Wimauma Voices

Community Report

2014

www.HispanicServicesCouncil.org

This report describes the challenges and opportunities in the community of Wimauma, Florida through the eyes and experience of Wimauma residents young and old.

The informal but participatory assessment was conducted by local residents in partnership with institutions including the Hispanic Services Council, the University of South Florida and with the financial support of the Allegany Franciscan Ministries.

The report summarizes the results of conversations held over the course of nine months with more than 400 residents and stakeholders and offers a set of recommendations to reduce the health disparities among residents of the community.

Hispanic Services Council 2902 N. Armenia Ave. Tampa, FL 33607 813.936.7700

Acknowledgments

Wimauma United and Unidos Members

Evelyn Adrian
Reyna Baragan
Shlonda Bankston
Pamela Berrien
Retha Braul
Rudy Calderon
Raquel Camacho
Margaret Claritt
Michael Cornier
Bill Cruz
Mark Dunn
Mayra Felix
Rosa Felix
Domingo Antonio Gonzalez
Eliud Gonzalez
Rosa Gonzalez
Juan Gomez
Reynaldo Hernandez
Tomas Hernandez
Velia Huitron
Carlos Irizarry
Hazel Jackson
Albert Knight
Maegen Knight
Joe La Forma
Laura Lerma
Rosaria Lomeli
Michael Long
Elia Lopez
Salvador Marcelo
Enrique Gallegos
Jennifer Moreno
Mercedes Nuñez
Margarita Murillo
Aracely Nanez
Irma Ornelas
Raquel Orendain
Mena Ramos
Brunilda Rentas
Laura Resendez
Alma Reyes
Delores Reyes
Ofelia Rivera
Shorty Robbins
Dagoberto Rodriguez
Miguel Rodriguez
Irene Rosas
Maricela Sanchez
Priscila Sanchez
Adrian Sarmiento
Raul Sarmiento
Abigail Saucedo
Magda Setzer
Braulia Verdugo
Nancy Perez
Rita West
Cynthia Wilcox
Pat Young
David Soriano
Juan Carlos Soriano
Milagros Concepción

"It can't be just one person, has to be the whole community.

Wimauma Youth

Executive Summary

Over the past nine months, Hispanic Services Council conducted a community assessment of the conditions of Wimauma, Florida as part of a three-year initiative called the Puentes de Salud (Bridges to Health) project to address health disparities. The project aims to engage residents in identifying key areas where the community can take action to improve community health and reduce health disparities.

The assessment was designed based on community-based participatory research approach (CBPR) to ensure the broadest participation and engagement of the community and the stakeholder group that provides leadership to the project's implementation. Over the course of nine months, a total of 400 interviews were conducted with residents through individual surveys, focus groups, and "charlas", which are informal mini workshops. In addition, stakeholder group members gathered data to document community conditions through video and photo observations, literature reviews and searches.

This report presents a summary of the voices of the community and their perceptions of the conditions, challenges and opportunities that exist to improve the quality of life of Wimauma.

Top Community Challenges:

1. Public Safety & Security
2. Access to reliable and affordable transportation
3. Access to affordable housing and health care
4. Insufficient educational resources for children, youth, and adults
5. Access to recreational resources for children, youth and families

Recommendations for Community Action

- **Data to Drive Community Change:** Develop a Health Equity Index to advance understanding of the social determinants of health and their correlation with community health outcomes.

- **Healthy Places. Healthy People**: Implement basic quality improvements to the built environment to increase the safety and "walkability" of neighborhood streets, provide access to public parks. Increase access to and quality of services offered by public and private institutions that provide educational, health care and social and community services and provide affordable housing.

- **Rights and Resource.** With the input of the local community, design and implement a culturally and linguistically appropriate community outreach and education campaign to increase the health literacy of residents and facilitate sound decisions and choices.

- **Increase Access to Health Care:** Establish a community health promotion & navigation model program that trains residents that represent the diversity of the community (culturally and linguistically) to provide basic health, education, screening, personal care management and navigation, support alternative transportation strategies and invest in high quality and comprehensive medical care facility.

