HEALTH DISPARITIES AMONG LATINA/0 ADOLESCENTS IN URBAN AND RURAL SCHOOLS: EDUCATORS' PERSPECTIVES

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Abstract:
This qualitative pilot study examined health disparities among rural and urban Latina/o adolescents from the perspective of middle and high school administrators, counselors, nurses, and teachers. Participants were asked to describe Latina/o health disparities in their schools, reasons attributed to health disparities, and school-based interventions for addressing health disparities. Focus group participants reported that common health disparities for Latina/o youth in rural and urban settings include poor vision care and high teenage pregnancy rates. However, participants reported differences in physical health and mental health disparities, as well as differences in social-cultural-economic contributors to disparities and school-based interventions.
Key Words: Health Disparities, Latina/o Adolescents in Urban and Rural Schools, Educators' Perspectives

Article:
Health disparities between people of color and white peers have been well documented (Dogra, 2004; Dyer, 2003; Villarruel, 2001) in dental health (Amschler, 2003) and mental health (Yeh, McCabe, Hurlburt, Hough, Hazen, Culver, Garland, & Landsverk, 2002), in minority health risk behaviors (Browne, Clubb, Aubrecht, & Jackson, 2001), posses-sion and use of health insurance (Shone, Dick, Brach, Kimminau, LaClair, Shenkman, Col, Schaffer, Mul-vihill, Szilagyi, Klein, VanLandeghem, & Bronstein, 2003), the effects of health disparities on adolescents of color (Guthrie & Low, 2006), and the relevance of residence in rural or urban settings (Eberhardt & Pamuk, 2004; Galambos, 2005; Hartley, 2004).

The growing US Latino population has brought increasing interest to Latina / o health disparities (Borders, Brannon-Goedeke, Arif, & Xu, 2004; Chowdhury, Balluz, Okoro, & Strine, 2006; Fornos, Mika, Bayles, Serrano, Jimenez, & Villarreal, 2005; Nies, Vander, Schim-Myers, Artinian, & Serrick-Escamilla, 2005; Zsembik & Fennell, 2005). Although US Latinas /os traditionally have lived in and around urban centers with large Latino populations, the most dramatic Latino population surges in recent years have occurred in rural communities without the social, educational, and public health infrastructure commonplace in urban settings (Pew Hispanic Center, 2005a). In addition, the median age for US Latinas/os is 11 years younger than for whites, and roughly 20% of the US Latino population are between the ages of 10-19, com-pared to 14% of the white population (Pew Hispanic Center, 2005b). The growth in school-aged Latina / o children has presented unique health and academic challenges for schools in general, and rural schools in particular (Frenn, Malin, Bansal, Delgado, Havice, Ho, & Schweizer, 2003; Slade, 2003; Wortham & Contreras, 2002). This pilot study examined the differences in health disparities of Latina / o adolescents from the perspectives of educators in rural and urban settings. Middle and high school administrators, counselors, nurses, and teachers met in school-based focus groups, and their responses were analyzed using qualitative methodology.

METHOD

Schools and Participants

Four schools (one rural and one urban middle school, and one rural and one urban high school) were represented in the study. The rural schools were in one county in North Carolina and the urban schools in a county in Florida. According to the US Bureau of the Census (n.d.), Latinas/os accounted for 6.5% of the population in the community in which rural schools were located and Latina /o students comprised 10.9% of

the total student population. The urban community was 60.6% Latina /o and Latina /o students made up 49.8% of the total student population in the school district (National Center for Education Statistics, n.d.). A total of 15 school-based educators agreed to participate in the study. Participants held the following positions: school administrator, school counselor, school nurse, and general education teacher. Eight of the 15 participants worked in rural schools. Of the total sample, 13 were women; the 2 men were administrators in the rural schools. All of the rural participants were white; 5 of the urban participants where Cuban American and fluent in English and Spanish, and the other 2 were white. Participants had worked an average of 12.8 years in school settings. On average, participants spent 37% of their time at school assisting Latina /o students in various capacities, with urban educators reporting higher percentages than rural educators (M = .57 compared to M = .18).

