FROM UNDERSTANDING TO TRANSFORMING HEALTH BARRIERS

A La Clínica del Pueblo Publication

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EXECUTIVE SUMMARY

This report presents insights derived from a Participatory Rapid Appraisal (PRA) undertaken at La Clínica Del Pueblo, a Federally Qualified Health Center (FQHC) offering various health services in the Washington DC Metropolitan area. The primary objective of the PRA was to identify community perceptions and priorities regarding the most pressing community health problems and social needs encountered by low-income Latino immigrants. A total of 77 participants, aged 15 to 77, primarily from El Salvador (32%), Honduras (13%), and Guatemala (12%), engaged in seven distinct community-based conversations organized by affinity groups.

Results show that mental health conditions (41%) and chronic diseases (28%) were the most worrying health conditions affecting their communities. Participants identified Psychosocial barriers (21%) such as depression, discrimination, and isolation, as well as limited access to care (16%) and immigration status (13%) as significant barriers. Participants also identified the nexus of socio-economic barriers related to occupation and income (17%) and material conditions such as access to food, housing, and neighborhood conditions (20%) as critical social needs influencing their health.

Collectively, PRA results add to the existing literature that immigration status is a determinant of health itself. To substantially improve health outcomes among the growing Latino immigrant population in the District of Columbia, policymakers, service providers, and other stakeholders should integrate policy and advocacy strategies that more accurately reflect the socioeconomic and living conditions of Latino immigrants residing in the District.

INTRODUCTION

Traditional health policy research framing of health inequities experienced by Latino immigrants in the United States often focuses on individual health-seeking behaviors, cultural beliefs, and language barriers. [1,2] Despite efforts to incorporate a broader perspective on social determinants of health,[3] a notable gap remains in understanding how immigrant communities perceive and prioritize key health concerns within their own individual, household, and community contexts. There is also a need to understand how immigrant communities prioritize major social barriers/needs that hinder progress in addressing significant health issues.

Furthermore, healthcare organizations are widely interested in capturing and addressing social needs. Among the initiatives the sector has implemented is the expanded practice of medical providers and care teams screening patients for social needs and fostering cross-sector partnerships to address material gaps.[4] However, immigrants are often in ambiguous and sometimes hostile relationships with the state and its institutions, including healthcare delivery, potentially impairing the effectiveness of social needs screening programs for these populations.[4,5] Successful utilization of resources on behalf of patients post screenings may be significantly hampered by difficulty navigating services due to language, eligibility to programs based on immigration status, low health literacy, poor patient-provider communication, and perception of cultural insensitivity.[6] Significant gaps also exist in frequency, standardization of screening tools, and time frame needs are collected that may not completely reflect the concurrent needs of immigrant populations.[5,6]

As one possible contribution to address both the limited scope of health policy approaches towards immigrant health and opportunity gaps within the health sector to address social needs, this report draws on the experience of implementing a Participatory Rapid Appraisal (PRA)[6], an example of Community-Based Participatory Research (CBPR).[7] Specifically, it explores its application within the context of Latino immigrants residing in Washington, D.C., who access health services at La Clínica Del Pueblo.

The report is presented in five key sections; the initial section outlines the demographic context of Latino immigrants in Washington, D.C., and outlines the health disparities they confront, including access barriers. The second section offers insight into La Clínica's position as a Federally Qualified Health Center (FQHC), emphasizing its endeavors to mitigate health inequities. Furthermore, it sheds light on its distinctive role in comprehensively capturing the social and economic root causes contributing to health disparities within immigrant communities and the scope of the study. The third section describes the PRA methodology, data collection, and analysis. The fourth section showcases the PRA outcomes and their applicability to health policy research. The fifth section shows how social barriers are interrelated with the diseases participants identified that are affecting them the most. Additionally, we urge other organizations advocating for immigrant health equity in the District of Columbia to consider the recommendations based on the findings presented in this report.

