that despite higher rates of HIV infection, many Latino MSM are not widely involved in existing AIDS prevention programs targeted to gay men. Many Latino MSM do not identify themselves as “gay” even if all of their sex partners are male because they feel that this label would diminish their ethnic heritage. (Singer and Marxuach-Rodriguez, 1996; Clair and Singer, 2005). Consequently, Latino MSM are less well known than their non-Latino white counterparts and their specific risk patterns and needs for AIDS prevention are less clear.

As part of a larger assessment of the utilization of AIDS services and the needs of “at-risk” MSMs in Connecticut, the Hispanic Health Council examined these issues among Latino MSM in the state. Key findings of the study were:

Experts predict that the number of new AIDS cases among Latinos in the U.S. will soon surpass that of non-Latino whites.

With regard to sexual orientation, a significantly larger percentage (23%) of Latino MSM identified as bisexual compared to 11% of African American MSM and 9% of non-Latino white MSM.

Latinos reported the highest rates of selling sex compared to the other groups. Overall, 19% of Latinos, 10% of African Americans, and 9.4% of non-Latino whites reported engaging in this behavior in the past six months.

Latinos were the most likely to report injection drug use, with 10% of Latinos, 6% of non-Latino whites, and 4% of African Americans reporting that they had injected drugs in the last six months.

Across a number of risk behaviors, Latinos reported perceiving themselves to be at lower HIV risk than the other ethnic populations in the sample and they were the least likely to report actually using condoms.

Latinos were the least likely to report communicating with their sexual partners about HIV.

More than one-third of this sample of “high risk” Latino MSM and more than one-fifth of the African Americans in the sample reported being HIV positive.

As these data indicate, Latino MSM are at greater risk and are more likely to be already infected than the participants from other ethnic groups, and yet they are the least likely to be aware of their level of risk, suggesting the need for more HIV prevention education and care services targeted to reach this population. Latinos engaging in very high levels of risk behavior are less likely to accurately perceive their level of risk than other groups. These patterns reflect the ineffectiveness of current AIDS education efforts among the Latino population, especially monolingual Spanish-speaking individuals. It does not appear mainstream AIDS prevention organizations and campaigns, are linguistically or culturally effective in reaching Latinos. These are key barriers to access that must be addressed.

■ CULTURAL NORMS & HIV/AIDS PREVENTION

Several studies have shown that the main HIV prevention strategy that both African American and Latino populations use is to choose a “good” partner, and for women, to be faithful to them (Sobo, 1995). Most of the communication strategies used with a new partner are designed to confirm the assumption that the potential partner is “safe”. Hidden in this strategy is the assumption that “unsafe” people are readily distinguishable.

Cultural factors may also be important in other ways as well. Latina wives, for example, may think that it is improper to discuss sexual behavior with their partners and they may tend to assume that their partners are always loyal.

“Latina immigrants sometimes find themselves at risk of HIV infection after reuniting with their husbands in the United States, who in the interim may have become HIV infected through commercial sex workers or other means” (Rios, 2004, 22).

Also, Latinas may be less likely to be aware that their partner is an injection drug user, as Latino men feel they have an obligation to keep their illicit behaviors away from their homes and families.

The AIDS epidemic, and all of the social baggage (e.g., stigma, discrimination, fear) that accompanies it, has put the Latino population of Connecticut at great health risk. From a public health policy standpoint, AIDS has brought into sharp focus the disparities Latinos face in accessing appropriate health and social services. It has also highlighted the effect various barriers to risk reduction (e.g. poverty) have on the health status of the Latino population of Connecticut. Of particular note, Latinos have been found to view AIDS as the number one health problem facing their communities and are more likely than non-Latino whites to view AIDS as an urgent health issue.

TUBERCULOSIS

Tuberculosis (TB) has re-emerged as an epidemic condition in the U.S. since the beginning of the AIDS epidemic. Indeed, HIV and TB co-infection is now common in U.S. inner-city communities where it is concentrated in lower income and ethnic minority populations (Rose et al., 2002). Research has shown that co-infection with HIV and TB can reduce the survival time of patients compared to those with just one of these diseases, suggesting a syndemical interaction with deadly consequence for co-infected individuals (Dye et al., 1999). Because HIV damages human immune systems, individuals with HIV disease who are exposed to TB are more likely to develop active and rapidly progressing tuberculosis compared to those who are HIV negative. In addition, Latinos account for 39% of all reported childhood cases of tuberculosis, a rate 13 times higher than for non-Latino whites (Flores and Zambrana, 2001).

From the mid-1980s through the end of the 1990s, the five-year annual average number of TB cases among Latinos in Connecticut rose steadily. During the same period, it fell steadily among non-Latino whites (Mueller and Hynes, 2005). As reflected in Table 12, the relative risk for TB among Latinos in the years from 1993 to 1997 was 8 times the

Latinos account for 39% of all reported childhood cases of tuberculosis, a rate 13 times higher than for non-Latino whites.

Table 12 | Tuberculosis Incidence Rates In CT, 1993-1997*

Ethnicity	Cases	Incidence**	Relative Risk***	Excess Deaths****
White	216	1.6	1.0	0.0
Latino	161	13.1	8.2	141
African Americans	201	14.8	9.3	179

*Source: Hynes et al. 1999.

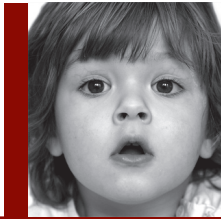
**Rate per 100,000 population

***Ratio of Latino and African American rates to White rate

****Deaths that would not have occurred if the Latino and African American rates were the same as the White rate

non-Latino white rate with an excess of 141 Latino TB cases compared to non-Latino whites. While the average number of TB cases per year among Latinos began to fall in the year 2000, the rate among Latinos remains several times that of non-Latino whites. Although data are limited, the frequency of TB among Latinos in Connecticut merits attention, especially with reference to TB and HIV co-infection, given the comparatively high rates of HIV/AIDS among Latinos in the state (Hynes et al., 1999).

The growing rate of infectious diseases such as HIV/AIDS, tuberculosis and others that go untreated until very late stages, or never, among Latinos and other underserved populations in Connecticut is a serious public health issue for all residents. This underscores the need for culturally appropriate education, outreach and prevention programs to stem the tide of infection among Latinos.



ORAL HEALTH

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

Oral disease, in the form of dental decay, is a painful, transmittable infectious disease. It is a process of progressive tooth destruction resulting from the metabolism by bacteria of carbohydrates in the mouth, and subsequent production of acids that damage teeth. Dental decay is the most common chronic childhood disease, five times more common than asthma.

Based on current research, there is a heightened awareness of the potential for oral disease to seriously impact a number of medical diseases and conditions, including: cardiovascular disease, diabetes, preterm low birth weight, cancer, HIV/AIDS and smallpox. It is currently thought that oral disease can also impact nutrition, speech, self-esteem and other psycho-social problems. (CT DPH, 2004).

It is well documented that lack of regular, preventive dental care leads to a progression of dental disease, resulting in:

- Diminished general health and quality of life
- Costly emergency visits and
- Only temporary solutions provided in Emergency Departments, due to a lack of dental services in these departments (U.S. GAO Report, 2000).

A series of national studies conducted between 1984 and 1997 showed that relative to more affluent segments of the population, low-income populations had a disproportionate level of dental disease. Poor children had five times more untreated dental caries than their more affluent counterparts, and poor adults were much more likely to have lost six or more teeth due to decay and gum disease than higher income adults. The Latinos included in these studies were Mexican Latinos, a growing Latino population in Connecticut, but not the majority Latino group, which is Puerto Rican. Study findings indicated that the Mexicans studied were 1.2 – 1.4 times as likely to have untreated tooth decay as non-Latino whites. (U.S. GAO Report, 2000)

Again, on the national level, the Commonwealth Fund (Doty, 2003) found that rates of dental visits among Latinos are very low compared with non-Latino whites and other Americans. Non-Latino whites, in fact, are twice as likely to report that they received a dental exam in the last year than Latinos. Data on Connecticut's Latino adults regarding oral health status and use of oral health care is limited. However, data on use of preventive dental care and treatment services by Connecticut's children on Husky A in 2004 and 2005 indicated the following:

It is currently thought that oral disease can also impact nutrition, speech, and self esteem and other psycho-social problems.

While dental care utilization has increased since the early years of the Husky Program, rates have not increased in recent years. Rates were similar in 2004 and 2005.

In 2005, only 41% received preventive care and only 22% received treatment services; for the 3-5 year age group these rates were 38% and 13% respectively.

Among Latino children, 43% received preventive care and 23% received treatment. These rates are slightly higher than the state average, but still indicate alarmingly low rates of dental care use. (Connecticut Voices for Children, 2006)

Structural barriers to oral health care must be addressed in order to eliminate the serious inequities in oral health experienced by Latinos and other low-income populations.



ENVIRONMENTAL DISEASES

SIGNIFICANT HEALTH ISSUES AMONG CONNECTICUT LATINOS

A report for the Natural Resources Defense Council, ‘Hidden Danger: Environmental Health Threats in the Latino Community’, provides an account of the multiple environmental health risks faced by Latinos in the U.S.. Many of these environmental threats to health exist in Connecticut, including poor air quality, exposure to agricultural chemicals, and lead and mercury poisoning (Quintero-Somaini & Quirindongo, 2004).

