

## EXPLORATION OF HEALTH CARE CONCERNS OF HISPANIC WOMEN IN A RURAL SOUTHEASTERN NORTH CAROLINA COMMUNITY

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**Key words:** Rural, Access to Health Care, Health Care Utilization, Hispanic Women

### ABSTRACT

**Background and Research Objective:** Hispanics experience substantial barriers to health care and a disproportionate negative health status in rural southeastern North Carolina. The purpose of this study was to explore concerns regarding health care utilization among eight Hispanic women residing in this locality.

**Sample and Methods:** The study utilized a qualitative research design drawing from semi-structured interviews. Information obtained from the interviews was categorized using the constructs of Andersen's Behavioral Model of Health Services Use: predisposing, enabling, and need characteristics.

**Results and Conclusions:** Limited access to health care service and lack of continuity of care were apparent in this Hispanic community and these were due to inability to afford services, difficulties with transportation and appointment schedules, dissatisfaction with services, language barriers, and inability to understand treatment plans. Culturally sensitive outreach nursing would be effective to promote preventive health maintenance and continuity of care for those with chronic illness.

### INTRODUCTION

Hispanics are the fastest growing minority group in the United States totaling 14.8% of the total U.S. population (US Census Bureau, 2008). Health indicators of Hispanics suggest that health outcomes continue to lag behind other population groups and remain below goals established by *Healthy People 2010*. The 2003-2005 North Carolina BRFSS telephone survey data indicated that a higher percentage of Hispanics reported fair or poor health than both whites and African Americans (NC DHHS, 2006). While Hispanics showed relatively poor health status, the population is faced with barriers to health access. In North Carolina, Hispanics had substantially higher percentages than whites and African Americans for all three measures of health access—no current health insurance, couldn't see a doctor due to cost, and no personal doctor (NC DHHS, 2006).

While many studies were focused on the barriers of health access for the Hispanic population, few studies have exclusively explored the experiences of the female population and their concerns regarding access to health care in the United States. The Hispanic population of North Carolina has more than quadrupled since 1990 (NC DHHS, 2006). As the Hispanic population increases in North Carolina, it is important to better understand the experiences of Hispanic women as they seek health care, in order to improve health related outcomes for this population. The purpose of this qualitative study was to explore concerns among Hispanic women experienced while they are seeking health care in rural southeastern North Carolina.

## LITERATURE REVIEW

Multiple internal and external factors, including language barriers, cultural differences, and low socioeconomic status, appear to be significantly related to health care access for Hispanics in a rural area. Fewer Hispanics than whites had a usual source (location and place) of health care and fewer had a usual primary care provider (Adams & Horn, 2007). According to the 2004 National Health Disparities Report, fewer Hispanics than whites had established a relationship to a physician or had made an outpatient visit in the past year (Agency for Healthcare Research and Quality, 2004). While members of the Hispanic community often seek emergency health care when needed, many do not seek routine health care for primary prevention or management of chronic illness.

The literature repeatedly supports the negative impact of limited English proficiency and low literacy levels on health care access and outcomes among the Hispanic population (Jacobs, Karavolos, Rathouz, Ferris, & Powell, 2005; Pippins, Alegria, & Hass, 2007). Timmins (2002) reported that non-English speaking status was a marker of population at risk for decreased access to health care. Through analysis of data obtained from 1997-2002 in Oakland, Los Angeles, and Newark for the Study of Women's Health Across the Nation (SWAN), Jacobs and colleagues found that percentages of women who received breast and cervical cancer screenings were 30-40% higher for those who were proficient in the English language than those who were not, concluding that optimal health care is greatly impacted by the inability to speak or read English (Jacobs et al., 2005). Likewise, Cohen and colleagues (2005) who analyzed data primarily from the admission and billing database of a large, regional, academic children's hospital, reported that hospitalized Spanish-speaking pediatric patients whose families had language barriers were two times more likely to experience a serious medical event than those whose families spoke English (Cohen, Rivara, Marcuse, McPhillips, & Davis, 2005).