Figure 1 PRA: Promotores Affinity Group

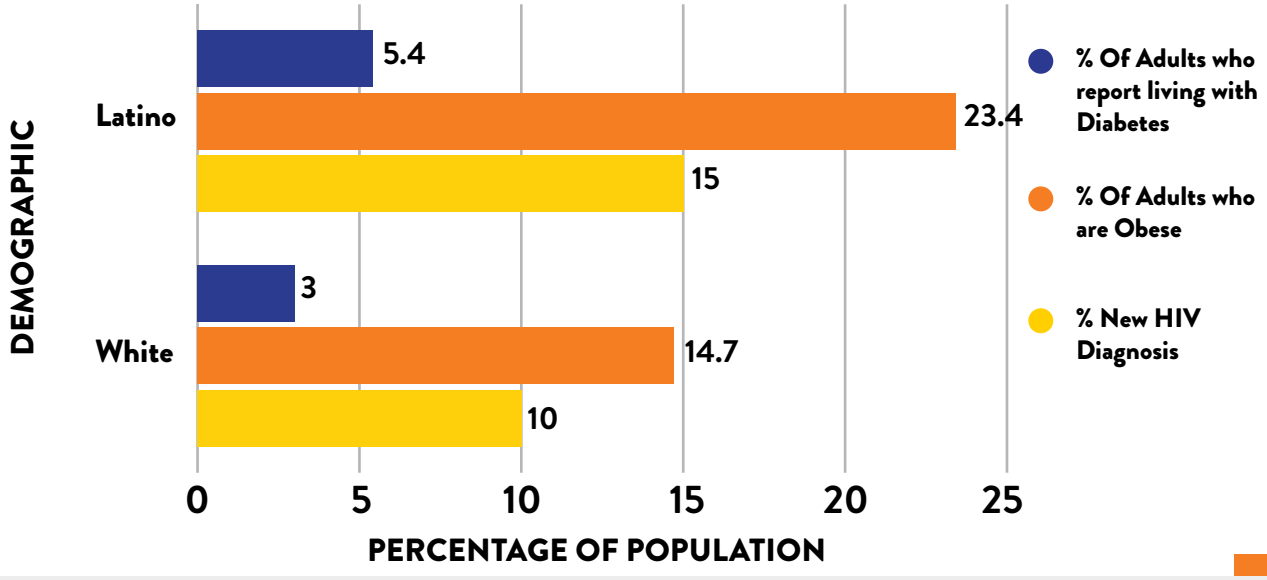
1.1 CONTEXT

According to data from the United States Census Bureau, the Latino population is the largest and most rapidly growing minority group in the United States, constituting approximately 19% of the nation's total population.[8] Currently, U.S.-born Latinos outnumber their foreign-born counterparts, except for large urban areas like the Washington DC metropolitan area.[9] In the District of Columbia, 35% of all foreign-born immigrants are Latino.[9] With the majority of immigrants coming from the Central American nations of El Salvador, Honduras, and Guatemala.[10]

1.2 HEALTH DISPARITIES IN THE DISTRICT OF COLUMBIA

Despite their growing presence, Latinos only represent 11.5%[11] of the total population in the District of Columbia; however, they are disproportionately affected by poor health outcomes and social inequities. As shown in Figure 2, Latinos residing in the District are more than twice as likely to be diagnosed with HIV[12], on average, have higher obesity rates,[13] and more likely to be diagnosed with Diabetes than their white counterparts.[14] Additionally, they report the highest number of poor mental health days within a 30-day timeframe compared to other racial and ethnic groups.[15]

Figure 2 Health disparities between Latinos and Whites in Washington DC



1.3 INEQUALITY

Many Latino immigrants in DC are employed primarily in low-paying service occupations,[16] which leads to Latinos having a poverty rate of 10.4%.[17] Reports also show huge wealth disparities structured along racial lines. In DC, white households have 81 times the wealth of Black households and 22 times the wealth of Latino households.[18]

1.4 ACCESS BARRIERS

Despite their health needs, research shows that Latinos have poorer access to health insurance and healthcare than non-Latino Whites.[19] Variations in access to quality care for Latino immigrants based on their immigration status contribute to a patchwork of coverage for some and a lack of coverage for others, including lawfully present migrants (see Figure 3). For example, after the implementation of the Affordable Care Act (ACA), those with Central American heritage remain less likely to be insured than non-Latino Whites.[20] Likewise, over 32,000 Temporary Protected Status (TPS) holders, the majority who are Salvadoran nationals, reside in the Washington D.C. metropolitan area.[21] TPS holders qualify for Affordable Care Act (ACA) subsidies and plans but not Medicaid. Medicaid, the primary public health program for low-income working-age adults, is limited to citizens and "qualified non-citizens," a category that requires both legal status and (in most cases) completion of a five-year waiting period to be eligible for public assistance programs.[22] Compounding this issue, is the fact the Latino's are employed in occupations, that offer limited access to employer-sponsored health coverage, and they often have comparatively lower incomes.[23] As a result, these individuals face barriers to accessing care when trying to afford employer-sponsored coverage, when available, or when navigating the individual health insurance market. While the DC Health Care Alliance is a nationwide model for providing medical assistance to those who are not eligible for Medicaid.,[24]significant parity gaps continue in the types of services members are eligible for. [25]

Figure 3 Variation in healthcare access based on immigration status obtained from State Health & Value Strategies 2021; A Robert Wood Johnson Foundation Grantee.

Table 1: Potential Eligibility for Federally Funded Coverage Programs Based on Immigration Status

Immigration Status	Marketplace Eligible[9]	Medicaid/CHIP Eligible[10]
Lawfully Present and Eligible for Federally Funded Coverage Programs		
Valid non-immigrant visa holders (e.g., student visas, worker visas)	✔	✖
Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)	✔	✖
Legal status conferred by other laws (temporary resident status, Legal Immigration Family Equity Act, Family Unity individuals)	✔	✖
Qualified non-citizens • Lawful Permanent Residents [(LPR)/Green Card Holder)]* • Paroled into the U.S. for at least one year* • Battered non-citizens, spouses, children, or parents* • People fleeing persecution (e.g., asylees, refugees) • Granted withholding of deportation • Cuban/Haitian entrants • Certain Amerasian immigrants • Members of a federally recognized Indian tribe or American Indian born in Canada • Veterans or active duty military and their family members • Victims of trafficking and their family members • Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories ["Compact of Free Association (COFA) migrants"][ii] • Granted Iraqi or Afghan special immigrant status • Children receiving foster care or adoption assistance • Conditional entrant granted before 1980	✔	✔