■ ■ ■ AIR POLLUTION

Most Latinos across the country, as well as in Connecticut, live in urban areas blighted by polluted air that holds significant risks for respiratory health problems. Air pollutants produced by power plants, factories, laundries, heavy machinery, and vehicles, including diesel-driven buses and trucks, can lead to heightened levels of asthma, lung cancer, allergies, and chronic bronchitis. Such problems have been noted in Connecticut.

A study of exposure to diesel exhaust from school buses among Connecticut children found that fine particulate concentrations measured on buses were five to ten times higher than the average levels measured at 13 fixed-site monitoring stations across the state. Levels were often higher when buses were idling with windows open, when buses ran through their routes with the windows closed, when buses moved through intense traffic, and when buses were idling when queued to load or unload students (Wargo and Brown, 2002).

In another study, Mitchell (1999), noting that 300 trucks per day deliver trash to the Hartford Trash Incinerator, measured diesel emissions from 102 trucks at two locations over three days. He found that 21% of the trucks that were observed showed heavy/dark smoke suggesting they may have been out of compliance with diesel exhaust opacity laws.

Air pollution from such sources is known to take a particularly high toll on pregnant women — a population segment that constitutes a higher percentage of the Latino population than of the population as a whole — thereby increasing the risk of complications during pregnancy and the risk of premature birth, low birth weight, and heart defects among newborns. Pollution also is a heightened risk for children, another group that comprises a larger percentage of the Latino population than of the non-Latino white population in Connecticut.

Most Latinos across the country, as well as in Connecticut, live in urban areas blighted by polluted air that holds significant risks for respiratory health problems.

■■■ CHEMICAL EXPOSURE

Outside of urban areas, Latinos comprise a significant share of the farm worker population, nationally and within Connecticut (where they comprise both a migrant population and a settled population).

Farm workers are exposed to pesticides at work, and they and their families are also exposed off the job when these chemicals drift through the air into nearby labor camps or rural towns, settle in drinking water, and cling to clothes and food. Often, farm workers are not given either proper training in the handling of pesticides and other dangerous farm chemicals, or safety equipment to reduce exposure.

Warning information is usually not available in Spanish. Even when safety equipment is made available, many farm workers receive no training in its use, or they receive training that is not language-appropriate. Additionally, exposure to pesticides may be increased because of a lack of water for washing off pesticide residues.

The health effects of exposure to various pesticides and other farm chemicals include skin rashes, burning eyes, cough, nausea, vomiting, diarrhea, and difficulty breathing. Longer term exposure to pesticides can lead to heightened levels of lymphoma, prostate cancer, and childhood cancers. Moreover, pesticide exposure may lead to miscarriage, premature and underweight birth, and birth defects. Children are particularly susceptible to harmful chemicals. While migrant farm workers in Connecticut often travel without their families, the children of settled farm workers who work in local agricultural industries (such as mushroom growing) with year-round employment may be exposed to pesticides on a daily basis.

Additionally, in a study of the farm worker population of Connecticut, the Hispanic Health Council found strong concern about exposure to pesticides and other chemicals among Latino farm workers in the Willimantic area. In a focus group conducted with these workers, researchers found that they were,

“Particularly interested in talking about working conditions and labor rights. They often worked long hours without a break, were not provided with adequate protective gear, and in general felt both exploited and powerless to do anything to rectify their situation” (Duke et al., 2003, 29).

These issues are not unique to farm workers; Latino migrants working in many different jobs may be exposed to hazardous substances and other health risks. These workers often do not receive safety training in their primary language and may not speak up about obtaining adequate information or gear due to fear of losing work or being deported.

LEAD POISONING

Comparatively high blood levels of lead have been found among Latino children, especially among those living in older buildings where lead in house paint has deteriorated and collected in floor dust and in the soil around housing structures. Much of the housing stock in Hartford, New Haven, Waterbury and Bridgeport predates 1978 when leaded paint was banned from use. These older properties are falling into disrepair, exposing children to toxic substances through peeling and chipping paint and dust. According to the Hartford Health Department (2001), 47% of approximately 350 Hartford children that have been identified with elevated blood lead levels are Latino.

Nationally, although blood lead levels have been going down, the NRDC report notes that twice as many Latino children as non-Latino white children have lead in their blood at levels deemed risky by the Centers for Disease Control and Prevention (Quintero and Quirindongo, 2004).

Lead can cause neurological problems in children even at very low doses and has been associated with declines in IQ, learning disabilities, hyperactive and violent behavior, and an increase in antisocial behavior. Lead exposure, however, is not just a problem for children. Among adults, it has been linked to neurological problems, high blood pressure, and kidney problems.

MERCURY EXPOSURE

Mercury, now believed to be unsafe at any level in the body, may also constitute a comparatively high risk for Latinos. As a group, they have greater than average levels of this toxic metal in their bodies. The two major ways that Latinos are exposed to mercury are by eating mercury-contaminated fish (as contaminated fish cannot be identified by taste, touch, sight, or smell) and by using mercury (sold in some local botanicas in Connecticut in capsule form or melted into candles) in folk healing remedies. The risk of exposure to this highly toxic substance is compounded by a lack of Spanish-language educational materials about the dangers of exposure to even small amounts of mercury. Mercury is known to accumulate in the fatty tissues of the body, where it remains for long periods. Although inhalation of vaporized mercury or consumption of it in food can cause significant health problems for anyone, two groups that are disproportionately represented in the Latino community, women of reproductive age and children, face the greatest risk. In a pregnant woman, mercury can damage the brain of a developing fetus. This risk continues after birth as the brains of children continue to develop, resulting in neurological and behavioral problems, and learning disabilities.

The majority of Latinos in Connecticut have their roots in the Caribbean where eating large quantities of fish is common. Additionally, the NRDC report cites a study done in New York City that found that canned tuna is the most popular fish among Latinos (Quintero and Quirindongo, 2004). In the year 2000, Federal Drug Administration (FDA) developed draft advisories that were presented to focus groups that warned women not to eat large quantities of canned tuna during pregnancy because it contains levels of mercury that can harm developing fetuses and nursing babies. Two years later, the FDA and the Environmental Protection Agency issued the first joint advisory on this topic. Ironically, mothers with low incomes, such as those receiving assistance from the Women, Infants, and Children (WIC) program, may unknowingly put their children at risk selecting tuna as an inexpensive, low-fat source of protein, because it is the only fish that is a WIC-eligible food. In 2002, Latinos became the largest group of WIC recipients in the nation. It is critical that we provide these mothers with the information they need to make healthy choices for themselves and their children.

To address the pressing issues facing Latinos and others residents of Connecticut we need a state wide effort to improve environmental conditions such as waste disposal, air pollution, and poor water quality.



AVAILABLE DATA

On Latino Health

In assessing the health status of the Latino population in Connecticut, we have rigorously reviewed available data, and have presented information from numerous databases, publications, and reports across a wide range of health issues, health indicators and other health-related factors. However, gaps in available data have presented challenges to providing a complete picture.

These gaps in available data were evident in numerous ways:

- The lack of available databases or studies on various health issues among Latinos
- Missing information on ethnicity in some databases
- The inability to report accurate statistics due to small numbers, especially for behavioral risk factors
- The inability to access information from multiple years so real trends can be identified rather than single-year changes in particular health conditions
- The inability to compare subgroups of Latinos both in terms of country of origin and by linguistic patterns (e.g., English-speaking vs. monolingual Spanish speaking individuals) and
- Variation in health beliefs, status and practices among and within Latino subgroups has been evident in many sections of this document.

The importance of assuring adequate data on health and related issues among Latinos cannot be overemphasized.

This variation in health beliefs, status and practices among and within Latino subgroups is further illustrated by the findings of the following two national studies. The first study examined private health insurance coverage by country of origin and found that time lived in the U.S. was a primary factor predicting health care coverage among Mexicans while for Puerto Ricans language barriers were more important than time lived on the mainland (Vitulo and Taylor, 2002).

The second study used the Community Tracking Survey for insured 18 to 64 year olds to identify subgroup disparities by linguistic patterns. This study found that while rates for English-speaking Latinos were similar to that of non-Latino whites, monolingual Spanish-speaking Latino patients were significantly less likely than non-Latino whites to have had a physician visit or an influenza vaccination during the year (Fiscella et al., 2002).

The importance of assuring adequate data on health and related issues among Latinos cannot be overemphasized. Data is needed for a clear understanding of the origins

of the health inequities experienced by Latinos, their trends and effective solutions. Evaluation of current research with regard to effective inclusion of Latinos, and expansion of research efforts on Latino health are essential steps toward filling the gaps in available data, and ultimately solving the enormous health inequities described in this profile.



CONCLUSIONS & RECOMMENDATIONS

Creating an Agenda For Change

Throughout this *Profile of Latino Health in Connecticut*, evidence of pervasive health inequities experienced by Latinos in our state represents an urgent call to action. The magnitude of the problem at hand is enormous, reflective of systemic root causes that must be addressed through decisive policy change.

In order to create the political will for change, a cohesive voice among Latinos and other advocates throughout the state must be as pervasive as the problems at hand and present at every policy table to represent the right to health for our state's fastest growing and drastically underserved population group. Across the many critical health problems covered in this document are a number of overarching related factors that must be addressed in order to achieve health for Latinos in Connecticut. These include the following:

Lack of Adequate Data on Latino Health

Our ability to sufficiently describe the status of Latinos in Connecticut with regard to many of the health issues included in the document is limited by lack of available data.