Low income, low educational attainment, and unemployment are all associated with a higher rate of health problems and poor health access (Miller, Guarnaccia, & Fasina, 2002; Rojas-Guyler, King, & Montieth, 2008). For example, surveys of Hispanic women in Georgia and Florida revealed that the respondents did not seek preventive health care services because of their inability to pay due to low income and/or no healthcare insurance which suggests that underutilization of preventive services, such as cervical cancer screenings, mammography, and family planning may adversely affect the health status of this group (Asamoia et al 2004).

In addition, access to care is dependent on the availability of health care providers and services. In a study by Casey and colleagues, information regarding barriers to health care access was provided by 54 Hispanic key informants interviewed in three rural Midwestern communities. The testimony of these informants showed that partial health care needs were being met in rural areas by federally funded community health centers for the urgent and primary care of the uninsured. However, the unmet needs identified by this group included primary care for men and older non-working adults, preventive services, continuity of care for adults with chronic illnesses, and coverage for prescription drugs (Casey, Blewett, & Call, 2004). Additional barriers identified in these rural areas were the shortage of physicians and other health care providers. Of those providing care in these rural areas, many were hesitant to accept new patients that would require extensive appointment times (office visits are longer with the use of interpreter services), and who are indigent or uninsured (Casey et al., 2004).

## CONCEPTUAL FRAMEWORK

Andersen's Behavioral Model of Health Services Utilization has served as the conceptual framework for this study. This model describes factors that inhibit or facilitate access to health care, and how these factors are operationalized in the process of healthy utilization (Andersen, 1995; Wallace, Scott, Klinnert, & Anderson, 2004). Population characteristics and health behaviors were the areas of primary focus within the model. Three constructs based on population characteristics that are thought to contribute to issues related to health care access have been identified in Andersen's model: predisposing, enabling, and need characteristics. These factors demonstrate the likelihood that people will need health care services.

Andersen (1995) suggested that people are predisposed to factors that impact ability or need to obtain health care. Demographics, position within the social structure, health beliefs, and psychosocial characteristics define and determine a person's access to care (Andersen, 1995). Such predisposing characteristics are present prior to illness and have great bearing on an individual's inclination to seek health care. Enabling characteristics are conceptualized as family and community resources such as finances and transportation. But the need characteristic is also based on the individual's perception, which impacts the resulting health behavior. Perceived need is demonstrated as degree of concern regarding illness, health risks, and health habits. Perceptions of health and need for care may be influenced by predisposing and/or enabling characteristics, suggesting that attributes and characteristics may overlap to impact health care access.

## DESIGN AND METHODS

A qualitative research design was utilized using semi-structured interviews among eight Hispanic women in Bladen County, a rural southeastern North Carolina county in which the estimated population was nearly 33,000 in 2006, with 5% of that population being Hispanic (U. S. Census Bureau, 2007). Industry employing the greatest number of Bladen County residents includes agriculture, construction, and manufacturing. Of those who are employed, the mean travel time to work is nearly 27 minutes, and there is no form of public transportation in this community.

## PARTICIPANTS AND PROCEDURES

Following approval from the university institutional review board, participants were identified and approached by a female Spanish speaking key informant of the same community, who provided verbal information of the study to the potential participants in Spanish. Participants were invited to meet as a group in the home of the key informant for the three interview sessions, and eight to ten women were recruited by the key informant for each interview session; only eight participants participated in two interview sessions (four for each).

The key informant served as the translator of the verbal communication between the researcher and the participants during the interviews. During each interview session, both the researcher and the translator were in attendance. An interview guide was utilized to prompt participants to share information regarding their health care experiences and concerns since they have been in the United States. At the conclusion of each interview, information was summarized and presented to the participants during a "debriefing" session without electronic

recording, allowing participants the opportunity to affirm or refute any information obtained, or to share information “off the record”.

For the purposes of data collection, each participant was assigned a number to serve as identification during the study. This method eliminated the use of names or any other identifying information, assuring anonymity during the interview process. All written information had been translated into Spanish by an on-line translator service, and back-translated by the key informant for accuracy and appropriateness for the participants of this community. All interviews were taped verbatim to capture the interview questions in English, the response in Spanish, and the translation of the responses from Spanish to English.

To ensure validity of translation, a second translator was utilized to review audio tapes for accuracy of initial translation. English portions of the audio tapes were transcribed into a written verbatim transcript, with integrity of the interaction between researcher and participants being verified by reading them with simultaneous playing of the tape. Internal validity was established through the use of quotations from the participants.