Moderator's Guide

As recommended by qualitative researchers (ICrueger, 1998; Morgan, 1997), a focus group moderator's guide was developed prior to meeting with participants. The guide consisted of three questions: (1) "What are the mental health and physical health disparities between Latino youth and their non-Latino peers at your school?," (2) "Why do you think health disparities occur between Latino youth and their non-Latino peers at your school, and what kinds of factors do you think are involved?," and (3) "What kinds of interventions/ programs/initiatives have you devised/implemented to address the mental and physical health disparities between Latino youth and their non-Latino peers, and how successful have they been?" Questions were established by reviewing the health disparities literature. The validity of the moderator's guide was determined by having experts in the field of health disparities, nursing, teaching, and counseling review the guide. The final questions reflect expert feedback. Follow-up questions based on participants' responses were asked when appropriate (Krueger; Morgan).

Procedure

Approval to conduct the study was granted by the Institutional Review Board from the University of North Carolina at Greensboro prior to contacting individual school districts in March 2006. Once school districts agreed to participate, school administrators within the districts were contacted with information about the study. Rural and urban educators agreed to participate in this study in April and May 2006, respectively. Focus groups were composed of one administrator, one counselor, one nurse, and one teacher, except in the urban middle school where the school nurse position had been eliminated due to budget cuts. The author, who is of Cuban-Colombian descent, conducted a 11 focus groups in English. An empty office at each of the four schools was used for the focus groups, so as to provide respondents with a familiar environment. Each focus group answered the moderator's guide questions and their responses were recorded and transcribed for analysis. Each focus group lasted about 1 hour, except for the urban high school group, which lasted about 90 minutes. Participants were compensated with $25 gift cards to a national retail store for their participation, and each school was provided with a $300 budget for purchasing health disparities-related supplies.

Data Analysis

Focus group transcripts were analyzed using the Consensual Qualitative Method (CQR), in which each focus group transcript is considered a separate case (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005; Williams, Wyatt, Resell, Peterson, & Asuan-O'Brien, 2004). Coders use CQR to develop a set of domains and core ideas, while establishing categories corresponding to each domain. Domains are general topics used to organize or group the data, while core ideas are definitions of each domain as determined by summarizing participants' quotes. Once domains and core ideas have been established, the analysis is continued to produce relevant categories, (and subcategories) in addition to determining the category type, which was based o-n occurrence (frequency). Categories are classified as "general," "typical," or "variant." General categories are those that appear in three or more cases, typical categories appear in two cases, and variant categories appear in one case.

RESULTS

A review of the four cases produced a total of 45'9 responses; 304 (66%) of these were derived from the urban school transcripts. Responses were organized in 4 domains and 60 categories (which includes 3 subcategories). Domains and corresponding core ideas are shown in Table 1. Domain categories (and subcategories) and their category type are shown in Tables 2 and 3.

Physical Health Disparities

In both rural and urban settings, educators reported that Latina /o adolescents appeared to have poorer vision care and higher pregnancy rates than their non-Latina /o peers. Specifically, Latina /o adolescents in rural settings were more likely than their peers to have ear infections, be diagnosed with ADHD, have poorer dental care, and have lapsed (out-of-date) vaccinations. Obesity, sexually transmitted diseases (STDs), and ill-nesses transferred between siblings (e.g., colds, stomach viruses, influenza) appeared to occur more often in urban Latina /o youth than in their to non-Latina /o peers, though these physical health disparities were not reported for Latina /o youth in rural areas. Pregnancy and STDs were reported more often for older students and more basic medical issues (e.g., poor dental care and ear infections) were reported more often for younger students.

Table 1. List of Domains and Corresponding Core Ideas

Domain	Core Idea
Physical Health Disparities	Latina/o adolescents in rural and urban areas share some health disparities; however, Latina/o adolescents in rural and urban areas share some health disparities; however, rural Latina/o adolescents are more prone to suffer from basic medical needs while urban peers tend to experience more complex and severe medical needs.
Mental Health Disparities	The type of community a Latina/o adolescent lives in can directly influence the type of mental health disparities they experience, and how these disparities are manifested in school.
Social-Cultural-Economic Contributors to Disparities	Rural and urban community settings mitigate the type of contributors to Latina/o adolescent health disparities.
School Interventions used to Address Disparities	With few exceptions, rural and urban schools have developed community-appropriate activities to help assuage the health disparities between Latina/o students and their non-Latina/o peers.