In order to ascertain the extent and nature of need and to determine appropriate solutions to the many health issues disproportionately affecting Latinos, current data is needed - on Latinos in general and on the various Latino subgroups in the state for whom healthcare access, health status and health behaviors often vary widely.

Poverty

Poverty is at the root of many problems of healthcare access, health status and health behavior. Evident in the report is the inequity in income experienced by Latinos, who experience the highest poverty rate and the highest unemployment rate of any ethnic group in the state. Evident as well is the association between poverty and compromised health status.

In order for real, long-term change in the health status of Latinos to occur, opportunities for a livable wage must be created.

Health Care Coverage

The profile depicts the disproportionate rate of uninsurance suffered by Connecticut's Latino population and the major impact this has on their health care utilization and on the economy of the state.

A cohesive voice among Latinos and other advocates throughout the state must be as pervasive as the problems at hand to create the political will for change.

Universal Health Care Coverage is an essential step towards solving the health inequities experienced by Latinos in Connecticut.

Health Literacy

The profile reports a disproportionately low level of educational attainment among Connecticut's Latinos and the related health impact. Health Literacy is defined by Healthy People 2010 as "the degree to which individuals have the capacity to obtain, process and understand basic health and services needed to make appropriate health decisions". The impact of inadequate health literacy is a growing concern nationwide. Evidence of the disproportionate challenges to obtaining adequate health literacy experienced by Connecticut's Latinos is documented throughout this report.

Health literacy is integrally linked to many of the barriers to health and health care already mentioned. However, a focus on health literacy in individual service provision and in the planning of health and education services, is critical to elevating the capacity for Latino communities throughout the state to effectively navigate health systems, adhere to health guidance and care for themselves adequately.

Cross Cultural Barriers

Growing awareness of the impact of cross cultural barriers to health care has resulted in federal requirements and numerous initiatives nationwide intended to address these issues, including cross cultural training of health care providers. A recommended training approach utilizes a broader definition of culture that includes economic class, gender, race, ethnicity, disabilities, sexual orientation, social class, literacy, language, age and spirituality. Such training requires profound conceptual exploration and personal reflection and is therefore process-rich and time consuming. A challenge to the adequate training of Connecticut's health care professionals and students is the lack of time within busy clinical work days and packed academic curricula to effectively deliver this content.

There is still much work to be done for Connecticut's health care system to assure that its care providers are skilled in working effectively with diverse populations. A critical need is the commitment of time and resources to assure a profound training that gets at the fundamental issues at hand and facilitates authentic change.

Language Barriers

The profile documents the fact that thousands of Connecticut Latinos need Spanish-language health care, that the capacity of the state's health care system to address the need, with Spanish-speaking providers or medical interpretation, is inadequate, and that this service gap impacts health literacy and health care utilization. Furthermore, the federal government requires Language Access Services in health care settings and payment for such services is feasible in Connecticut.

While medical interpretation is second best as a solution to language barriers in the health care setting, the ideal being providers who speak the language of the patients, it is a necessary and affordable step towards solving this urgent problem.

Health Care Access

Throughout this profile, difficulties in accessing health care services and in managing chronic disease and changing health behavior, are common across the series of health issues discussed. One (partial) solution to these problems mentioned in various chapters (diabetes, nutrition, child health) is the utilization of peer health educators/peer counselors/care coordinators as a strategy towards facilitating access to care, reinforcing clinical guidance and supporting health behavior changes. Public health literature has regularly affirmed the effectiveness and cost effectiveness of this approach, as has the local research cited in this document.

The potential for utilizing peer health support as a strategy toward facilitating access to care and adherence to clinical guidance should be rigorously explored with carefully planned and evaluated pilot studies focused on the critical health areas in which health inequities are experienced. Effective models should be supported as one of a number of necessary solutions to health inequities.

The breadth of these recommendations reflects the seriousness and complexity of the work that lies ahead. As highlighted in the recent report by Meyer and Hadley (2006, 14),

“health coverage is vital - but it is not enough. We need a combination of outreach to vulnerable populations, public health investments, education about behavior and lifestyle, and a reduction in racial and ethnic disparities in access to health services to make good health a reality.”

Implementing the recommendations above and achieving long-term improvements in the quality of health among Connecticut’s growing Latino population will require building a broad coalition of community organizations, service providers, research and advocacy organizations and others concerned with Latino health, all coming together as a unified and powerful force for change. As part of that broader effort, the Hispanic Health Council is launching the Latino Policy Institute to bring these stakeholders together as partners in creating and acting upon an agenda for change in health care policy and practice throughout the state.

While the enormity of the issues at hand may appear overwhelming, hope and persistence must prevail as we move forward. When Puerto Ricans are asked, “Cómo estás?” (how are you?), a common answer is “En la lucha...” (in the struggle). The struggle of attaining good health for Connecticut’s Latinos is an essential one towards assuring the well-being of the entire state. The Hispanic Health Council looks forward to working with you as part of our Latino Policy Institute. In the struggle of health for our communities in Connecticut, Venceremos! (We shall overcome!)



ENDNOTES & REFERENCES

ENDNOTES

1. Although researchers acknowledge that mortality and morbidity rates are generally underestimated for this group.
2. Approximately 47% of Latino households are headed by single females, contributing to a Latino child poverty rate of 31%. Latinos also have the highest unemployment rate (9.3%) and the second highest rate of under-employment (16.7%) in the state. Moreover, 42% of Latino adults age 25 or above do not have a high school diploma.
3. This differs from national studies that have demonstrated lower substance use among Hispanic students than among their non-Latino white counterparts. (In both the national and state studies, African American students showed lower use than non-Latino whites or Latinos.
4. After adjusting for a variety of factors including patients' age, gender, insurance status, symptom severity, number of primary care visits for asthma, number of urgent visits to the regular provider, family income, maternal education, and site of care.
5. The overall median prevalence rate for never having had a Pap test and not within the last three years was 6% and 12% respectively. In Maine, Massachusetts and New Hampshire, median prevalence rates were 5% and 11%, 5.4% and 10%, and 3% and 10%, respectively (Holmquist, 2000).
6. No objective has yet been set for reducing the prevalence of overweight.

REFERENCES

- Adams, M. (2000). Connecticut behavioral health risks: Factors related to cancer. Hartford, CT: Connecticut Department of Public Health.
- Adams, M. (2004). Connecticut behavioral health risks: Older adult health. Hartford: Connecticut Department of Public Health.
- Agency for Healthcare Research and Quality. (2006). National Healthcare Disparities Report, 2005. Rockville, MD: Agency for Healthcare Research and Quality.
- American Academy of Pediatrics. (2005). Children Health Topics/Breastfeeding. At <http://www.aap.org/2005>.
- American Cancer Society. (2001). Cancer facts and figures for African Americans 2000-2001. Atlanta, GA.
- (2003). Cancer facts and figures for Hispanics/Latinos. Atlanta, GA.
- American Lung Association. (2005). Lung Disease Data in Culturally Diverse Communities 2005. New York, NY. Available at <http://www.lungusa2.org/embargo/lddcdc/LDD.pdf>. Information on Lung Cancer and Hispanics/Latinos available at: <http://www.lungusa.org/site/pp.asp?c=dvLUK900E&b=326641>.
- American Lung Association Epidemiology & Statistics Unit Research and Program Services. (2006). Trends in Asthma Morbidity and Mortality.
- American Obesity Association. (2002). Obesity in the U.S. AOA Fact Sheets. Available at: http://www.obesity.org/subs/fastfacts/obesity_US.shtml.
- Anderson, A., Damio, G., Himmelgreen, D., Peng, Y., Segura-Perez, S., & Perez-Escamilla, R. (2004). Social capital, acculturation and breastfeeding initiation among Puerto Rican women in the United States. *Journal of Human Lactation*, 20(1): 39-45.
- Andrews, E. (2005). CT's health care system. New Haven: Consumer Health Action Network. Powerpoint presentation at: http://www.cthealthpolicy.org/ppts/ct_health_care_system_200511.pps/.