Table 1: Potential Eligibility for Federally Funded Coverage Programs Based on Immigration Status

Immigration Status	Marketplace Eligible[9]	Medicaid/CHIP Eligible[10]
Ineligible for Federally Funded Coverage Programs Due to Immigration Status		
Undocumented immigrants • Individuals who entered the country without authorization • Individuals who entered the country lawfully and stayed after their visa or status expired	✖	✖[iii]
DACA: Temporary status allowing individuals who came to the country as children to remain in the U.S.	✖	✖
Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA): Temporary status allowing parents of citizens or LPRs to remain in the country	✖	✖

2. COMMUNITY INITIATIVES OF FEDERALLY QUALIFIED HEALTH CENTERS FOR LATINO IMMIGRANTS

Because of their limited access to health care and socioeconomic constraints, Latino immigrants often seek services at community health centers (CHCs), where they can access care without insurance; over 35% of CHC patients in the US are Latino. Federally Qualified Health Centers (FQHCs) are community health centers federally mandated to provide comprehensive primary and preventive care to medically underserved populations such as low-income individuals, migrant workers, and other marginalized groups. FQHCs play a significant role in reducing racial and ethnic health disparities. The success of these centers in narrowing these gaps is attributed to the wide range of services they offer, culturally competent care, and strong relationships built with underserved communities.

2.1 LA CLÍNICA DEL PUEBLO

La Clínica Del Pueblo (La Clinca), is a FQHC that offers primary healthcare services, mental health services, interpreter services, comprehensive health education, and navigation support to address patients' social needs to a majority Latino Immigrant population in Washington D.C and Prince George's County, Maryland. La Clínica provides services to over 4,000 patients and over 60,000 touch points to community members through its Community Health Action and Health Equity departments. Since all direct service staff are bilingual, and most are first-generation Latino immigrants, La Clínica provides much-needed culturally and linguistically appropriate health care to a large yet excluded population.

Figure 4 La Clínica Del Pueblo's 15th Street Entrance. Located in Columbia Heights. Since 1983, La Clínica has been addressing the distinct health needs of Central American and Latino Immigrants

In addition to delivering exemplary care, FQHCs are required to regularly conduct or update a needs assessment for their current or prospective service population every three years. This mandate is designed to improve and optimize service delivery. Given their distinctive and trusted position within the communities they serve, FQHCs are uniquely positioned to investigate, diagnose, and address health problems and hazards affecting the community. This information not only contributes to enhancing the organization's service delivery but also strengthens, supports, and mobilizes communities and partnerships to improve health.

2.2 SCOPE

La Clínica is well-positioned to analyze the social, economic, and environmental root causes of immigrant health from multiple sectors and sources, due to its trusted position in the community. Cost-effective and replicable methodologies that directly engage communities in both data collection and outcome discussions can serve the dual purpose of producing information that helps enhance the organization's service delivery and informing the community on how to advocate for improvements with different public and private organizations. This report showcases the result of a Participatory Rapid Appraisal (PRA), a possible solution to address both the limited scope of health policy approaches towards immigrant health and opportunity gaps within the health sector to address social needs.

3. METHODS

Participatory Rapid Appraisals (PRA) have been applied to different economic and environmental problems within urban contexts. For example, the PRA methodology La Clínica adapted has been used with vulnerable and resource-poor communities to address issues such as climate change impacts, urban violence, and the informal economy.[28] PRA employs various tools, including focus groups, participatory quantification methods like listing and ranking, and causal flow diagrams to identify causes and consequences (see Table 1 for description of tools used). This methodological approach aligns with Community-Based Participatory Research (CBPR)[29], common among public health research as it shares several key aspects that are central to CBPR such as, emphasizing collaboration, community involvement by asking for community health priorities, and collaboratively developing or adopting interventions, championing the integration of culturally based evidence, and equalizing power relations.

TABLE 1 AREA OF INTEREST, GUIDING QUESTIONS, AND PARTICIPATORY DATA COLLECTION TOOLS ASSOCIATED WITH PRA

Area of interest	Guiding Questions	Data Collection Tools	Description
Identification of the most common health problems in the community	What are the most common health problems affecting our community? From these which affect you and your community the most?	Listing and ranking	•Listings identify perceptions of types of health problems/ social needs within communities. •Ranking to prioritize which type of health problems and social need affect local communities most. •Participants choose three problems out of the list and rank them (3=most important; 2=second most important; 1= third most important). •Results are tallied
Main barriers associated with prioritized health conditions	What barriers prevent people from getting better in your community?	Casual flow diagram	•Identifies leading causes and health problems associated with health conditions. •Relationship between health problems and social conditions is visualized.
Identification and prioritization of barriers	From these which are the most significant to overcome for you and your community?	Listing and ranking	•Listings identify perceptions of social needs within communities. •Ranking to prioritize which type social needs affect local communities most. •Participants choose three problems out of the list and rank them (3=most important; 2=second most important; 1= third most important). •Results are tallied

3.1 RECRUITMENT AND IMPLEMENTATION OF AFFINITY GROUPS

La Clínica's implementation of the Participatory Rapid Appraisal (PRA) method involved community engagement through targeted sampling of affinity groups. These groups were selected based on age, gender, and belonging to a La Clínica health education/support group or sharing health conditions or being an active community health worker (promotor de salud). Each group was convened in a community-based conversation and employed the same qualitative data collection tools listing and ranking to prioritize health problems and barriers, along with causal flow diagrams to identify the root cause of those health problems. After all conversations were held, results were tallied and clustered through content analysis.

