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Community Health Leaders Address Health and Health Care for Immigrants and Their Families

by Flavia Walton, Ph.D.

San Diego Peer Exchange

In May 2008, Community Health Leaders (CHL) from the southwest border states of Arizona, California, New Mexico and Texas met in San Diego to deliberate a crosscutting issue of great concern and controversy. It is an issue having a major impact in their communities: health and health care for immigrants and their families in the southwest United States. As peers they exchanged knowledge and experiences, and developed a consensus on recommendations to improve practices and policies.

The states along the southwest border are major ports of entry for immigrants coming to the United States by land, sea and air. CHL report attitudes and behavior in communities based on myth and incorrect information that contribute to and exacerbate impediments and barriers to health and health care for immigrants, their families, and persons perceived as immigrants.

The 2007 National Survey of Latinos conducted by the Pew Hispanic Center reports just over one-half of Hispanic adults in the United States worry that they, a family member, or a close friend could be deported.¹ The worries are fueled by attitudes that feed on myth and incorrect information and generate prejudice and biased actions by individuals and groups.

Findings from the pre-conference survey of Peer Exchange participants revealed the following information:

- Eighty-six percent of CHL serve or interact with immigrants and their families in the normal course of their work.
- Only one of the participating CHL routinely determines the citizenship status of the persons they serve. While the decision to determine citizenship status is generally influenced by requirements of the funding source and/or local laws, CHL are often forced to make a choice between attending to compelling human needs and obeying the law or the requirements of funders.
- Asked to rank order the immigrant groups they serve, all CHL reported Hispanics as number one, followed by Africans and Europeans tied in the number two position. Asian immigrants ranked number three.

Other immigrant groups listed, but not ranked in the top three, are Pacific Islanders and immigrants from the Middle East. (This follows closely the immigrant population breakdown reported by The Center for Health and Health Care in Schools).²

- During the last three years, all but one of the participating CHL reported an increase in the number of immigrants served. The remaining leader reported no change in the numbers served during the same time period.

CHL attributed the following factors to changes in the number of immigrants with whom they work or serve:

- An increase in the number of immigrant families in the community
- Immigration problems at the borders leading to more people staying in the area rather than returning to Mexico and trying to get back again
- Growth in local jobs, e.g., the wine industry in Northern California
- The positive reputations of CHL and other programs for providing safe, quality services to immigrants
- Strengthened collaborative partnerships among groups and clinics serving the immigrant population
- Low-cost, community-based health services being the only alternatives in many communities for the working poor who have no health insurance through work and/or no money to purchase it
- Accessibility and cultural sensitivity of CHL to the individuals they serve
- Services such as family planning clinics and interpreter/translation services
- The closures of hospital and other health care facilities
- An increased community awareness of services provided by community health centers.

The majority of leaders reported that the health status of immigrants in their communities had worsened, generally because of emerging health issues including,

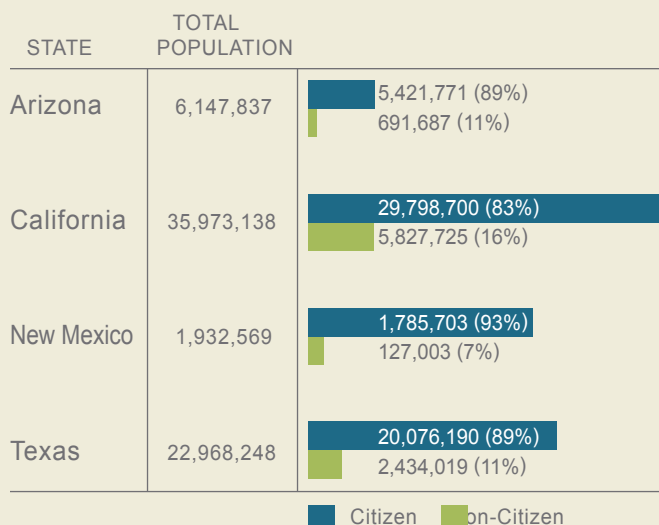
but not limited to, diabetes, domestic violence, mental health issues, alcohol and drug abuse, and poor oral health. Several leaders attributed these health issues to stress and the reluctance to seek health care as a result of the fear of being caught.