Mental Health Disparities

The occurrence of specific mental health disparities was related to where Latina/o youth lived. Urban youth experienced mental health disparities in the area of academic stress, physical abuse victimization, sexual abuse victimization, acculturative stress, migratory/seasonal worker transient stress, drug use, and deportation-related anxiety. Depression, immigration-related trauma (including suffering from grief at the loss of relatives remaining in the country of origin), negative emotional affect (e.g., sadness, frustration, low self-esteem, confusion), and self-alienation from non-Latina/o peers were reported only by educators in rural settings. Also, as illustrated in Table 2, mental health disparities were more common in middle school than in high school settings.

Social-Cultural-Economic Contributors to Disparities

Participating educators reported that various factors contributed to Latina/ o adolescent health disparities. Social issues included limited parental education, in-adequate psychological testing on the part of schools, immigration status, migrant/ seasonal worker status, lack of awareness of health resources, limited access to Medicaid, and inability to understand the US medical system. Language barriers, being less likely to use birth control (related to language barriers or cultural conflict), lack of parental medical follow-up, parental support of youth cohabitation, cultural differences between parents and schools, differences within different Latina /o groups, and lack of athletic programs oriented towards Latina/ o youth were noted as cultural barriers. Finally, economic contributors included limited health insurance, parents' need to work long hours in arduous occupations, lack of transportation services, lack of school resources (e.g., lack of a school nurse position), and poor medical care. Contributors to Latina /o adolescent health disparities appeared to occur across school levels.

School Interventions used to Address Disparities

Educators shared specific school interventions relevant to their communities. Aside from the national assistance program of free and reduced lunches for students from low-income families, the only common school intervention used by both the urban and rural schools in the study was use of translated documents. Translated documents included Spanish-version monthly newsletters at the rural high school, Spanish-versions of medical information forms at the rural middle school, and web-based materials for parents in English and Spanish at both urban schools. Interventions appeared to be unique to the educational setting, with a few exceptions.

DISCUSSION

The common health disparities reported for rural and urban for Latina/o youth, high pregnancy rates and poor vision care, are consistent with previous findings (Browne et al., 2001; Chowdhury et al., 2006). Poor vision care, the most common Latina / o adolescent physical health disparity noted in this study, is best explained by what the urban high school nurse said: "I have many kids coming in that don't have good vision. I'm like, well, do you function in class? I mean, do you sit in the front of the class, what do you do?"

The findings also pointed to differences in disparities for Latina /o adolescents based on rural versus urban settings, and these have not been reported previously. For example, though obesity appears to be common among Latina/ o youth (Frenn et al., 2003), only educators in the urban schools reported disproportionate Latina / o obesity rates (Galambos, 2005; Zsembik & Fennell, 2005). The most common rural physical health disparity reported here and in other studies the literature (Chowdhury et al., 2006) was lapsed vaccinations, which affected not only the health of the child but also school attendance. This was explained by the rural high school nurse as: "... I have to make sure all the [transfer-ring] Hispanics have all their shots. Most don't have this round of shots that are past due on registration day. Well, I have to send them home, expel them from school, until they can get that. So, if they are limited in being able to get that done, it's — it adds to their absences, which hurts them."

Clearly, Latina /o youth in rural settings need more basic medical care, such as eye exams, hearing checkups, dental visits, and vaccinations, while urban Latina /o youth need to be monitored for weight-control, sexual activity, and the spread of common illnesses.

The occurrence of sexual and physical abuse with urban Latina / o youth depicts complex and severe health disparities, as illustrated by a teacher's account: "I have had children who are in abuse situations with step-parents, horrible situations of child abuse. Physical abuse and even rape. I've seen this in the Hispanic population more than I have in [others]."

These types of experiences were elaborated upon by the urban high school counselor who continued by saying, "I think these students they — their bodies are here. Their minds are not. I mean it's very hard for them to focus on school, passing the [state standardized test], all these things that they're being asked to do when, you know, they're thinking about when they go home who's going to abuse them next or who's going to rape them."