Individuals were required to be members of a La Clínica Del Pueblo Health Education or Health Promotion group activities to be included in the PRA. Table 2 shows the date on which affinity groups were convened, the distinctive characteristics of each group, and the number of participants. Participants under the age of 18 obtained prior parental consent to participate, as the activity was associated with quality improvement initiatives benefiting La Clínica. All group participants were Latino immigrants able to communicate in Spanish.

To ensure a representative sample of the community that La Clínica serves, groups were composed of participants of different ages, genders, sexual orientations, and differences in health conditions, including a range of chronic diseases, experiences of domestic violence, HIV status, history substance use, experience with mental health conditions and chronic conditions and residence in either DC or Prince George's County.

Affinity groups participated in 90-minute conversation dynamics to offer their perspectives on pressing health issues affecting their communities. The conversations were led by La Clínica del Pueblo facilitators and trained consultants, who served as note-takers. Participation in the community-based conversation was voluntary, and rejecting participation even during the conversation would not affect their receipt of La Clínica's services.

TABLE 2 PRA: DATE OF COMMUNITY CONVERSATIONS HELD WITH AFFINITY GROUPS AND CHARACTERISTICS.

Date	Affinity Group (Translated to English)	Shared Characteristics	% (N)
July 25, 2023	Empoderate (Empower) Group #1	Male, Female, and Transgender, LGBTQ community members over 18 years old and/or Living with HIV	15.6% (12)
July 27, 2023	Empoderate (Empower) Group #2	Male, Female, and Transgender, LGBTQ community members over 18 years old and/or Living with HIV	9.2% (7)
August 21, 2023	Volviendo A Vivir (Back to Life)	Male participants over 18 years old who are enrolled in Substance Use Recovery	5.2% (4)
August 31, 2023	Entre Amigas (Among Friends)	Women over 18 years old, survivors of intimate partner violence	18.2% (14)
October 25, 2023	Promotores (Health Promoters)	Female and Male over 18 years old community members working to amplify LCDP's health promotion strategies through community outreach.	19.4% (15)
October 26, 2023	Mi Refugio (My Refuge)	Female, and Male youth aged 15-21. Receiving in-school based mental health service	15.6% (12)
October 28, 2023	Comité de Pacientes (Patient Committe)	Female and Male over 18 years who are La Clínica patients receiving primary care, mental health services or participation in health education group advising Executive Director on institutional topics	16.8% (13)
TOTAL			100% (77)

3.2 DATA COLLECTION

Facilitators and note-takers of the PRA were trained to implement the participatory techniques and tools required for the methodology. Each affinity group conversation began by encouraging participants to identify prevalent health issues within their community and list them. After elaborating on the list of health conditions, each participant was requested to vote and rank their three most critical conditions (See Figure 5). After identifying the primary health concern, affinity groups used causal flow diagrams to identify the possible reasons the community perceives this health issue as a problem and/or what barriers prevent people in their community from improving (See Figure 6). Once the discussion was completed, the groups listed and ranked the most pressing barriers to be addressed. Upon completion of the activities, the facilitator and note taker debriefed on the data collected and impressions of the group, including major quotes, activities conducted, group dynamics, and transcription.

Figure 5 List and ranking of health issues affecting the community.

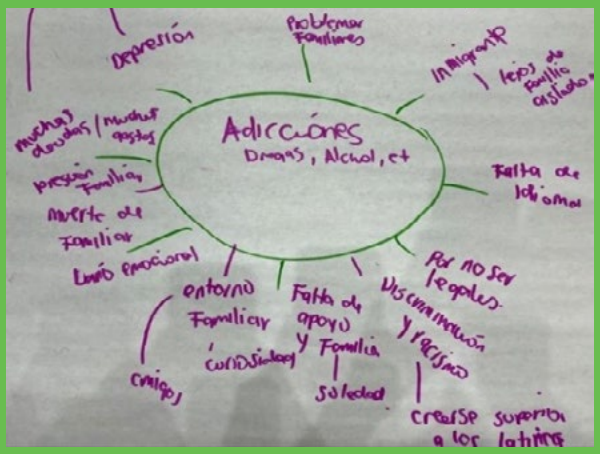
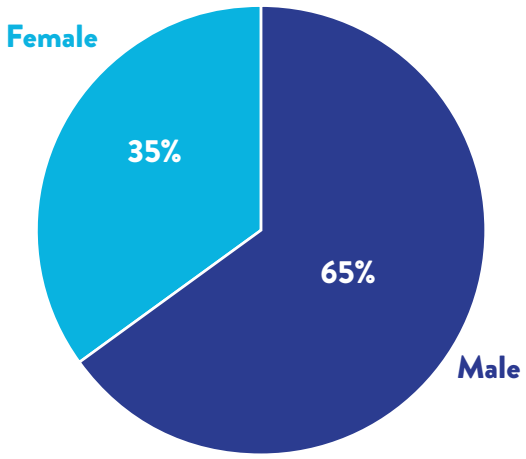


Figure 6 Completed causal flow diagram.