Background

Hispanic Services Council is a community organization that is committed to improving the quality of life of Hillsborough County by increasing access and opportunities for Latinos in the areas of education, health, wealth and civic engagement. In 2007, in partnership with the Children's Board of Hillsborough County, Hispanic Services Council conducted a multi-year initiative to address issues of academic success among children living in communities in the Southern parts of the County. Our work with individual families living in Wimauma, one of the target communities, revealed the challenges that an overwhelming number of families affected by chronic illnesses and lack of access to quality medical care were facing.

The National Institute of Health defines health disparities as the "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific populations." A review of the multiple stories about the challenges reported by providers serving Wimauma from 2007 through 2012 indicated that several of these factors appeared to be present and largely impacting the health and safety of Wimauma residents.

It was then that in 2012, with a major grant from the Allegany Franciscan Ministries, Hispanic Services Council, embarked on a three-year initiative; PUENTES de Salud/ Bridges to Health to explore more in depth the presence and impact of these factors in Wimauma, Florida. The initiative set out to identify the level of awareness about these issues among its community members and explore the possibility to partner with community stakeholders to initiate a change process that would build upon Wimauma's assets and uniqueness. The initiative was designed consistent with the principles described by the National Institute of Health and the Prevention Institute as a "promising practice "to address the environmental, policy and systems issues" that are drivers of health disparities.

Since the project's inception, a coalition of residents and stakeholders has emerged and are working together to inform, educate and engage the broader community to spark community change at all levels: individual, systems and community. Community change occurs when those most affected are involved in identifying the problems and the solutions, therefore, group members (residents of the community) participated in the development of the scope of the community assessment effort and actively participated in the data collection process. Results of the assessment will be shared throughout the

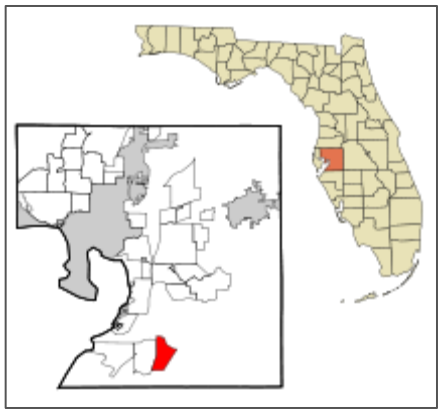
community to engage the largest and broadest participation of residents in the definition of community priorities and action steps resulting from this work.

Puentes de Salud/ Bridges to Health project is staffed by a three-member Hispanic Services Council team and the project is led by a 45-member resident and stakeholder group. The community assessment project activities were conducted with the assistance of a research consultant, supported by members of the University of South Florida Latino Style Research project and the College of Behavioral and Community Sciences and the University of South Florida School of Social Work.

The community assessment process was designed consistent with the principles of Community Based Participatory Research, (CBPR), an approach that lends itself to facilitate the engagement of a maximum number of residents and stakeholders in the efforts to collect data about the local conditions and community perceptions. This report describes the results of the Community Based Participatory Research, CBPR (community assessment) implemented over the course of nine months.

Wimauma Community Profile

Located in unincorporated South Hillsborough County, Florida, Wimauma is near the Manatee County Line, just west of the intersection of County Road 579 and State Road 674. Wimauma occupies 25 square miles and has a population of 6,373 (U.S. Census). The population is predominantly Latino 73.4%, among the highest in the County and is 18.8% White and 6.2% African-Americans. Among its residents, 25.7% are foreign born individuals, 57.6% speak a language other than English (compared to 27.3% in Florida overall).



Among residents 25 and older, 50% graduated high school and 3.6% hold a bachelor's degree (compared to 26.2% in Florida overall). Reports indicate that 37.4% of the population lives below the poverty line and in 2011 had a per capita income less than half of Hillsborough County's $26,733; $12,296.

The leading industries in Wimauma, Florida are Agriculture, forestry, fishing and hunting, and mining, 20%; Educational, health and social services, 12%; and Construction, 9%. Approximately 81% of workers in Wimauma work for private companies in the area's most common occupations, which include production, transportation, materials moving (23%), service (18%), government (6%), sales/office (14%) and self-employment (6%).

Although large in land area, the community has limited opportunities to access basic public services. Currently there are three major government facilities, which include a fire station, senior center and one recreation center. There are two elementary schools that serve the area's 1,200 school aged population. The community has access to one privately owned and managed health clinic that provides affordable medical services to the population's low-income community. Three major non-profit groups provide human services to residents and offer programs to serve the area's large migrant farm worker community. Faith based organizations have a significant presence in the community, anchored by the camp established by the Church of God in the early 1800's. There are twelve protestant churches and one catholic mission and parish.