SPOTLIGHT

La Maestra Family Clinic, a federally qualified health center in San Diego, is an example of the complexity and the success of providing health care for immigrants and their families. La Maestra, headed by Executive Director **Zara Marselian, M.A. (2004 CHL)**, is a large, comprehensive program that provides health care, social services and translation services to immigrants and their families in over 19 different languages. The program, housed in several converted homes spread over multiple city blocks, will soon move into a state-of-the-art facility. The program has an impressive complement of paid and volunteer staff, and volunteers from local hospitals and medical centers. www.lamaestra.org.

THE FACTS

The Kaiser Family Foundation State Health Facts 2005–2006 report population data for the four states as follows:³



Data and research gathered by the Center for American Progress and the California Immigrant Policy Center refute the five most prevalent myths misinforming the current debate on immigration.

MYTH: Public health insurance programs are overburdened with documented and undocumented immigrants.

FACT: Undocumented immigrants have very little access to publicly funded health care programs and are reluctant to use services because of fear and confusion over eligibility rules. Immigrants are much less likely to use emergency rooms than native-born citizens. Federal law requires that immigrants wait five years after obtaining lawful permanent residency to apply for federal benefits.

MYTH: Immigrants consume large quantities of limited health care resources.

FACT: The majority of people who lack insurance are U.S. citizens. Unauthorized immigrants make up only a fraction of the uninsured population. The majority of the growth in the number of uninsured from 2000–2006 occurred among citizens, not legal and undocumented non-citizens. RAND Corporation researchers estimate that undocumented adult immigrants make up about 3.2 percent of the population, but account for only about 1.5 percent of U.S. medical costs. In total, non-citizens make up only about 20 percent of the 46 million uninsured people in the United States.

MYTH: Immigrants come to the United States to gain access to health care services.

FACT: Immigrants come to the United States to find work. Immigrants are most likely to work in the agricultural or construction industry where the rates of uninsured exceed 30 percent for all workers compared to 19 percent for workers across all industries. Federal law generally bars undocumented immigrants and recent legal immigrants from receiving Medicaid and SCHIP coverage.

MYTH: Restricting immigrants' access to health care will not affect American citizens.

FACT: Anyone who resides in the United States

should be able to seek and receive medical attention to stop the spread of disease, control health epidemics, and ultimately hold down associated costs for everyone. The consequences of limiting or terminating immigrants' access to health care are costly and endanger families, communities, and health care systems.

MYTH: Undocumented immigrants are “free riders” in the American health care system.

FACT: Immigrants are drawn to states where jobs are available, not to states that provide the most health services and benefits for their residents. In 2001 the Social Security Administration (SSA) reported that undocumented immigrants accounted for a major portion of the billions of dollars paid into Social Security that does not match SSA records. Those payees, many of whom are undocumented immigrants, can never draw upon their benefits.⁴

Participating CHL represented an array of programs and strategic approaches that are diverse in size, funding, and location. They range from small community-based organizations and coalitions that struggle to keep their doors open to large, well-funded, comprehensive programs associated with hospitals, academic institutions, and public and private service organizations. One program conducts an aggressive, well-organized fund-raising campaign in the community, while other programs depend solely on successfully competing for public and private funding.

Programs also vary with the diversity of the immigrant populations they serve; some programs serve only one population while others serve multiple immigrant populations. Whether the programs are located in small towns, rural areas or large metropolitan centers, they are among a few, if not the only programs, providing health care to immigrants and their families in their respective communities, readily and courageously braving the ever-present possibility of unexpected raids by the Immigration and Naturalization Service (INS), Immigration & Customs Enforcement (ICE) and other law enforcement agencies.

One health leader in Arizona reported operating under the constant threat of an infamous sheriff who

frequently conducts raids in search of immigrants, entering facilities with battering rams. Another program in Arizona enjoys a positive relationship with the border enforcement agency and both work together on immigration issues. While laws still impede the ability to serve those most in need, a positive relationship affords a less contentious environment in which to find workable solutions to difficult challenges.

A program located in a remote area in New Mexico provides the only affordable health services in the area for cash payers, many of whom are immigrants without health insurance or money to pay for it.