- Annie E. Casey Foundation. (2003). The Right Start for America's Newborns: A Decade of City and State Trends (1990-2000). Baltimore: Annie E. Casey Foundation.
- Annie E. Casey Foundation Kids Count Pocket Guide (2003). Latino Children: A State-Level Measures of Child Well-Being From the 2000 Census. Available at: http://www.aecf.org/publications/data/latino_pocketguide.pdf.
- (2005). *Kids count 2005 databook*. Retrieved July 29, 2005, from: <http://www.aecf.org/kidscount/sld/databook.jsp>.
- Applied Research Center and Northwest Federation of Community Organizations. (2005). Closing the gap: Solutions to race-based health disparities. Retrieved July 20, 2005, from: http://www.arc.org/downloads/closingthegap_sum.pdf
- Asencio, M "Machos and Sluts: Gender, Sexuality and Violence among a Cohort of Puerto Rican Adolescents," *Medical Anthropology Quarterly*, 13(1) (1999): 107-126.
- (2002). *Sex and Sexuality among New York's Puerto Rican Youth*. Boulder: Lynne Rienner.
- Bennett, G. (2005). The Contribution of Racism to Racial and Ethnic Disparities in Health. Presented at The Special Commission to Eliminate Health Disparities, Massachusetts State Legislature. Retrieved from: <http://www.bennettlab.org/downloads/Bennett%20-%20Discrimination%20and%20Disparities%20-%20Feb%201%202005.pdf>.
- Berg, J., Wahlgren, D., Hofstetter, C., Meltzer, S., Meltzer, E., Matt, G., Martinez-Donate, A., & Hovell, M. (2004). Latino children with asthma: Rates and risks for medical care utilization. *Journal of Asthma*, 41(2): 147-57.
- Bermudez-Millán, A., Perez-Escamilla, R., Gonzalez, A., & Segura-Perez, A. (2004). Food safety knowledge, attitudes and behaviors among Puerto Rican caretakers living in Hartford, Connecticut. *Journal of Food Protection*, Vol. 67, No. 3, 512-516.
- Bourgeois, P. (1995). *In Search of research: Selling crack in el barrio*. Cambridge: Cambridge University Press.
- Breast Cancer Fund. The Demographics of Breast Cancer in the U.S. Available from: <http://www.breastcancerfund.org/site/pp.asp?c=kwKXLDPaE&b=84427>.
- Brownson, R., Remington, P., & Davis, J. (1998). *Chronic disease epidemiology and control, 2nd edition*. Washington, DC: American Public Health Association.
- Budrys, G. (2003). *Unequal health: How inequality contributes to health or illness*. Roman & Lanham, MD: Littlefield Publishers.
- Burke, G., Maljanian R, Sabo M, Clark PJ, Estrada E. (2001). Incidence of obesity among Hartford school children. Presented at the 7th Maternal and Child Health Epidemiology Conference, U.S. Centers for Disease Control and Prevention/Maternal and Child Health Bureau, Clearwater, FL.
- Canino, I. A., Gould, M. S., Prupis, S., & Shaffer, D. (1986). A comparison of symptoms and diagnoses in Hispanic and black children in an outpatient mental health clinic. *Journal of the American Academy of Child Psychiatry*, 25, 254-259.
- Canny, P. (2000). Children's health in Connecticut. Presented to Second Year Medical Students, Yale University Medical School. Retrieved July 17, 2005, from: <http://www.ctkidslink.org/publications/h02EPH02Fall11.pdf>.
- Canny, P., Hall, D., & Geballe, S. (2002). Child and family poverty in Connecticut: 1990 and 2000. New Haven: Connecticut Voices for Children.
- Carillo, J.E., Treviño, F.M., Betancourt, J.R., & Coustasse, A. (2001) "Latino Access to Health Care: The Role of Insurance, Managed Care, and Institutional Barriers", In M. Aguirre-Molina, C. W. Molina, & R.E. Zambrana (Eds.), *Health Issues in the Latino Community* (p. 61). San Francisco: Jossey-Bass.

- The Center for Research and Public Policy. (2000). Latino socioeconomic study. Hartford: LPRAC.
- (2002). Third Latino socioeconomic study. Hartford: Latino and Puerto Rican Affairs Commission (LPRAC).
- Centers for Disease Control and Prevention (1998). Internet State-Specific Prevalence Estimates of Uninsured and Underinsured Persons—Behavioral Risk Factor Surveillance Systems, 1995. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/00051237.htm>.
- (2000). 1999 HIV/AIDS surveillance report. Atlanta: CDC.
- (2001). DATA2010 . . . the healthy people 2010 database. Hyattsville, MD: National Center for Vital Health Statistics.
- (2003a). Behavioral Risk Factor Surveillance System: Trends Data Connecticut. Atlanta: CDC. At: <http://www.apps.nccd.cdc.gov/brfss/Trends/trendchart.asp?qkey=10010&state=CT>.
- (2003b). Sexually transmitted disease surveillance, 2002. Atlanta: CDC. Retrieved September 25, 2005, from: <http://www.cdc.gov/std/stat02/>.
- (2003c). Breastfeeding practices: Results from the 2003 national immunization survey. Atlanta: CDC. At: http://www.cdc.gov/breastfeeding/NIS_data.
- (2004a). Infant Mortality Statistics: Results from the 2002 Period Linked Birth/Infant Set. National Vital Statistics Reports 53(10). Table 2. Atlanta: CDC. Retrieved on April 6, 2006 from: <http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53-10.pdf>.
- (2004b). National Center for Chronic Disease Prevention and Health Promotion National Diabetes Fact Sheet. Atlanta: CDC. At: <http://www.cdc.gov/diabetes/pubs/estimates.htm>.
- (2005). Diabetes surveillance system. Atlanta: CDC. Retrieved March 25, 2005, from: <http://www.cdc.gov/diabetes/statistics/index.htm>.
- Chapman, D., Damio, G., Young, S., & Pérez-Escamilla, R. (2004). Effectiveness of breastfeeding peer counseling in a low-income, predominantly Latina population, *Archives of Pediatric Adolescent Medicine*, 158, 897-902.
- Child Trends Data Bank. (2006). Teen Births. Available at: <http://www.childtrendsdatabank.org/indicators/13TeenBirth.cfm>.
- Children's Defense Fund. (2005). Food Insecurity 2005: Over 13 million children face food insecurity. Retrieved August 23, 2005, from: <http://www.childrensdefense.org/FamilyIncome/foodinsecurity2005>.
- Clair, S. & Singer, M. (2005). 2005 HIV status, risk, and prevention needs among Latino and non-Latino MSM in Connecticut. In D. Feldman (Ed.), *AIDS, Culture, and Gay Men*. Greenwood Press.
- Collins, K.S., Hall, A., & Neuhaus, C. (1999). *U.S. Minority Health: A Chartbook*. New York: The Commonwealth Fund.
- Connecticut Alcohol & Drug Policy Council. (2005). 2005 report to Governor M. Jodi Rell & the CT General Assembly. Retrieved March, 2006, from: <http://www.dmhas.state.ct.us/documents/ADPCreport.pdf>.
- Connecticut Department of Public Health. (1999). Breast cancer in Connecticut: A handbook for health care providers. Hartford: CT Department of Public Health, Breast and Cervical Cancer Early Detection Program.
- (2000a). 2000 vital statistics. Hartford: CT Department of Public Health. Retrieved September 15, 2005 from: <http://www.dph.state.ct.us/OPPE/RR2000/9.xlsunin>.
- (2000b). *HIV/AIDS surveillance report, year-end edition*. HIV/AIDS Surveillance Program. Hartford: CT Department of Public Health.
- (2001a). Unpublished data. Division of Policy, Planning, and Analysis.
- (2001b). Asthma in Connecticut. Hartford: CT Department of Public Health. Retrieved April 6, 2006, from: http://www.dph.state.ct.us/BCH/new_asthma/asthmaeapi.htm.
- (2001c). Epidemiological profile of HIV and AIDS, 2001. Hartford: CT Department of Public Health.
- (2001d). Chapter 20: Sexually transmitted diseases. Hartford: CT Department of Public Health. Retrieved September 15, 2005, from: http://www.dph.state.ct.us/OPPE/CTWH/Chpt%2020_Sexually%20Transmitted%20Diseases.pdf.
- (2002). Epidemiological profile. Hartford: CT Department of Public Health.
- (2002). Connecticut teen pregnancy facts, statistics, and programs.
- (2003a) Asthma in Connecticut UPDATE. Hartford: CT Department of Public Health. Retrieved April 6, 2006, from: http://www.dph.state.ct.us/BCH/new_asthma/asthmaeapi.htm.
- (2003b). Epidemiological profile of HIV and AIDS in Connecticut. Infectious Disease Division. Hartford: CT Department of Public Health.
- (2004). Facts about the relationship between medical diseases and oral health. Available at: http://www.dph.state.ct.us/bch/oralhealth/publications_reports.html.
- (2004a). The Connecticut cancer control plan, 2001-2004. Hartford: CT Department of Public Health.
- (2004b). Sexually transmitted diseases. Connecticut STD Control Program. Retrieved May 12, 2005, from: http://www.dph.state.ct.us/BCH/infectiousdis/STD_2003/std_gc_table10.htm.
- (2005a). Diabetes fact sheet. Hartford: CT Department of Public Health.
- (2005b). "Diabetes alert day," *News*. Hartford: CT Department of Public Health.
- Connecticut Health Foundation. (2005). Pathways to equal health: Eliminating racial and ethnic health disparities in Connecticut. Recommendations of the Connecticut Health Foundation's Policy Panel on Racial and Ethnic Health Disparities. New Britain, CT: CT Health Foundation.
- (2006). Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients. Anne Bagchi, Ph.D., Beth Stevens, Ph.D. New Britain, CT: CT Health Foundation.
- Connecticut Office of Health Care Access. (2002). Center for Survey Research & Analysis. "A Report Prepared for Office of Health Care Access Report". Online at: <http://www.ohca.state.ct.us/Publications/2001HouseholdSurvey.pdf>.
- (2004). CT Latinos: Lower age adjusted death but higher premature mortality rates compared with white residents. Hartford: CT Office of Health Care Access.
- (2005a). Snapshot: CT's Health Insurance Coverage Report, Results of the OHCA 2004 Household Survey. Hartford: CT Office of Health Care Access.
- (2005b). Preventable Hospitalizations in Connecticut: Assessing Access to Community Health Services in Hartford, FYs 2000-2004. Hartford: CT Office of Health Care Access. Retrieved February, 2006, from: <http://www.ct.gov/ohca>.
- Connecticut Tumor Registry. (1999). Cancer incidence in Connecticut, 1997. Hartford: Connecticut Department of Public Health.
- Connecticut Voices for Children Report . (2006). Asthma and Asthma-Related Health Care in Children Enrolled in HUSKY A: 2004. Connecticut Voices For Children, New Haven, CT.
- Conyers, J. (2003). A Fresh Approach to Health Care in the United States: Improved and Expanded Medicare for All. *American Journal of Public Health*, 93(2):193
- Cook, M.J., Ungemack, J.A., & Mark, H. (2001). Patterns of recent alcohol, tobacco, and other drug use among Caucasian, black and Hispanic students attending racially homogeneous and heterogeneous school districts. Brewster, NY: Scifor, Inc.
- Cruz, Yanira L. 2006. NHCcA Leadership Roundtable Identifies Policy Priorities, National Hispanic Council on Aging. Available at: <http://www.nhcoa.org>.
- Current Bibliographies in Medicine* (2004-1). Understanding Health Literacy and its Barriers. U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health. Available at: <http://www.n.m.nih.gov/pubs/cbm/healthliteracybarriers.html>.
- Dey, A. N., Schiller, J. S. & Tai, D.A. (2004). Summary health statistics for U.S. children: National health interview survey, 2002. National Center for Health Statistics. *Vital Health Stat*, 10(221): 1-78.