Table 2. Summary of Domains, Categories, and Subcategories of Health Disparities between Latina/o Adolescents in Rural and Urban Schools

Domain, Category, (Subcategory)	Rural High School	Rural Middle School	Urban High School	Urban Middle School	Category Type (General, Typical, Variant)
1. Physical Health Disparities					
Poor vision care	✓	✓	✓	✓	General
High pregnancy rates	✓		✓		Typical
Poor dental care		✓			Variant
Ear infections		✓			Variant
ADHD		✓			Variant
Lapsed vaccinations	✓	✓			Typical
Obesity			✓		Variant
Sexually transmitted diseases			✓		Variant
Illnesses transmitted between siblings				✓	Variant
2. Mental Health Disparities					
Depression		✓			Variant
Immigration-related trauma		✓			Variant
(Grief and loss for relatives in remaining in country of origin)		✓			Variant
Negative emotional affect (sadness/frustration/low self-esteem/confusion)	✓				Variant
Self-alienation from non-Latina/o peers	✓				Variant
Schizophrenia			✓		Variant
Academic stress (related to testing)			✓		Variant
Physical abuse victimization			✓	✓	Typical
Sexual abuse victimization			✓		Variant
Acculturative stress			✓		Variant
Migratory/seasonal worker transient stress				✓	Variant
Drug use				✓	Variant
Deportation-related anxiety				✓	Variant

Educators in rural settings reported more basic mental health disparities in their Latina / o students. For example, the rural middle school counselor said, "I see signs of depression. I provide group counseling, grief therapy, to children from Mexico whether they've left family in Mexico or whether they've lost family members here or lost family members in Mexico and moved to the United States."

The rural high school teacher also expressed her views on Latina/ o emotional affect and self-alienation when she said, "I think we do have some mental health issues with our Hispanic population not fitting in, feel- ing excluded, especially the ones that come in with no English. They sit around confused and sometimes look sad. And they're off to themselves." Thus, Latina /o students in rural schools may need assistance with more fundamental psychosocial stressors, while urban youth could benefit from programs which address the complexity and seriousness of their experiences.

Findings of social-cultural-economic contributors to disparities, such as transportation needs, limited health insurance, lack of school resources, and low parental education, were supported by previous research (Amchler, 2003; Fletcher, 2004; Nies et al., 2005; Shone et al., 2003). However, categories for this domain were, with few exceptions, unique to urban or rural settings. One of the exceptions, immigration status, is best explained by the rural middle school counselor, who said, "I think sometimes [Latinas/os are] afraid.

They're afraid to go to any officials because I think they are afraid that they are, you know, not legal citizens." An urban high school teacher shared her views on Latina / o students' immigration status: "The reason why [Latina /o students] are not getting the mental health care or the medical care is because the majority of our students are illegal. And they are afraid of being deported."

Though several of the contributors to health disparities listed were noted in both rural and urban settings, these educators were focusing their concerns on factors influencing the occurrence of health disparities in their particular schools. For example, lack of transportation in rural settings is best illustrated by the rural high school teacher who shared her Latina / o students' needs to fit in and feel connected at school: "But they don't have the transportation after school. And it goes back to, I know this mental health world I see from, a sense of belonging. They want to belong. But I think a lot of times they want to feel more like a part of the group and can't because of the transportation."

Urban educators noted differences between different Latino groups (i.e., "Cuban," "Central American," "Mexican" and migrant/seasonal worker status, high-lighting the heterogeneity of the US Latino population (Zsembik & Fennell, 2005), and the need for schools to recognize the different countries of origin for their Latina /o students. For example, the urban middle school teacher said, "We service a couple of [migrant] camps here. And I know the living conditions, you know, that they would be in the lower echelon area. The living

Table 3. Summary of Domains, Categories, and Subcategories for Contributors to Health Disparities between Latina/o Adolescents in Rural and Urban Schools, and Related School Interventions

Domain, Category, (Subcategory)	Rural High School	Rural Middle School	Urban High School	Urban Middle School	Category Type (General, Typical, Variant)
1. Social-Cultural-Economic Contributors to Disparities					
Immigration status	✓	✓	✓	✓	General
Cultural differences between school and families	✓		✓	✓	General
Limited health insurance	✓	✓	✓		General
Language barriers	✓	✓	✓	✓	General
(Specifically contributes to limited birth control use)	✓				Variant
Parents not at home due to work commitments	✓		✓	✓	General
Inadequate psychoeducational testing		✓			Variant
Limited access to Medicaid		✓			Variant
Limited parental education		✓			Variant
Lack of parental medical follow-up		✓			Variant
Parents not understanding U.S. medical system		✓			Variant
Parents unaware of available health resources	✓				Variant
Lack of transportation services	✓				Variant
Lack of athletic programs geared for Latinas/os	✓				Variant
Less likely to use birth control due to cultural conflict			✓		Variant
Limited use of mental health services			✓		Variant
Cohabitation at a younger age			✓		Variant
Differences between different Latino groups			✓	✓	Typical
Lack of school resources			✓	✓	Typical
(No school-based nurses)				✓	Variant
Migrant/Seasonal worker status			✓	✓	Typical
Poor medical care				✓	Variant
2. School Interventions used to Address Disparities					
Free-reduced lunch programs	✓	✓	✓	✓	General
Translated documents	✓	✓	✓	✓	General
Linking families to community resources	✓	✓	✓		General
Introductory English programs for Latina/o parents	✓				Variant
Spanish Parent-Teacher-Association meetings		✓			Variant
School nurse serves as medical liaison	✓	✓			Typical
School-based medical screenings		✓			Variant
School-based migrant counselor				✓	Variant
Bilingual school counselors			✓	✓	Typical
After-school programs				✓	Variant
School-based social workers				✓	Variant
Teen mother support group			✓		Variant
Removing softdrinks from school vending machines			✓		Variant
School-based health clinics			✓		Variant
Abstinence programs			✓		Variant
School-based translators			✓	✓	Typical