3.3 DEMOGRAPHICS

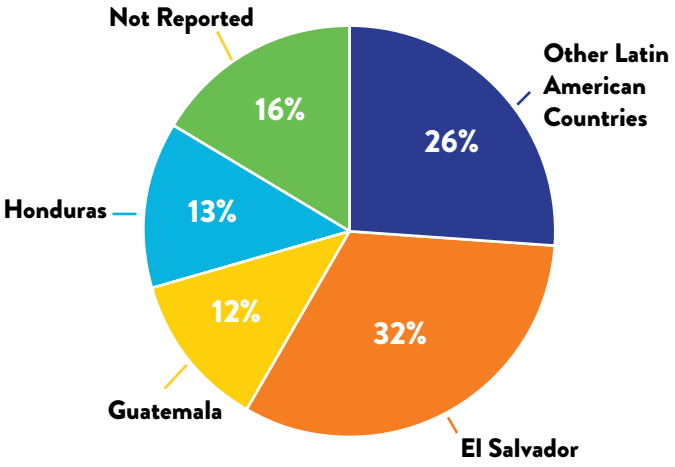
Overall, 65 % of participants in the PRA were women compared to 27% of men. Participation among age groups was diverse, ranging between 15-77 years old, with the majority age group being between 15-28 (32.5%), followed by 28-41 (24.7%) and 41-54 (24.7%). As for country of origin, the majority came from El Salvador (32%), Honduras (13%), and Guatemala (12%), with some participants not disclosing their country of origin. Participants' places of residence varied. For reporting purposes, we focused on the D.C. zip codes; the most common were 20001, 20017, 20009, and 20010.

TABLE 3 DEMOGRAPHIC ANALYSIS



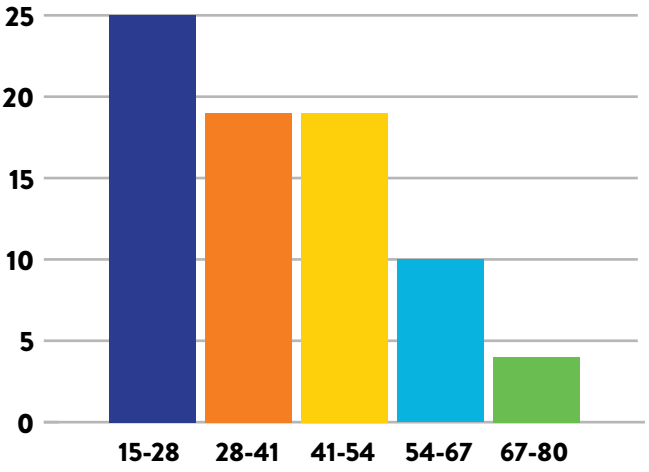
Sex/Gender	Total	%
Female	50	65%
Male	27	35%
Total	N=77	

COUNTRY OF ORIGIN



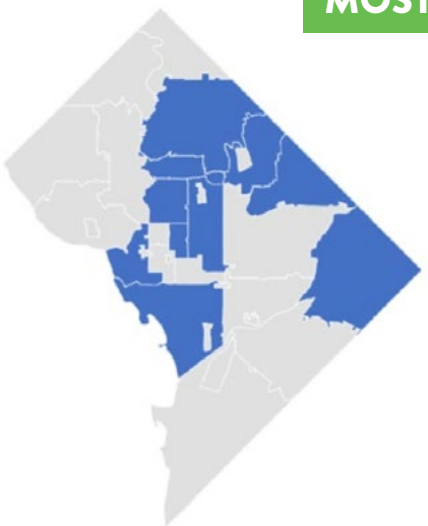
	(n)	%
Bolivia	5	6%
Colombia	4	5%
Dominican Republic	2	3%
Ecuador	1	1%
El Salvador	25	32%
Guatemala	9	12%
Honduras	10	13%
Mexico	5	6%
Nicaragua	3	4%
Puerto Rico	1	1%
Not Reported	12	16%

AGE RANGE



Age Range	15-77
15-28	N=25 (32.5%)
28-41	N=19 (24.7%)
41-54	N=19 (24.7%)
54-67	N=10 (13.0%)
67-77	N=4 (5.2%)
Mean	39

MOST COMMON ZIP CODES



Zip Code	%
20001	3%
20017	5%
20009	6%
20010	9%
20011	9%
Zip Codes in Maryland and Virginia	68%

3.4 DATA ANALYSIS

After completing the seven affinity groups, results were aggregated and analyzed by La Clínica's Health Equity team through in-depth content analysis to generate thematic clusters. Clusters were created following the World Health Organization's (WHO) mortality database and Social Determinants of Health Conceptual Framework.

TABLE 4 SAMPLE OF CLUSTERS CAPTURED IN AFFINITY GROUP CONVERSATIONS.