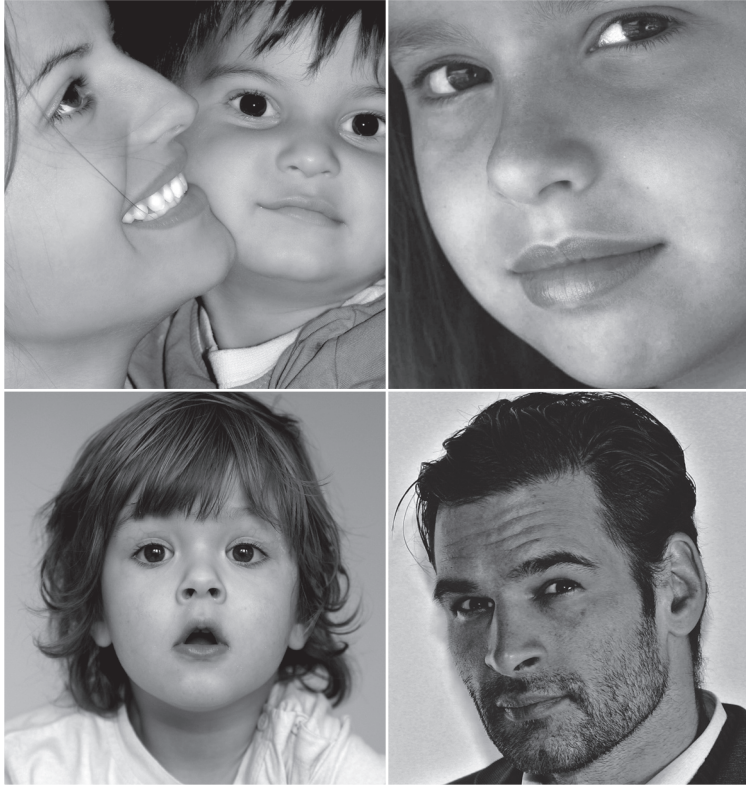
- Diaz, R.M., Ayala, G., & Bien, E. (2000). Latino gay men and HIV: Risk behavior as a sign of oppression. *Focus: A Guide to AIDS Research and Counseling*, 15(7): 28-39.
- Ditsler, E., Fisher, P. & Gordon, C. (2005). On the fringe: The substandard benefits of workers in part-time, temporary, and contract jobs. New York: The Commonwealth Fund.
- Doty, M. (2003). Insurance, access, and quality of care among Hispanic populations. Chartpack. New York: The Commonwealth Fund.
- Duke, M., Santelices, C., Nicolaysen, A.M., & Singer, M. (2003). "No somos la migra": The challenges of research among stationary Mexican farmworkers in the northeastern United States. *Practicing Anthropology*, 25(1): 26-29.
- Dye, C., Scheele, S., Dolin, P., Pathania, V., & Raviglione, M. (1999). Consensus Statement. Global Burden of Tuberculosis: Estimated Incidence, Prevalence, and Mortality by Country. WHO Global Surveillance and Monitoring Project. *Journal of the American Medical Association*, 282(7): 677-686.
- Elder, J., Castro, F., & de Moor, C. (1991). Differences in cancer risk related behaviors in Latino and Anglo adults. *Preventive Medicine*, 20:751-763.
- Eliaseo, J., Peréz-Stable, A. M., Nápoles-Springer, & Miramontes, J.M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension and diabetes. *Medical Care*, 35:12: 1212-1219.
- Evans, T., Whitehead, M., Wirth, M., Epstein, H., & McNees, P. (2001). Summary of the book: *Challenging inequities in health*. New York: Rockefeller Foundation. At <http://www.rockfound.org/library/Challenging_Inequities_In_Health_-_From_Ethics_to_Action.pdf>.
- Families USA. (2006a). Improving health coverage and access for Latinos. Making public programs work for communities of color: An action kit for community leaders. Washington, D.C.: Families USA. Retrieved February, 2006, from: <http://www.familiesusa.org/resources/tools-for-advocates/kits/minority-health-tool-kit/Improving-Latinos.pdf>.
- (2006b). Improve public programs, improve minority health. Making public programs work for communities of color: An action kit for community leaders. Washington, D.C.: Families USA. Retrieved February, 2006, from: <http://www.familiesusa.org/resources/tools-for-advocates/kits/minority-health-tool-kit/Improve-Programs.pdf>.
- Farley, T., Hadler, J., & Gunn, R. (1990). The syphilis epidemic in Connecticut: relationship to drug use and prostitution. *Sexually Transmitted Disease*, 17(4): 163-168.
- Findley, S., Lawler, K., Bindra, M., Maggio, L., Pinocchio, M., & Maylahn, C. (2003). Elevated asthma and indoor environmental exposures among Puerto Rican children of East Harlem. *Journal of Asthma*, 40(5): 557-569.
- Fiscella, K., Franks, P., Doescher, M., & Saver, B. (2002). Disparities in Health Care by Race, Ethnicity, and language among the insured: Findings from a national study. *Medical Care*, 40(1): 52-59.
- Flores, G., Abreu, M., Olivar, M.A., & Katsner, B. (1998). "Access barriers to health care for Latino children," *Archives of Pediatrics and Adolescent Medicine*, 152, 1119-1125.
- Flores, G., Fuentes-Afflick, E., Barbot, O., Carter-Pokras, O., Claudio, L., Lara, M., McLaurin, J., Pachter L., Ramos-Gomez, F., Mendoza, F., Valdez, R., Villarruel, A., Zambrana, R., Greenberg, R., & Weitzman, M. (2003). The Health of Latino children: Urgent Priorities, Unanswered Questions, and a Research Agenda. *Journal of the American Medical Association*, 288(1): 82-90.
- Flores, G., & Zambrana, R.E. (2001). "The Early Years: The Health of Children and Youth," Health Issues in the Latino Community, eds. Marilyn Aguirre-Molina, Carlos W. Molina and Ruth Enid Zambrana. San Francisco: Jossey-Bass.
- Flournoy, R. & Treuhart, S. (2005). Healthy food, healthy communities: Improving access and opportunities through food retailing. Oakland, CA: PolicyLink for the California Endowment. Retrieved February, 2006, from <<http://www.policylink.org/pdfs/HealthyFoodHealthyCommunities.pdf>>.
- Foland, J. (2002). 2005 Issue Brief #2002-1 Cardiovascular Disease: CT's Leading Killer. Hartford: CT Department of Public Health. Retrieved September 14, 2005, from: <http://www.dph.state.ct.us/OPPE/pdfs/cvd.pdf>.
- The Food Research and Action Center. (2005). State of the states: 2005. Washington, D.C.: The Food Research and Action Center. At: <http://www.frac.org>.
- Gannotti, M., Kaplan, L., Handwerker, W.P., & Groce, N. (2004). Cultural Influences on Health Care Use: Differences in Perceived Unmet Needs and Expectations of Providers by Latino and Euro-American Parents of Children with Special Health Care Needs. *Journal of Developmental Behavior and Pediatrics*, 25(3): 156-165.
- GayHealth. (2005). Syphilis rising in Connecticut. Retrieved May 23, 2005 from: <http://www.gayhealth.com/templates/1117080615645231687928/common/feature.html?record=1015>.
- Geballe, S. (2002). The state of children's mental health in Connecticut: A brief overview. New Haven: Connecticut Voices For Children.
- Georgetown University Health Policy Institute. (2004). A Consumer's Guide to Getting and Keeping Health Insurance in Connecticut. Washington, D.C.: Georgetown University.
- Giachello, A. (1996). Health outcomes research on Hispanics/Latinos. *Journal of Medical Systems*, 20:5: 235-254.
- Grant, E., Daugherty, S., Moy, J., Nelson, S., Piorkowski, J., & Weiss, K. (1999). Prevalence and burden of illness for asthma and related symptoms among kindergartners in Chicago public schools. *Annals of Allergy, Asthma and Immunology*, 83: 113-20.
- Grosvenor, B.M. & Smolin, L. A. (2002). *Nutrition from science to life*. Orlando: Harcourt College Publishers.
- Guarnaccia, P., Peltó, P., & Schensul, S. (1985). Family health culture, ethnicity, and asthma: Coping with illness. *Medical Anthropology*, 9(3): 203-224.
- Gunnell, D.J. et al. (1998). Socioeconomic and dietary influences on leg length and trunk length in childhood: a reanalysis of the Carnegie (Boyd Orr) survey of diet and health in prewar Britain (1937-39): In Diet, nutrition and chronic diseases in context, Diet, Nutrition and the Prevention of Chronic Disease, Food and Agriculture Organization, reference # 27: *Pediatric and Perinatal Epidemiology*, 12 (Suppl. 1): 96-113.
- Halfon, N., & Newacheck, P. (1993). Childhood asthma and poverty: differential impacts and utilization of health services. *Pediatrics*, 91: 56-61.
- Hall, D.J. & Geballe, S. (2004). The state of working CT, 2004. New Haven: Connecticut Voices for Children.
- Harlan, L., Bernstein, A., & Kessler, L. (1991). Cervical cancer screening: Who is not screening and why? *American Journal of Public Health*, 81(7): 885-890.
- Harman, J., Edlund, M., & Fortney, J. (2004). Disparities in the adequacy of depression treatment in the United States. *Psychiatric Services*, 55(12): 1379-85.
- Harmon, M., Castro, F., & Coe, K. (1996). Acculturation and cervical cancer: knowledge, beliefs, and behaviors of Hispanic women. *Women and Health*, 24(3): 37-57.
- Hartford Health Department. (2000). "Hartford Health Survey 2000: Your Health Counts." Hartford: Health Department.
- (2001). Health Hartford: Hartford's lead problem. Retrieved July 16, 2005, from: http://www.healthy.hartford.gov/Lead_Poisoning/PbConcern.htm.
- (2003). "Hartford Health Survey 2003: Your Health Counts." Hartford: Health Department.
- Harrison, P.M. & Beck, A. J. (2003). Prisoners in 2002. Bureau of Justice Statistics Bulletin. Washington, D.C.: U.S. Dept. of Justice. Retrieved March, 2006, from: <http://www.ojp.usdoj.gov/bjs/pub/pdf/po2.pdf>.
- Hazelwood. (2003). Internationally Recommended Definitions, Concepts, and Methodologies: Core Health Indicators, Health Analysis and Information Systems.
- Health Literacy [Internet], New York: Literacy Assistance Center. Retrieved from: <http://www.lacnyc.org/resources/healthlit/definition.htm>.