## **FINDINGS**

Eight Hispanic women over the age of 18 years participated in this study. One participant was in the 18-29 years age group. All others were in the 30-49 years age group. Ethnicity of the participants was Mexican (5), Central American (2), and Guatemalan (1). Of these participants, three had been in the United States one to five years, three had been here six to ten years, and two had been in the U. S. more than 11 years. All were first generation immigrants except for one participant who was a second-generation immigrant. Six were married with one never having been married and the other divorced. Three participants reported that they did not have a support system outside of the family. All others reported having an extended support system, but did not elaborate on the dynamics. Of those reporting, the highest annual income was \$20,800. Participants had an average 6.5 years of education. Spanish was the primary language for all participants. Three spoke some English, and the other five spoke no English. Six participants perceived their health status to be average, while the other two reported their perceived health status as good. One participant reported that she never utilizes the health care system. Five reported utilizing the health care system one to five times annually for themselves or their family members. Two reported utilization of the health care system six to ten times per year.

## **HEALTH CARE UTILIZATION**

Information obtained from the interviews was categorized using the constructs of Andersen’s Behavioral Model of Health Services Utilization: predisposing, enabling, and need characteristics (See Figure 1). Though backgrounds were varied among these participants, many common themes regarding access to health care emerged from the interviews. Illnesses among these women and their families included sinus problems, stomach pain, asthma, diabetes, pregnancy complications, and accidental injuries. Considering the seriousness of their health status, none of the study participants or their families had a primary care health care provider. A common report among all participants was the utilization of emergency departments or urgent care centers for most of their health care needs. They also reported using home remedies and over the counter medications instead of seeking professional medical attention for most illnesses.

### *Cultural Influences and Family Structure*

In many cases the statements of participants reflected the influence of their culture in the manner in which they sought health care. Participants reported they had learned practices for use with specific symptoms or illnesses through traditions that have been passed down through the generations. One participant shared that she frequently uses practices learned from her parents and grandparents. She reported using a honey and lime poultice for cough and cold symptoms. She also reported the use of over-the-counter medications to cure her daughter's asthma. However, she states, "...if the cough persists, and ...nothing is going away with that kind of medicine,...[I] find a way to go to Urgent Care...." Her daughter was not born in the U.S., is uninsured, and the family cannot afford primary health care or maintenance and emergency medications for this child.

Status within the family structure also seems to have some bearing on access to health care. One participant reported that her husband discourages use of the professional health care system, stating "... [He] doesn't like to pay the bills. He says, 'you go to the doctor and you waste your money because he only gives you a little pill...don't help you for nothing and they get all your money'." She told of an incident when she was very sick. "My potassium was very low. My blood pressure was low, and I almost passed out. My husband wanted to wait until the next day [to seek medical attention] to see what was going to happen." However, she stated that the final decision to seek health care is hers. "If I feel sick, I go to the doctor."