Affinity Group	Cluster	Quote
Prevention	Income and Occupation, Psychosocial Factors, Language Barrier	"Lack of income" is due to the fact that Latinos are often isolated due to their immigration status (lack of documents), lack of opportunities, the language barrier, among others.
Prevention	Immigration Status, Income, and Occupation, Psychosocial Factors	"Due to immigration status, there is difficulty living in a place where there are many rules and restrictions, since they cannot apply to a home ... Then people fall into depression."
Entre Amigas	Material Conditions: Access to Food	"Lack of information about what healthy products are, because ... you're busy moving from job to job, not spending time figuring out what is good for your body."
Health Promoters	Income and Occupation	"People are experiencing more stress over time, but I think it's related to inflation, the low likelihood of getting ahead, of being able to plan and grow. There may be a lot of work, but it's not well paid."

4. OUTCOMES

4.1 HEALTH PROBLEMS

According to the composite data collected from all affinity groups, mental health conditions (41%), chronic diseases (28%), and behavioral factors associated with substance use (17%) are the most important health concerns (See Table 5). The affinity groups associated mental health conditions primarily with stress, depression, and anxiety. Chronic conditions were primarily associated with diabetes, hypertension, and other cardiovascular conditions. Finally, substance use was associated with both drugs and alcohol, but no distinction was made regarding the type of drugs.

TABLE 5 AGGREGATED HEALTH CONDITIONS FROM AFFINITY GROUPS

Health Condition	Aggregated Total Votes by Affinity Groups (n)	%
Mental health conditions	157	41%
Chronic Disease	107	28%
Behavioral Factors-Substance Use	66	17%
Infectious Disease-Sexual Transmission	25	7%
Infectious Disease-Respiratory Transmission	14	4%
Respiratory conditions	6	2%
Other	3	1%
Environmental conditions	1	0%
Grand Total	**379**	**100%**

4.2 BARRIERS

According to the composite data collected from all affinity groups, occupation and income (17%) was cited as the most pressing barrier, followed by access to health services (16%), and immigration status (13%) (See Table 6). However, when aggregating psychosocial factors, they represent the most pressing barrier (21%). Similarly, together, material conditions, such as housing, food, and neighborhood quality (20%), were also ranked high. Surprisingly, contrary to most public health and health policy literature, access to access to care (16%) was not perceived unanimously as the major barrier among all groups. Rather, proximal factors associated with income, material circumstances, and experience of discrimination connected with immigration ranked higher than access alone.

TABLE 6 AGGREGATED BARRIERS BY AFFINITY GROUPS

Barriers	Aggregated Total Votes by Affinity Groups (n)	%
Occupation and Income	63	17%
Health System: Access to health services	62	16%
Immigration Status	48	13%
Material circumstances: Access to food	40	11%
Language barrier	34	9%
Psychosocial Factors: Depression	27	7%
Psychosocial Factors: Discrimination	21	6%
Material circumstances: Housing	20	5%
Psychosocial Factors: Isolation	17	4%
Psychosocial Factors: Low self-esteem	16	4%
Material Circumstances: Neighborhood Quality	16	4%
Other	11	3%
Health System: Health literacy	2	1%
Psychosocial Factors: Coping styles	2	1%
Grand Total	**379**	**100%**

5. DISCUSSION

5.1 MENTAL HEALTH BARRIERS

As identified by all affinity groups, mental health conditions such as depression, anxiety, and stress are a big concern. As noted by a participant in the Empoderate # 1 group, one of the barriers associated with mental health conditions is experiencing "discrimination as a social problem that does not allow Latinos to improve from depression." Furthermore, the Promotores affinity group noted that increasing levels of stress in the community are related both to the low likelihood of getting ahead, being able to plan and grow, and the lack of well-paying jobs. As one participant noted, "there may be a lot of work, but it's not well paid."

In addition to material needs such as lack of access to well-paid jobs and experiencing discrimination as an immigrant, feelings of isolation also contribute to their mental health conditions. For example, one participant in the Mi Refugio affinity group cited, "We came to this country, and we don't have family; we feel alone, without support."

5.2 CHRONIC DISEASES BARRIERS

The prevalence and incidence of chronic diseases like type 2 diabetes among Latinos in the United States are higher than the national average. This is partly due to social factors, such as lower income and decreased access to health care. However, one element that is not given sufficient attention is the types of employment many immigrants do that do not allow them time or income to purchase or prepare adequate food. One participant in the Entre Amigas affinity group pointed out that "poor diet" is a problem related to "work" and "heavy schedules." The same participant also mentioned that "healthy foods are expensive."

Participants connected neighborhood quality to the types of foods they can access. For example, one participant in the Entre Amigas affinity group mentioned the "area in which we live...where fast food predominates, which is not healthy; instead... there are other areas... where there are stores that sell healthy foods, but those who live there are only Americans, whites, and those who work in offices, and the rent of the houses there is very expensive; Latinos can't go live in that area because they're more preoccupied with their jobs, having to go and live in cheaper places where healthy foods are hard to come by".