PRESENTERS

CHL heard special presentations from **Luis Moisés Escalante**, health and benefits access education coordinator, Interfaith Coalition for Immigrant Rights (ICIR); **Ann Tartre**, director, U.S.-Mexico Border Philanthropy Partnership, The Synergos Institute; and **Joseph Gallegos**, senior vice president for western operations, National Association of Community Health Centers. They provided examples of existing programs and strategies that effectively increase the availability and access to quality health care by identifying and utilizing special funding sources, networking with community service organizations and faith-based organizations, and building cross-border health coalitions and services. **Joseph Gallegos** presented a compelling case for the role of community health centers as the primary sources of health care for immigrants and their families. He underscored the need for consumer representation on boards and in decision-making positions in community health centers. Such participation would encourage advocacy for consumer interests and inform policy and the delivery of health care services.

THE ISSUES

CHL identified several issues in their discussions. The following summarizes the major issues that have

an impact on their ability to provide health care to immigrants and their families.

Myths—incorrect perceptions that immigrants overburden the health care system or that they bring all kinds of diseases with them.

Racism—often influences access to and the type of health care received. It also influences other social determinants of health, e.g., living environment, employment, life style, etc.

Americans or immigrants—what do they look like and how does one tell the difference? Americans perceived to be immigrants are often refused health care and other services based on appearance and/or the perceptions of others.

Contentious and punitive environment—discourages providing health care and other needed services and encourages punishment for immigrants as well as service providers.

Scapegoat—immigrants are often blamed for everything negative that happens in communities, including public health issues.

Religion/faith and health care—often negatively influence access to funding according to the targeted priorities and preferences expressed by funders or ideology.

Cultural disconnect—the differences between Western medicine and practices in countries of origin often influence the ability to deliver health care and other services.

“New Community” issues—immigrants suffering from the consequences of torture, female mutilation, gender roles, etc. are among the new medical issues challenging CHL.

Insufficient numbers of interpreters—there is a dearth of well-versed medical translators who can also interpret the cultural nuances relating to health and health care. The shortage of medical translators too often creates situations where children are asked to interpret for their parents, an untenable situation within the parents’ cultural orientation.

Increase in the number of cross-cultural, cross-national families—increases the need for cross-cultural understanding and health care services.

RECOMMENDATIONS FROM THE LEADERS

Leaders developed recommendations in four general areas: social determinants of health; funders' attitudes and requirements; enforcement; and diseases and conditions (any change or emerging diseases specific to populations served in the past two years).

- Social determinants of health must be integral components of community strategies to improve the health of immigrants. Discrimination and prejudice, housing, language barriers and culture are key elements that influence access and effectiveness of any efforts or services to improve health or delivery of health care to immigrants and their families, including environmental health issues.
- Funders' attitudes and requirements must integrate consideration for those issues that influence the lives of immigrants in developing goals for positive social change and health care. Funders and philanthropies vary widely by community and according to the perspectives and policies of their management and donors. There is a vast difference between the manner in which local and national philanthropies and funders determine goals for social change and funding strategies. While not specifically excluding certain cultural groups, some funding policies will establish strategic goals that emphasize certain social and health issues at the expense of those issues that have the greatest impact on immigrant communities.
- Enforcement policies and practices should not deter the delivery of health care for immigrants and their families. Communities should hold policy-makers and power brokers accountable for draconian and predatory practices against documented and undocumented immigrants that have the practical impact of discouraging them from seeking health care for themselves or their families. Disincentives should be established for those entities that unnecessarily collaborate with Immigration Services in such a way that negatively affects the health-seeking behavior of the immigrant (documented and undocumented).

- Specific diseases and conditions are statistically increasing among immigrants and their families and require aggressive comprehensive strategies. Rising rates of diabetes, high blood pressure, mental health, and occupational health issues can be reduced through a combination of health services, culturally sensitive community education, and research into factors that may contribute uniquely to issues within immigrant communities.

CONCLUSION

Community Health Leaders are committed to working for healthy communities and access to care that can assure and sustain health for individuals and families. Tensions created by the current socio-political atmosphere have the potential to jeopardize the health of immigrants and their families and ultimately entire U.S. communities. According to U.S. census data, 85 percent of immigrant families with children are mixed-status families with at least one immigrant parent and at least one citizen child. The overall health of U.S. communities is assured by providing access to quality care for every individual. The country should not establish standards and criteria for delivering care based on whom it will exclude. Such practices establish precedents for escalating decisions about who will be excluded next.

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Acknowledgements: Thanks to Rachel Gonzales-Hanson (1995 CHL), CEO Community Health Development Inc.; Uvalde, Texas, for assistance and developing background for this publication.

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