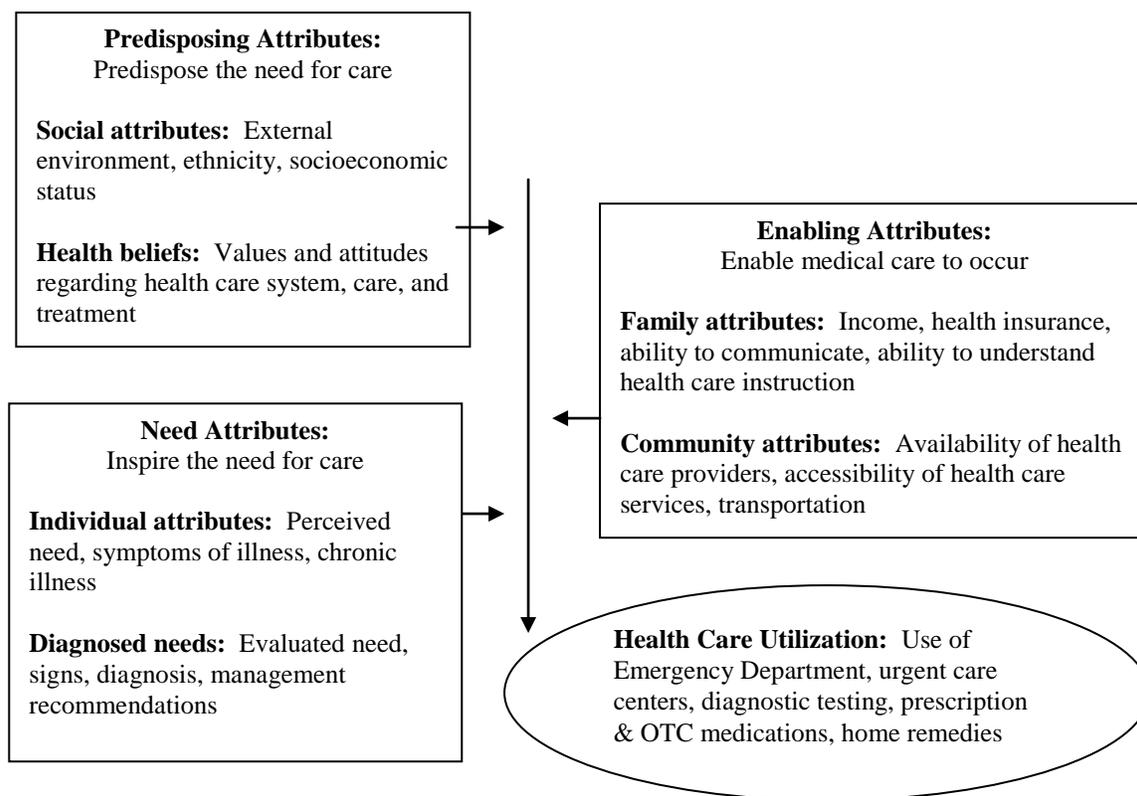


Figure 1 Andersen's Behavioral Model of Health Care Utilization by Hispanic Women in Bladen County, N.C. (Modified from Wallace, Scott, Klinnert, & Anderson, 2004)

Another participant echoed the same decision-making authority when her children are sick. She stated, “I try other kinds of things [home remedies] first. If it don’t work...I take the kids [to the doctor]. She also stated, “As a mother... [I am] the one to make that decision.”

### ***Language Barriers/Literacy Levels***

One participant, whose husband has diabetes, reported that language barriers existed, complicating communication with health care providers. They had difficulties explaining her husband’s symptoms to health care providers, and were not able to understand the treatment plans since interpreters were not utilized. She stated, “We do what we can understand to take care of his diabetes.” Similar instances were reported as another participant reported an instance in which she accompanied a friend to serve as his interpreter when he went in for a colonoscopy. An interpreter had not been utilized during her friend’s pre-procedure interview, and he had not understood the prep procedure. The colonoscopy was rescheduled because he was not adequately prepped. In addition, he was charged for an office visit for the original day of the procedure. He did not return to have the colonoscopy.

Additional issues were identified that impeded access to health care as reported by this group. When questioned about their feelings regarding the use of interpreters, one participant stated,

... [I] have to tell the other person everything—what [I am] feeling, what is happening...even though [I] want it ...or don’t want it. If it’s a stranger or if it’s not a stranger... [I have] to get through with what is needed, or nothing is going nowhere.

Many participants also reported the need for diagnostic studies or procedures for diagnosis of symptoms. One participant, who was insured, reported having a CT of her abdomen and an endoscopy for her complaints of abdominal pain. She stated, “I don’t understand what [the tests] were for... they didn’t help me any.” Thus, she discontinued the use of her prescription medication and drank milk to minimize her pain. She reported, “There is nothing else I can do. I’m just trying to live with it.”

### ***Low Income/Uninsured Status***

A common thread of concern among all participants was lack of health access for themselves and their family members because of their uninsured status and low-income status. All of the women complained of the expense of office visits, medications, and tests as reasons for their inability to achieve optimal health. One participant, whose children are uninsured, reported, “I take the children to Urgent Care...it’s not too expensive and I can pay a little bit at a time. That is the only way.” This group also expressed concern that because they are not able to afford a primary care provider, there is no follow-up of chronic illnesses, such as asthma and diabetes. One participant tearfully accounted her experiences with her husband’s diabetes care:

My husband is very sick with diabetes...he is not able to work at this moment. No one in the family is working. He is seen in the emergency room [for his diabetes]. He does not have a doctor. They are giving him

some pills for his diabetes, but he has a lot of headaches. I think he's not controlling his sugar right.