5.3 DATA VALIDATION

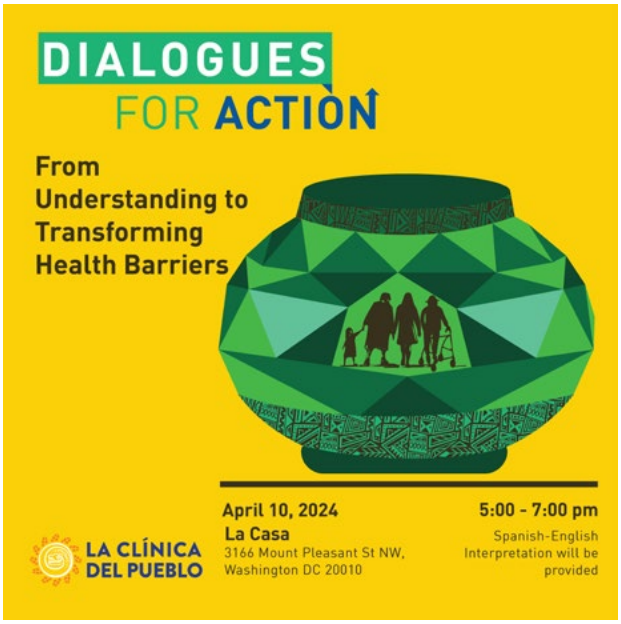
According to a national survey conducted by the Migration Policy Institute, which referred to the U.S. Census Bureau's American Community Survey, Central Americans had a median household income of $55,000 in 2021. This figure is lower than that of both all immigrants and U.S.-born individuals, who had a median household income of $70,000.[32]

As shown in our PRA, most participants are Central Americans, and income and occupation are central to their understanding of health. Furthermore, as shown in peer-reviewed research, low income is demonstrably correlated with poor mental health and the incidence and prevalence of chronic diseases.[33, 24]

Our data reflects the recent Census Bureau National Household Pulse Survey, which collected timely information on individuals' and households' economic and health-related well-being during the COVID-19 pandemic. Surveys were conducted from 2021-2022 and they showed that 37 percent of Latino adults with lower incomes (defined here as less than 200% of the federal poverty line) and living with children reported frequent anxiety or depressive symptoms. This included 33 percent of Latino adults who reported frequent anxiety symptoms, 26 percent who reported frequent depressive symptoms, and 22 percent who reported both; these rates are statistically higher than seen among their higher-income Latino peers.[34]

Finally, because immigration status is a shared experience among all participants and primary data assessing the health status of undocumented persons is hard to come by. We relied on secondary sources which have demonstrated the impact of immigration policies on mental health. For example, in a mixed methods study involving 20 participants, fear of deportation led to chronic anxiety among immigrant communities.[35] Likewise, undocumented participants revealed that higher fear of deportation scores were associated with a significant likelihood of avoiding healthcare due to concerns about immigration status.[35]

6. RECOMMENDATIONS



Based on PRA data, validation, and continuous monitoring and service provision, La Clínica recommends incorporating Health in All Policies (HiAP) to advance immigrant health equity. This approach entails that policymakers should not only aim to prevent poor health outcomes by avoiding harmful policies but also actively work to improve migrant health through inclusive policy efforts that extend beyond healthcare access alone.

Based on the key health and social barriers identified by Latino immigrants residing in the District, La Clínica held an event on April 10, 2024, called *Dialogues for Action Event: From Understanding to Transforming Health Barriers.* The following recommendations and policy actions were formulated by the community:

6.1 INCOME AND OCCUPATION

Participants consider their income and occupation to be the most significant barrier. This perception is validated by various studies showing that Central American immigrants have an average household income of $55,000 nationally.[32] This figure is lower than that of all immigrants and U.S.-born individuals, who have an average national household income of $70,000.[1] This figure is even lower when compared to the household income in the District of Columbia, which is currently $101,722.[18]

To mitigate this effect, the District of Columbia government should offer protections that guarantee fair and insured wages for all workers and require all employers to meet this requirement. To ensure compliance, the District should

continue investing in the Workplace Rights Grant Program through the Office of the Attorney General (OAG) and distribute funds to organizations that serve immigrant workers.

Many immigrants with professional degrees also face barriers in validating their credentials, which significantly reduces their employment opportunities and earning potential. One example the District could follow is replicating the Welcome Center in Montgomery County, Maryland. These centers help internationally trained healthcare professionals reenter the workforce in the United States. The Center offers a coordinated approach to overcoming licensing and certification barriers. Such programs would also help bridge the gap for employers needing skilled labor in healthcare, education, and construction industries.

Another aspect limiting immigrants is the cost of childcare. Programs that subsidize childcare should be made more flexible to include all parents regardless of immigration status. An example the District could follow is implementing the recommendations of the DC Action Coalition, which seeks to increase the affordability of childcare and improve the DC Child Care Subsidy Program by simplifying enrollment and promoting it to more parents, as current utilization is low.