Community Data Gathering Process

The community assessment process sought to achieve several project goals including: 1) build the capacity of residents to evaluate local conditions, systems and services, 2) engage stakeholders in the design and implementation of the assessment process as well as in the data collection and analysis and 3) inform the stakeholder group's community's action planning and priority setting efforts.

To achieve the community assessment goals, the assessment was implemented over the course of nine months using a Community Based Participatory Research (CBPR), approach. This assessment was designed to collect data jointly with the residents for planning purposes and was not intended to be implemented as a research project. Therefore, there are some limitations that must be considered in reviewing the data presented through this report: the sample was relatively small in comparison to the population size, some data did not capture or measure effectively all respondent's perceptions or views, and the limited statistical data and health indexes at the neighborhood level collected were not as comprehensive.

The implementation of the community assessment was led by Amparo Nunez, Puentes de Salud Project Director and implemented with the assistance of collaborating HSC staff and CBPR Consultants; Doctoral Student and Graduate Teaching Assistant Dept. of Applied Anthropology University of South Florida, Sara Arias-Steele, Ercilia Calcano, University of South Florida Mental Health Law & Policy, FMHI, Iraida V. Carrion Ph.D., LCSW, Associate Professor and Chair of the MSW Program University of South, Florida School of Social Work and partners including the National Council of La Raza, and members of the project stakeholder group.

To ensure the broadest participation by members of the stakeholder group and to gain the greatest insight from participating residents in the assessment, six diverse methods were used to collect and gather community data. Members of the staff and stakeholders were trained to conduct each of the various methods used in the data collection process. The following provides a detailed description of each of the methods used and the activities conducted throughout the course of the community assessment:

Asset Mapping

To explore and reveal the diversity of the community's resources and assets; informal or institutional, a total of fifty-two local organizations (public and private) with facilities within the geographic boundaries of Wimauma were surveyed using specific tools particular to each type of organization and resource, among them; five public organizations including three schools, twenty eight local businesses, a civic organization, three non-profit service providers, three farms and two health care facilities, and one low-income affordable housing complex. The data of businesses and organizations surveyed have been collapsed into a directory of services and maps. Those surveyed represented a limited number among the multiple resources available in the community.

Community Surveys

A total of three surveys were conducted among two hundred and forty-five (245) residents using three different survey tools. Two of the tools were designed through special projects led by the National Council of La Raza;1) *Seleccion Sana, Vida Saludable* focused on gathering data about the behaviors and attitudes of residents with respect to healthy living and eating and their response to educational intervention provided by "community promotores" and 2) *Hispanic Health and Chronic Disease* Survey designed to gauge the chronic disease burden among community residents and behavior based on utilization of resources and management of their illnesses. The third tool, *Puentes De Salud/ Bridges to Health* Survey, focused on gathering data on the experience and perceptions of the environmental factors and behaviors in the community.

Focus Groups

A total of six focus groups were conducted involving sixty residents that represent particular segments of the population including farm workers (male and female) in separate sessions, youth, parents, service providers, and resident consumers of local medical and human services. The focus group sessions were designed in collaboration with the University of South Florida and facilitated by teams comprised of University of South Florida students and staff along with members of Hispanic Services Council staff.

Informal small group conversations (charlas)

A total of ten community "charlas" or informal mini workshops and small group conversations were conducted with a total of one hundred residents. The conversation guides and survey tools were designed by the National Council of La Raza and implemented by a special team of 11 residents trained as "promotores de salud" health

promoters to conduct the conversations and gather the community data. The survey tool was designed to collect data about the change in the knowledge about healthy habits and healthy living and the change in attitudes towards a healthier way of living after these “health charlas”. Two focus groups led by a representative from the National Council of La Raza were conducted with 2 groups reporting having one or more chronic illnesses: one with 10 women and one with 8 men to expand the information about the prevalence of chronic disease among residents of the community and the resources to manage their illnesses in their community.

Photo & Video observations

To effectively capture community conditions, twelve stakeholder group members were provided and trained to use disposable cameras and video cameras to document community conditions. In all, over one hundred and eighty-two images were captured that describe many conditions in the community.