This participant reported that she encourages her husband to go to the doctor even though there is no availability of financial resources. The implied perception is that her husband's health care outcome would be improved if adequate resources were available to him.

### ***Transportation***

All participants reported that they have difficulties with arranging and keeping appointments due to transportation issues. One participant reported that it is difficult to get to a specific place at a specific time when one is dependant on another for transportation. Another gave an "off the record" report that her driver's license had expired, without eligibility for reinstatement. She also shared that her husband's driver's license will expire in two years, at which time he also will not be eligible for reinstatement of his license. The current and future dilemma is the lack of independent transportation to meet their needs. She is concerned that their vulnerability will increase when neither of them has driving privileges. When participants have been able to access the health care system in this community in the past, perceptions varied regarding their care and subsequent health behaviors.

### ***Perceptions of Health Care***

Many participants reported situations such as "too many tests and I didn't get well," "nothing works [so I] stopped doing it," and "they didn't do nothing... I had to pay and didn't get nothing." Some of these women were being treated for chronic illnesses for which there is no short term treatment plan—no "cure" for diabetes or asthma. These statements indicate that their perception of care included the expectation that diagnostic tests and short-term treatment would result in wellness. This perception has resulted in apparent dissatisfaction with the health care system.

The youngest participant reported that she had been diagnosed with diabetes at an urgent care center. She understood from the health care provider that she is to eat a restricted diet, exercise, and take medication to maintain glucose control. However, she is no longer following health care recommendations. She stated, "The pills are expensive...nothing works, and I just stopped doing it. The more medicine I take, the more headaches I have, and I feel more tired... But, now that I've stopped taking everything and started working...I've started feeling better."

Another participant compared her current situation to what she had experienced previously in another state:

In California the doctor gives you a prescription for a year... Here you have to go back every three months and they give prescriptions for only three months, and you have to go back. I stopped taking it [medicine] because I had this payment of fifty dollars all the time... so I spend money for nothing.

In conclusion, access to health care services has been reported to be limited among Hispanic women in one rural southeastern N.C. community. While all the participants in the study desired improved overall health status for themselves and their families, it seems that they

have experienced many health care disparities influenced by their population characteristics. Recurrent themes in the study suggest that socioeconomic status, transportation, lack of insurance, and timing of office hours are barriers to health care access. Additionally, language barriers and literacy levels impede comprehension and knowledge of necessary health care practices among this group. Perception of health and of the need for services was influenced by predisposing and enabling characteristics, as well as other external factors. While some still maintained hope that changes in the health care system would help to resolve some of these issues and concerns, others seemed to have given up on the prospect of having adequate health care services, feeling that they were destined to continue to maintain health and wellness “the best way that I can do it”.

## DISCUSSION

This study was a qualitative exploration of concerns among Hispanic women seeking health care and confirmed the conceptualization of health care utilization suggested by Andersen (1995). Findings support that predisposing characteristics such as acculturation significantly impact health care among the Hispanic population. All except one participant was a first generation immigrant to the U.S. Reportedly, none of the participants or their family members had a primary care provider, although there were many reports of chronic illnesses such as diabetes and asthma among them. The first generation immigrants are more likely to preserve and use traditional health practices while seeking health care than second-generation immigrants and/or those of poor English speaking ability. This conclusion is confirmed by the findings of a previous study which suggested that less-acculturated individuals may possess greater language barriers, limiting social interaction and ability to acquire information (Lopez-Quintero, Shtarkshall, & Neumark, 2005). Likewise, a review of data in 2003 from the Third National Health and Nutrition Examination Survey (NHANES III) revealed that Mexican American children, specifically of first generation immigrants, were at a substantially greater risk for health care disparities due to higher poverty levels and lack of health care insurance among other issues (Burgos, Schetzina, Dixon, & Mendoza, 2005). According to Timmins (2002), the failure to develop adequate spoken English also stood as a marker of a population at risk for decreased access to health care.