6.2 ACCESS TO HEALTH SERVICES

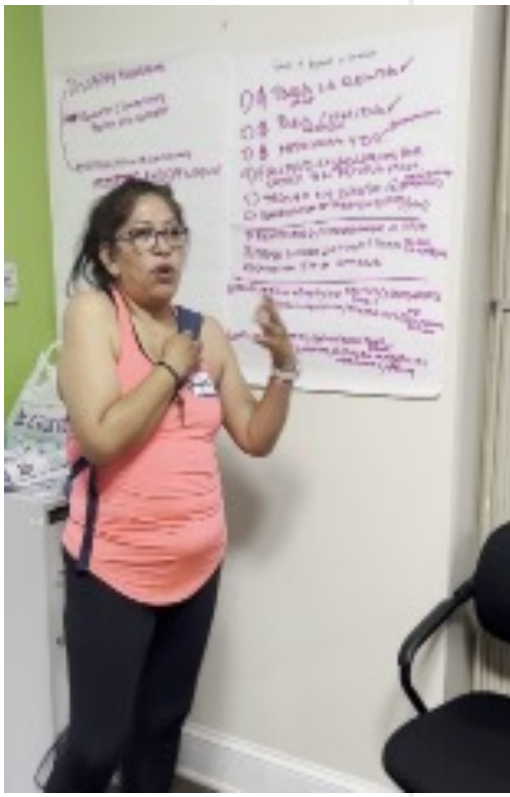
In the United States, only six states and the District of Columbia offer public health insurance to income-eligible immigrant adults, regardless of immigration status, who do not qualify for Medicaid.[22] The DC Alliance Program has been a significant support for immigrants in the District. The shift to an annual certification process in 2022 was a positive step in eliminating barriers to accessing the program. However, many people are currently encountering issues when trying to renew their insurance. These issues often arise from inconsistencies, a lack of clarity in the application submission process through the portal, and a lack of accountability when a complaint is submitted.

Additionally, participants felt that this insurance should offer the same services as Medicaid. For instance, payments to doctors, nurses, and other healthcare providers should be equalized to the rates they receive for Medicaid. Furthermore, participants emphasized increasing resources available for community health centers, access to medicines, and sexual and reproductive health procedures, among others. The District of Columbia could consider innovative models that allow for better coverage and less fragmentation in service delivery. An example is California's Medicaid program (Medi-Cal), which covers all state residents who meet Medicaid income eligibility requirements regardless of immigration status.

6.3 IMMIGRATION STATUS

As immigration status fluctuates and can change, it is crucial for immigrants to have legal support to establish themselves in the city. However, the high costs of accessing an attorney are seen as a significant barrier. In Washington, DC, two key programs already fund entities providing various immigration legal services: the Immigrant Justice Legal Services (IJLS) Grant Program and the Access to Justice (ATJ) Grants Program. These two programs are essential in guaranteeing their rights. Another federal program that should be more widely known among organizations is the Recognition & Accreditation (R&A) Program. This Department of Justice program offers training for individuals within organizations that serve immigrants. The goal is for these individuals to gain sufficient knowledge to advise immigrants on their immigration consultations and have access to competent and ethical legal services. This program provides a structured framework for accrediting organizations as legal service providers.

6.4 ACCESS TO FOOD



Participants considered food assistance programs to be crucial as many perceive a high cost of food. Although there are federal programs like the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), many are either unaware of how to access these programs or do not qualify due to their immigration status. According to local coalitions working on food insecurity, increasing SNAP benefits is an effective strategy that would help. The government of the District of Columbia could also initiate campaigns to inform immigrants about these programs and facilitate enrollment. Since immigration status is a barrier for many immigrants, the District could look to programs like California's Food Assistance Program, which covers many groups excluded from SNAP and WIC. Participants also recommend strengthening programs like the Produce Plus Program, which provides fresh, locally-grown fruits and vegetables to people with limited access to fresh and healthy foods. They also recommended establishing community kitchens close to areas where large immigrant communities reside.

6.5 LANGUAGE BARRIER

Participants believe that the language barrier can be addressed in several ways. The government can provide more resources so that schools, churches, and universities can offer basic and technical English classes without access restrictions and require a minimum grade to continue the course for free, thereby incentivizing people to continue their studies until they achieve better language comprehension.

Finally, although there are laws requiring access to medical interpretation and language access in government offices, people perceive a lack of resources for obtaining interpreter assistance to access social services. The District of Columbia should implement the recommendations made by the D.C. Language Access Coalition to enforce the Language Access Act of 2004, including a system of fines for agencies that refuse to provide language access services.

7. CONCLUSION

Many low-income immigrants are excluded from accessing social benefits. Undoubtedly, these barriers prevent individuals from having the support of a social safety net, creating health disparities. Collectively, the results of the PRA add to the existing literature that highlights immigration status as a determinant of health in itself.

To substantially improve health outcomes among the growing Latino immigrant population in the District of Columbia, policymakers, service providers, and other stakeholders must integrate policy strategies that more accurately reflect the socioeconomic and living conditions of Latino immigrants residing in the District.

In addition to considering the aforementioned recommendations, investment should be made in strengthening and coordinating government actors such as the Mayor's Office on Latino Affairs (MOLA) and the Office of Migrant Services (OMS) to work together with community organizations to address these barriers. One example suggested by participants is to create a coordinated campaign that outlines and explains the resources, programs, and existing organizations in the District that can support social needs such as access to health, education, food, housing, employment, and legal assistance. These organizations can also help build narratives of inclusion for immigrants as a way to address discrimination based on race, gender, or social status.

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