- Himmelgreen, D.A., Pérez-Escamilla, R., Segura-Millán, S., Peng, Y.K., González, A., Singer, M., & Ferris, A. (2000). Food insecurity among low-income Hispanics in Hartford, Connecticut: Implications for public health policy. *Human Organization*, 59: 334-342.
- Hoberman, H. (1992). Ethnic and minority status and adolescent mental health services utilization. *Journal of Mental Health Administration*, 19, 246-267.
- Hofmann, M., & Hooper, M. A., eds. (2001). Connecticut women's health. Hartford: CT Department of Public Health.
- Holahan J., Dubay, L., & Kenney, G. (2003). Which children are still uninsured and why. *The Future of Children*, 13(1): 68-70.
- Holmquist, N. (2000). Revisiting the effect of the pap test on cervical cancer. *American Journal of Public Health*, 90: 620-623.
- Huerta, E. (2003). Cancer statistics for Hispanics, 2003: Good news, bad news, and the need for a health system paradigm change. *CA-A Cancer Journal for Clinicians*, 53(4): 205-207.
- Human Resources and Services Administration. (2001). *Cultural competence works*. Merrifield, VA: Department of Health and Human Services. No. 98-0372(P).
- Hynes, M., Mueller, L., Bower, C., & Hofmann, M. (1999). Multicultural health: The health status of minority groups in Connecticut. Hartford: CT Department of Public Health.
- Hynes, M., Amadeo, F.A., & Mueller, L.M. (2005). 1999-2001 Connecticut Resident Mortality Summary Tables by Gender, Race, and Hispanic Ethnicity. Hartford, CT: Connecticut Department of Public Health.
- Institute for Community Research, and the Hispanic Health Council. *Findings from the Pathways to High-Risk Drug Abuse Among Urban Youth Study* (1997-2002). Hartford, CT.
- Institute of Medicine. (2003). *Hidden costs, value lost: Uninsurance in America*. Washington, D.C.: National Academies Press.
- Interagency Forum on Child and Family Statistics (2005). America's children: Key national indicators of well-being, 2005. Retrieved July 19, 2005, from <http://www.childstats.gov/americaschildren/ack.asp>.
- Intercultural Cancer Council. (2001). Hispanics/Latinos and cancer. Retrieved September 9, 2001, from <http://www.latinoaids.org/setting.htm>.
- Joseph, C., Foxman, B., Leickly, F., Peterson, E., & Ownby, D. (1996). Prevalence of possible undiagnosed asthma and associated morbidity among urban schoolchildren. *Journal of Pediatrics*, 129: 735-42.
- The Henry J. Kaiser Family Foundation. (2002a). Kaiser State Health Facts.org: Connecticut At-A-Glance, Minority health: Overweight and obesity rate by race/ethnicity. Washington, D.C.: Kaiser Family Foundation. Retrieved September 15, 2005 from <http://www.statehealthfacts.kff.org>.
- (2002b). Kaiser State Health Facts.org: Connecticut At-A-Glance, Minority health: Cigarette smoking rate by race/ethnicity. Washington, D.C.: Kaiser Family Foundation. Retrieved September 15, 2002, from <http://www.statehealthfacts.kff.org>.
- (2002c). Kaiser State Health Facts.org: Connecticut At-A-Glance, Minority health: Poverty rate by race/ethnicity, state data 2002. Washington, D.C.: Kaiser Family Foundation. Retrieved September 15, 2005, from <http://www.statehealthfacts.kff.org>.
- (2002d). Kaiser State Health Facts.org: CT/Minority health distribution of nonelderly with employer coverage by race and ethnicity state data 2002-2003; U.S. 2003. Washington, D.C.: Kaiser Family Foundation. Retrieved September 15, 2005 from <http://statehealthfacts.org>.
- (2002e). Kaiser State Health Facts.org: Connecticut At-A-Glance, Minority Health: CT Minority NonFederal Physicians. Washington, D.C.: Kaiser Family Foundation. Retrieved September 15, 2005, from <http://www.statehealthfacts.kff.org>.
- (2004a) Kaiser State Health Facts.org: Minority health, CT: Percent of mothers beginning prenatal care in the first trimester by race/ethnicity, 2002. Washington, DC: Kaiser Family Foundation. Retrieved September 15, 2005, from <http://www.statehealthfacts.kff.org>.
- (2004b). Kaiser State Health Facts.org: Connecticut At-A-Glance, Minority health: Rate of teen births per 1,000 population by race/ethnicity, 2002. Washington, D.C.: Kaiser Family Foundation. Retrieved September 15, 2005, from <http://www.statehealthfacts.kff.org>.
- Kaiser, L.L., Melgar-Quifiones, H., Townsend, M.S., Nicholson Y., Fujii, M.L., Martin, A.C., & Lamp, C.L. (2003). Food insecurity and food supplies in Latino households with young children. *Journal of Nutrition Education Behavior*, 35(3): 148-53.
- Landale, N.S. & Hauan, S.M. (1996). Migration and premarital childbearing among Puerto Rican women. *Demography*, 33: 429-442.
- Latino Commission on AIDS. (2001). *HIV prevention for immigrant and migrant communities*. New York: Latino Commission on AIDS.
- Latino Gerontological Center. (2002). *Older Hispanic-Americans left behind and in greatest need*. New York: Latino Gerontological Center.
- Latino Mental Health Summit. (2005). Available online at: http://www.csulb.edu/misc/inside/archives/vol_57_no_3/feature4.shtml.
- Lee, M.A. (2005). Health care coverage for CT's low income families. Presentation at Connecticut Health Care Summit of the Greater Hartford Interfaith Coalition for Equity and Justice on April 8, 2005. Hartford, CT: Connecticut Voices for Children.
- Lopez, C., & Yzaguirre, R. (1992). Researching and serving Hispanic elderly. Washington, D.C.: National Council of La Raza.
- Lopez, R.A., Martin, J., Tchumtchoua, S., & Drake, L. (2005). Community food security in Connecticut: An evaluation and ranking of 169 towns. Storrs and Hartford, CT: Connecticut Food Policy Council, University of Connecticut and Hartford Food System.
- Luchsinger, J.A. (2001). "Diabetes," Health Issues in the Latino Community, eds. Marilyn Aguirre-Molina, Carlos W. Molina and Ruth Enid Zambrana. San Francisco: Jossey-Bass.
- Madey S.F. (2005). An Aging Society in The Social Psychology of Aging. Available at: <http://www.ship.edu/~sfmade/ebook/agingociety/chap1.html>.
- Malentacchi, M., Cruz, N., & Wolf, S. (2004). An Assessment of Hispanic Health Status. *Connecticut Medicine*, 68(1): 37-41.
- Mansergh, G., Marks, G., Colfax, G., Guzman, R., Rader, M., & Buchbinder, S. (2002). 'Barebacking' in a Diverse Sample of Men Who Have Sex with Men. *AIDS*, 16: 653-659.
- Marotta, S., & Garcia, J. (2003). Latinos in the United States in 2000. *Hispanic Journal of Behavioral Sciences*, 25:13-34.
- Matthews, Menacker, MadDorman. Infant Mortality Statistics from the 2001 Period Linked Birth/Infant Death Set, National Vital Statistics Reports, Division of Vital Statistics, Vol. 52, No. 2 (9/15/2003).
- McMillen, S., Parr, K., & Sharma, M. (2004). Uninsured: The costs and consequences of living without health insurance in Connecticut. Storrs: Center for Economic Analysis of the University of Connecticut for the Universal Health Care Foundation of Connecticut. Retrieved on September 5, 2005, from <http://www.universalhealthct.org/>.
- Meyer, J.A., & Hadley, J. (2006). Mapping health spending and insurance coverage in Connecticut. Meriden, CT: Universal Health Care Foundation.
- Miskell, P., Coleman-Mitchell, M. A., & Lee, M.A. (2003). Asthma in Connecticut, update. Hartford, CT: Connecticut Department of Public Health.
- Mitchell, M. (1999). Findings from the Hartford Trash Incinerator Air Toxin Reduction Program. Hartford, CT.
- Mitchell, M. & Lipsett, G. (2001). Chronic recurrent respiratory ailments in Hartford. Presented to the Hartford Health Department, Asthma Call to Action Conference, Hartford, Connecticut.
- Morbidity and Mortality Weekly Report. (2002). Invasive cervical cancer among Hispanic and non-Hispanic women – United States, 1992-1999. 51(47): 1067-1070.
- Modiano, M.R (1995). Breast and cervical cancer in Hispanic women. *Medical Anthropology Quarterly*, 9(1): 75-79.