It is also noticeable that enabling characteristics greatly influenced access to health services in the study. All participants of this study strongly voiced low income, lack of insurance, and difficulties with transportation as major factors that limit their access to health care services. The women in the study asserted unanimously that their poor economic status was the number one barrier. Though language barriers and low literacy levels were issues that impacted their care, these factors were of overall less importance to the participants.

The findings of the current study offer a framework to better understand health-seeking behaviors among Hispanic women. Their perceptions of health care needs were based on cultural influences and past experiences with health care in the United States. Many of them reported the use of family or cultural practices and over-the-counter medications before they felt the need to pursue professional health care services. Some reported dissatisfaction with the health care system, which negatively impacted their perception of need. The focus of this group seemed to be on current illness, as there was no discussion of preventive health care practices. This fact implies that the perception of preventive health care among this group is of minimal importance. Findings in this study were consistent with a previous study by Zunker and colleagues (2005)

who surveyed 112 elderly Mexicans living on the U.S.-Mexico border, found that the participants did not access the health care system at the first sign of illness, but relied on family and cultural practices as an initial response. They cited dissatisfaction with care and services provided, as well as negative experiences to explain the lack of traditional health care. These participants also perceived that preventive health care is available only to those who can afford it.

### **IMPLICATIONS**

There are growing numbers of Hispanic population in rural areas. This research provides useful insight into the factors that impact health care access among Hispanics in a rural community. Nurses and practitioners working in rural clinics need to possess cultural knowledge which includes cognitive understanding of the client's culture, involving socio-environmental factors in addition to specific beliefs and practices (Kim-Godwin, Alexander, Felton, Mackey, & Kasakoff, 2007). While the participants and their families suffered from significant chronic illnesses in spite of their hope of improved health status, the lack of continuity in services remained apparent. Understanding of their present time orientation as well as the shortage of enabling factors would help to develop culturally effective educational programs that would improve the continuity of care. Also, translators should be utilized to improve communication and understanding of necessary health care in rural clinics.

To meet these needs an additional program of "outreach nursing" such as a low cost mobile community program for low income Hispanics should be considered. In this rural area, there is a large population of Hispanic migrant farmworkers who would benefit from low cost health care services delivered directly to them. With limited income and transportation, and inability to meet appointment schedules, outreach nursing utilizing a mobile care unit would be an effective strategy to meet preventive and acute health care needs, as well as provide education on health related issues to this underserved population (Diaz-Perez et al., 2004). Strategies should be developed to promote preventive health maintenance, as well as low cost continuity of care for those with chronic illness. Advanced practice nurses, who have historically gone out into the less desirable locations to provide care to the disadvantaged, are perfectly positioned to provide these outreach services at an affordable cost.

### **LIMITATIONS**

Several limitations of the current study should be noted. First, the small numbers of participants and selection of the group of women who participated in the study restrict the generalization of the findings. Although attempts were made to recruit a larger sample size, many of these women were reluctant to participate, fearing deportation following the disclosure of names or other relevant information, with the result that only eight women participated in the interviews. Hispanic women have historically been difficult to recruit for participation in research studies due to the lack of culturally appropriate strategies for recruitment and retention (Naranjo & Dirkson, 1998). In addition, the women who participated in the interviews may be different from other rural Hispanic women. Among this small group there was very little variation in themes throughout the interviews. Except one, all of the participants were first-generation immigrants to the U.S. The biases of the key informant in the identification of appropriate participants for the study also had the potential to affect validity as well (Kapborg &

Bertero, 2002). External validity could have been strengthened with a larger group of participants to provide greater transferability (Kapborg & Bertero, 2002).

Due to the very limited Spanish vocabulary of the researchers, the language barriers that existed between the researchers and the participants placed great limitations upon this study. Since the researchers were not of the same ethnicity, participants may have also been reluctant to speak freely about particular cultural practices in the presence of one from outside their own culture. Although the key informant who identified participants and also served as the translator is very well known and highly respected throughout the community for her involvement in “bridging the gap” between the Hispanic and non-Hispanic populations, she was not trained in translation for research procedures. Due to a limited Spanish vocabulary, the researchers were unable to control for the risk of elaboration or limitation of questions or the responses of the participants during translation. Thus, content and meaning in some responses to questions could have been lost in translation, which would pose a threat to the validity of the study.

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