conditions, the housing conditions, I don't think they would be as good [as for other Hispanics]. Plus, they move a whole lot. We have a very transient population here."

The urban high school teacher alluded to the notion of different levels of health disparities between Latina /o youth because, "Different cultures are different. The majority of students here are Cuban. And some are Central Americans. And I think we have more Mexicans." For example, this high school teacher reported higher incidents of sexual and physical abuse in Mexican students compared to Cuban students, and that Mexican and Central American families were much more likely to be migrant workers than Cubans.

Noticeably, all Latina / o youth face obstacles to adequate physical and mental health. Yet some of the Latina /o health disparities reported in Table 2 can be attributed to school location and community characteristics. For example, rural school nurses noted their role as liaison between Latinas/os and the medical community. One rural high school nurse said, "I do a lot of linking to resources. And sometimes these kids need help getting there. So, I help with transporting to appointments, eye appointments, the health department appointments, things like that." Similarly, the rural middle school nurse reported that "...[W]e try to connect with [Latina / o students and parent] and talk... and try to give them information about the health department to go - they can go there."

Spanish-speaking and Latina / o staff members were more prevalent in urban schools due to the historical presence of Latinas /os in the community, thus counseling services were available in Spanish to assist Latina /o students with their mental health problems. For example, both urban school counselors in this study were bilingual and of Cuban descent, and they provided services in both languages. The urban middle school counselor said, "And then I can also say that we have bilingual - actually we have a tri-lingual counselor. And, then, the other two guidance counselors and the trust counselor and the social worker, we're all bilingual [in Spanish and English]. So we have that input."

Although it would be useful to explore school-based interventions for alleviating Latina / o adolescent health disparities, it would be unrealistic to expect a surge in bilingual educators and community mental health workers to the level present in urban settings. In addition, school-based clinics may not be affordable in smaller, rural school districts with limited budgetary resources. Results of this study, however, indicate that schools and educators are offering contemporary and complementary services to Latina / o youth in their schools specific to their rural and urban settings. Furthermore, results from this study support the need to develop additional rural-specific school health interventions rather than rescaling public health interventions from urban areas to rural areas (Phillips & McLeroy, 2004).

Limitations to this study were observed. Specifically, the sample size and qualitative nature of this pilot study make it difficult to generalize findings to all settings and communities. Moreover, participants were self-selected and their responses may not be representative of educators declining to participate in the study. Also, the findings would have been enhanced if the urban middle school had not lost the funding for their school nurse position prior to commencing this study. In addition, the researcher believes his ethnicity and bilingual skills may have contributed to more detailed urban focus group discussions and less detailed rural focus group discussions, since most of the urban participants were of Cuban descent and all of the rural participants were white. Finally, collecting responses to the facilitator's guide from Latina /o adolescents and families could have confirmed or challenged educators' responses while presenting beneficial details.

CONCLUSION

Rural and urban Latina /o adolescents experience many health disparities, as detailed in the literature and in this study. Based on participants' response:3, these disparities are manifested in different ways, based on location. Because the broader concept of a school's health is tied to the neighboring community, it is in the best interest of school personnel to determine how their urban or rural surroundings may influence mental and physical health disparities in their Latino student body. This study provides educators with reference

points and a starting place to begin addressing the health disparities of Latina /o adolescents, for the benefit of the individuals, their schools, and their communities.

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