- Mosaic and Educational Development Center Report Series (2004). Beneath the Surface-Working with the complexity of Latino American demography, 6(1): 4-6. Available at: <http://main.edc.org/Mosaic/Mosaic9/beneath.asp>.
- Moore, J. (1978). *Homeboys: Gangs, drugs and prison in the barrios of Los Angeles*. Philadelphia: Temple University Press.
- Mueller, L. & Hynes, M. (2005). Health disparities in Connecticut: Current surveillance data. Hartford: Multicultural Advisory Commission, Connecticut Department of Public Health, Health Information Systems and Reporting Division.
- National Center for Cultural Competence and the Georgetown University Center for Child and Human Development (GUCCDC). (2001). Policy brief 1: Rationale for cultural competence in primary health care. Washington, D.C.: GUCCDC. Retrieved September 28, 2005, from: <http://gucdc.georgetown.edu>.
- National Centers for Health Statistics. (2002). A demographic and health snapshot of the U.S. Hispanic/Latino population. Atlanta, GA: Centers for Disease Control and Prevention.
- National Centers for Health Statistics. (2005). Asthma prevalence, health care use and mortality 2002. Retrieved March 24, 2005, from: <http://www.cdc.gov/nchs/products/pubs/hesstats/asthma/asthma.htm>.
- National Committee on Vital and Health Statistics Subcommittee on Populations. (2005). Eliminating health disparities: Strengthening data on race, ethnicity, and primary language in the United States. Hyattsville, MD: National Committee on Vital and Health Statistics.
- National Council of La Raza. (2001). Beyond the census: Hispanics and an American agenda. Washington, D.C.: National Council of La Raza.
- National Heart, Lung and Blood Institute. (2006). Latino Cardiovascular Health Resources. Bethesda, MD: National Heart, Lung and Blood Institute. Retrieved March 30, 2006, from: http://www.nhlbi.nih.gov/health/prof/heart/latino/latin_pg.htm.
- National Institute on Drug Abuse. (2004). 2003 monitoring the future study. At: <http://www.nida.nih.gov>.
- National Latino Behavioral Health Association. (2005). Connecticut Latina wins prestigious behavioral health award. Online at: http://nlbha.org/news_sp.htm#advocate.
- Navarro-Rivera, J. (2001). *Monograph #9: Latinos in Connecticut: A decade of change*. Storrs: University of CT.
- Nord, M., Andrews M., & Carlson, S.. (2004). Household food security in the United States, 2003. USDA Food Assistance and Nutrition Research Report, Number 42. Washington, D.C.: Economic Research Service, U.S. Dept. of Agriculture.
- O'Brian, K., Cokkinides, V., Jemal, A., Carnidez, C., Murray, T., Samuels, A., Ward, E., & Thun, M..(2003). Cancer statistics for Hispanics, 2003. *CA-A Cancer Journal for Clinicians*, 53(4): 208-226.
- O'Connor, S., West, S., Lorntz, B., Vinicor, F., & Jorgensen, C. (2004). Women and infectious disease-chronic disease interactions [conf. summary]. Emergent Infectious Disease [serial on the Internet]. Retrieved May 18, 2005, from: http://www.cdc.gov/ncidod/EID/vol10no11/04-0623_14.htm.
- Office of Minority Health. (2000). Assuring cultural competence in health care: Recommendations for national standards. Retrieved July 18, 2005, from: <http://www.omhrc.gov/cls/po.htm>.
- (2005a). Cardiovascular disease (CVD) fact sheet. Atlanta: Centers for Disease Control. Available at: <http://www.cdc.gov/omh/AMH/factsheets/cardio.htm>.
- (2005b). Fact sheet: Eliminate disparities in cancer screening and management. Atlanta: CDC. At: <http://www.cdc.gov/omh/AMH/factsheets/cancer.htm>.
- Office of Research on Woman's Health. (1998). *Women of color data book*. Washington, D.C.: National Institutes of Health, Publication no. 98-4247.
- Ortega, A., Gergen, P., Paltiel, A., Baucher, H. Belanger, K. & Leaderer, P. (2002). Impact of site of care, race, and Hispanic ethnicity on medication use for childhood asthma. *Pediatrics*, 109(1):E1.
- Pachter, L., Cloutier, M., & Berstein, B. (1995). Ethnomedical (folk) remedies for childhood asthma in a mainland Puerto Rican community. *Archives of Pediatric Adolescent Medicine*, 149: 982- 988.
- Pappas, Greg, Queen, S., Hadden, W., & Fisher, G. (1993). The increasing disparity in mortality between socioeconomic groups in the United States, 1960 and 1986. *The New England Journal of Medicine*, 329(2): 103-109.
- Pérez-Escamilla, R., Himmelgreen, D.A., & Ferris, A. (1997). Community nutritional problems among Latino children in Hartford, CT. Connecticut Family Nutrition Program Technical report #1, Storrs and Hartford CT.
- Pérez-Escamilla, R., Himmelgreen, D., Segura-Millan, S., Gonzalez, A., Ferris, A.M., Damio, G., & Bermudez-Vega, A. (1998). Prenatal and perinatal factors associated with breast-feeding initiation among inner-city Puerto Rican women. *Journal of the American Dietetic Association*, 98: 657-663.
- Pérez-Escamilla, R., Himmelgreen, D., Segura-Millán, S. González, A., Méndez, I., and Haldeman, L. (1999). Knowledge of folic acid and neural tube defects among inner city residents: Have they even heard about it? *Journal of the American Dietetics Association*, 99: 80-83.
- Pérez-Escamilla, R., Himmelgreen, D., Bonello, H., González, A., Haldeman, L., Méndez, I., Cruz, J., Segura-Millán, S. (2000). Nutrition knowledge, attitudes, and behaviors among Latinos in the USA: Influence of language. *Ecology of Food and Nutrition*, 40(4): 321-324.
- Pérez-Escamilla, R., Himmelgreen, D., Bonello, H., González, A., Haldeman, L., Méndez, I., Cruz, J., & Segura-Millán, S. (2001). Nutrition knowledge, attitudes, and behaviors among Latinos in the USA: Influence of language. *Ecology of Food and Nutrition*, 40: 321-345.
- Pérez-Escamilla, R., Damio, G., Fitzgerald, N., Segura-Pérez, S., & Peng, Y.K. (2004). Diabetes among Latinas in Hartford: Key findings & recommended actions. Storrs and Hartford, CT: University of Connecticut and the Hispanic Health Council.
- Pérez-Escamilla, R. (2005). Influence of breastfeeding on psychosocial development. Encyclopedia on Early Childhood Development, Center for Excellence for Early Childhood Development. Published online, April 18, 2005.
- Pew Hispanic Center. (2002). National survey of Latinos. Menlo Park, CA: The Henry J. Kaiser Family Foundation.
- Quintero-Somani, A. & Quirindongo, M. (2004). Hidden danger: Environmental health threats in the Latino community. New York: Natural Resources Defense Council. Retrieved July 25, 2005, from: http://www.nrdc.org/health/effects/latino/english/latino_en.pdf.
- Ramirez, Roberto & de la Cruz, P. (2003). The Hispanic population in the United States: March 2002, population characteristics. Washington, D.C.: U.S. Bureau of the Census.
- Ramsden, I. (1990). *Whakaruruhau: Cultural safety in nursing education in Aotearoa*. Auckland: Maori Health and Nursing, Ministry of Education, Government of New Zealand.
- Randall, V. (1999). Latino elderly health status inequities. Dayton, OH: Institute on Race, Health Care and the Law, The University of Dayton School of Law.
- Ríos, E. A. (2001). Good intentions are not enough! New York: Latino Commission on AIDS.
- Rios, E.A. (2004). Las olvidadas (the forgotten ones): Latinas and the HIV/AIDS epidemic. New York: The Hispanic Federation, Inc.
- Robert Wood Johnson Foundation. (2005). Characteristics of the uninsured: A view from the states. Princeton, NJ: Robert Wood Johnson Foundation.
- Rosado, J. W., & Elias, N. J. (1993). Ecological and psycho-cultural mediators in the delivery of services for urban, culturally diverse Hispanic clients. *Professional Psychology: Research and Practice*, 24, 450-459.
- Rose, A., Sinka, K., Watson, J., Mortimer, J. & Charlett, A. (2002). An estimate of the contribution of HIV infection to the recent rise in tuberculosis in England and Wales. *Thorax*, 57(5): 442-445.
- Rouse, B. (1995). *Substance abuse and mental health statistics sourcebook*. Washington, D.C.: U.S. Government Printing Office (SMA) 95-3064.

- Ryan, S., Franzetta, K., & Manlove, J. (2005). Hispanic Teen Pregnancy and Birth Rates: Looking Behind the Numbers (Research Brief). Washington, DC: *Child Trends*. Retrieved on November 2006 from: <http://www.childtrends.org>.
- Scott, J. (2005). Life at the top in America isn't just better, it's longer. *New York Times*, May 16.
- Selig Center for Economic Growth. (2002). *Multicultural economy 2002: Minority buying power in the new century*. Athens: University of Georgia.
- Shields, A., Comstock, C., & Weiss, K. (2004). Variations in asthma care by race/ethnicity among children enrolled in a state medicaid program. *Pediatrics*, 113(3): 496-504.
- Singer, M. (1995). Providing substance abuse treatment to Puerto Rican clients living in the continental United States. In *Substance Abuse Treatment in the Era of AIDS*, Vol. II, pp. 93-142. Omowale Amuleru-Marshall, Ed. Rockville, MD: Center for Substance Abuse Treatment.
- (1999). Why do Puerto Rican injection drug users inject so often? *Anthropology and Medicine*, 6(1): 31-58.
- (2005). Latinos and AIDS. *The Oxford Encyclopedia of Latinos and Latinas in the United States*. Oxford: Oxford University Press.
- Singer, M. & Jia, Z. (1993). AIDS and Puerto Rican injection drug users in the United States. In: *Handbook on Risk of AIDS: Injection Drug Users and Sexual Partners*. Edited by Barry Brown and George Beschner, pp. 227-255. Westport, CT: Greenwood Press.
- Singer, M., Jia, Z., Schensul, J.J., Weeks, M., & Page, J.B. (1992). AIDS and the IV drug user: The local context in prevention efforts. *Medical Anthropology*, 14: 285-306.
- Singer, M., & Marxuach-Rodriguez, L. (1996). Applying Anthropology to the Prevention of AIDS: The Latino Gay Men's Health Project. *Human Organization*, 55(2): 141-148.
- Singer, M., Stopka, T., Shaw, S., Santilices, C., Buchanan, D., Teng, W., Khoosnood, K., & Heimer, R. (2005). Lessons from the field: From research to application in the fight against AIDS among injection drug users in three New England cities. *Human Organization*, 64(2): 179-191.
- Singer, M. & Weeks, M. (1996). Preventing AIDS in communities of color: Anthropology and social prevention. *Human Organization*, 55(4): 488-492.
- Sobo, Elise. (1995). Finance, romance, social support, and condom use among impoverished inner-city women. *Human Organization*, 54(2): 115-128.
- State of Connecticut. (2005) Childhood Obesity in Connecticut: Where We Stand. Hartford, CT: General Assembly, Commission on Children. Retrieved April 7, 2006, from: http://cga.ct.gov/coc/PDFs/021005_obesity_bullet_points.pdf.
- Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, 59: 533-540.
- Surgeon General. (1999). Mental health: A report of the surgeon general. Washington, D.C.: U. S. Department of Health and Human Services, U.S. Public Health Service.
- Swift, Mike & D'Arcy, Janice. (2000.) Hispanic Population Growing, Changing: Latin American Influx Alters Makeup of Neighborhoods. *Hartford Courant*, November 26.
- Teaster, P. (2001). A response to the abuse of vulnerable adults: The 2000 survey of state adult protection services. Washington, DC: The National Center on Elder Abuse.
- Thackeray, R., Merrill, R. M., & Neiger, B. L. (2004). Disparities in diabetes management practice between racial and ethnic groups in the United States. *The Diabetes Educator*, 30(4): 665-675.
- Trinity College. (2001). Hartford Primer and Field Guide. Hartford, CT: Cities Data Center, Trinity College.
- Turner, C., Miller, H., & Moses, L. (1989). *AIDS: Sexual behavior and intravenous drug use*. Washington, D.C.: National Academy Press.
- United Health Foundation. (2005). America's Health Rankings. Online at <http://www.unitedhealthfoundation.org/shr2005/states/Connecticut.html>.
- Urbina, I. (2006). Bad blood: In the treatment of diabetes success often does not pay. *New York Times*, January 11.
- U.S. Census Bureau. (2000a). Census 2000: Summary File 4: CT Hispanic or Latino (of any race) Median Family Income in 1999 (Dollars) by Family Size. Washington, D.C.: U.S. Census Bureau. Retrieved September 12, 2005, from <http://www.census.gov>.
- (2000b). Census 2000 Summary File 3, CT: Profile of Selected Social Characteristics. Washington, DC: U.S. Census Bureau. Retrieved September 21, 2005, from: <http://www.census.gov>.
- U.S. Department of Health and Human Services (DHS). (2003). National healthcare disparities report. Washington, DC: U.S. DHS.
- Healthy People 2010. Washington, D.C.: Government Printing Office. At <http://www.healthypeople.gov/publications>.
- (2004). Pediatric Nutrition Surveillance 2003 report. Atlanta, GA: CDC.
- U.S. Department of Health and Human Services and National Institutes of Health. Understanding adult obesity. Available at: <http://win.niddk.nih.gov/publications/understanding.htm>.
- U.S. General Accounting Office (2000). Oral Health – Dental Disease Is a Chronic Problem Among Low-Income Populations. Available at: <http://www.gao.gov/archive/2000/000072.pdf>.
- U.S. Office of Management and Budget. (2002). Report to Congress, Assessments of the total benefits and costs of implementing executive order no. 13166: Improving access to services for persons with limited English proficiency. Washington, D.C.: U.S. Office of Management and Budget.
- U.S. Preventive Services Task Force. (2001). Screening for chlamydial infection: Recommendations and rationale. *American Journal of Preventive Medicine*, 20(3S): 90-94.
- U.S. Small Business Administration, Office of Advocacy. (2005). Small business profile: CT. Washington, DC: SBA, Office of Advocacy. Retrieved October 3, 2005, from <<http://www.sba.gov/advo/stats/profiles/04ct.pdf>>.
- Valleroy, L., MacKellar, D., Karon, J., Rosen, D., McFarland, W., Shehan, D., Stoyanoff, S., LaLota, M., Celentano, D., Koblin, B., Thiede, H., Katz, M., Torian, L., & Janssen, R. (2000). HIV prevalence and associated risks in young men who have sex with men. *Journal of the American Medical Association*, 284(2): 198-204.
- Vitullo, M. & Taylor, A. (2002). Latino adults' health insurance coverage: An examination of Mexican and Puerto Rican subgroup differences. *Journal of Health Care for the Poor and Underserved*, 13(4): 504-25.
- Wagner, P. (2004). Latinos are overrepresented in Connecticut's prisons and jails. Northampton, MA: Prison Policy Initiative. Graph at: <http://www.prisonpolicy.org/graphs/CT.Latino.shtml>.
- Waitzkin, H. (2006). Social Structural and Economic Influences on Health Care Disparities. Presented on NIH Conference on Understanding and Reducing Health Disparities, Bethesda, MD, October 23.
- Wargo, J. & Brown, D. (2002). Children's exposure to diesel exhaust on school buses. North Haven, CT: Environment & Human Health, Inc.
- Webber, M., Carpiniello, K., Oruwariye, T., & Appel, D. (2002). Prevalence of asthma and asthmalike symptoms in inner-city elementary schoolchildren. *Pediatric Pulmonology*, 2: 105-11.
- Weeks, M., Grier, M., Romero-Daza, N., Puglisi, M. & Singer, M. (1998). Streets, drugs, and the economy of sex in the age of AIDS. *Women and Health*, 27(1/2): 205-228.
- Weissman, J., Betancourt, J., Campbell, E.G., Park, E.R., Kim, M., Clarridge, B., Blumenthal, D., Lee, K.C., & Maina, A.W. (2005). Resident physicians' preparedness to provide cross-cultural care. *Journal of the American Medical Association*, 294: 1058-67.
- Whitman, S., Williams, C., & Shah, A. (2004). Sinai Health System's improving community health survey. Chicago, IL: Sinai Urban Health Institute. Report No.1.
- Wilson, A. A. (2004). Road map to health. Hartford, CT: CT Department of Public Health. Retrieved August 28, 2005, from: http://www.dph.state.ct.us/Publications/BCH/roadmap_2004.pdf.

¡Adelante!



Please join the Latino Policy Institute as we work to give a face and a voice to Connecticut Latinos in the struggle against health disparities.

Juntos venceremos las desigualdades de salud.



Hispanic Health Council

175 Main Street
Hartford, CT 06106

p 860.527.0856

F 860.724.0437

<hispanichealth.com>

LATINO POLICY INSTITUTE