Internet Search

With the assistance of one team member of the community stakeholder group, a comprehensive search and review of demographic data, community and health reports, policies and systems were collected.

Figure 1. Wimauma United & Unidos Member

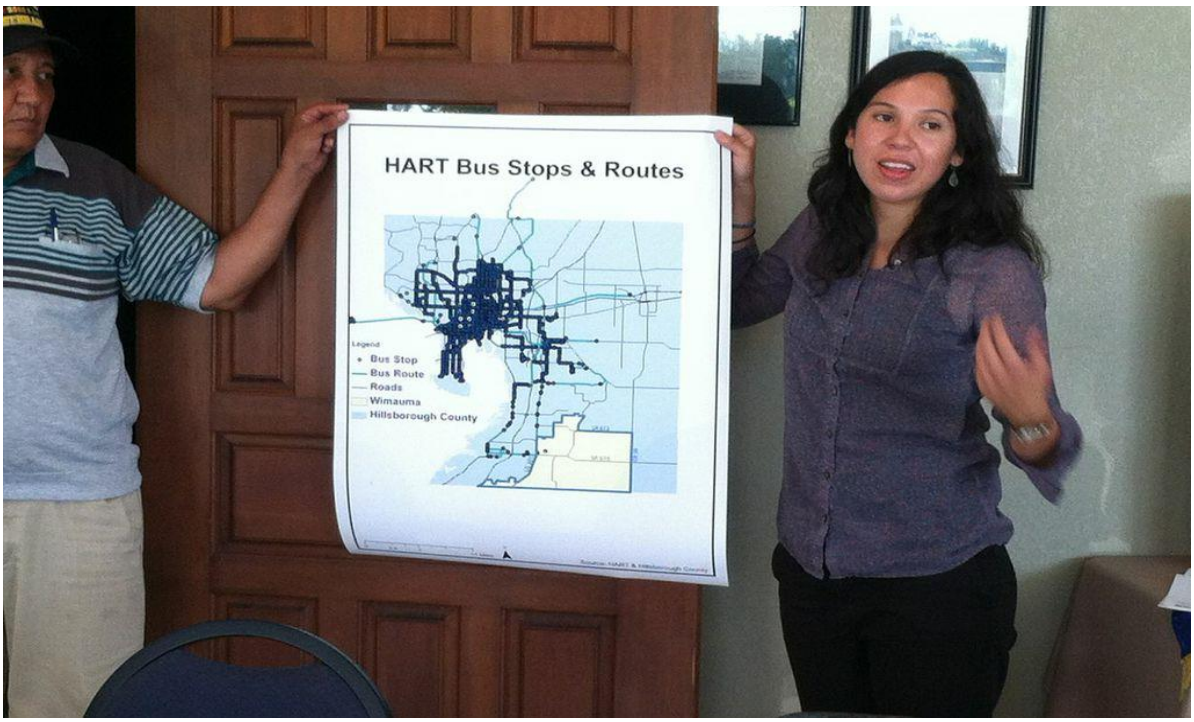


Figure 2. Inadequate Public Transportation Routes in Wimauma

About Wimauma's people … We Learned…

- Wimauma is a community of concerned people that **care deeply** about their neighborhood. People are **hopeful and believe** that they can make a difference and improve the quality of life of their community.
- There is a **sense of community**, people know each other and interact, help each other and contribute generously to the community through their local churches.
- Wimauma residents are **talented** and **generous** people who are willing to share whatever they have for the **benefit of the common good.**
- **Young people** in Wimauma are **bursting** with creative energy waiting to be harnessed and dreams unfulfilled that can become the next best thing.
- Wimauma residents **aspire** **for more** than what has been made available to them and they are open and willing to learn from one another and to work together to make Wimauma a great place for everyone.
- Wimauma is rich with **untapped** **bountiful natural resources** and unique cultural places on the highway and off the beaten path that can be a source of enjoyment for all.

About Wimauma: The Place - We Learned…

- **Safety is upper-most** in the minds of residents where walking down the streets can present a threat to most everyone, particularly women, children and young girls. Too often and in too many areas, children must walk long distances along unlit, unpaved, dangerous roads without sidewalks, to catch a bus for school or to get to the nearest store.

- **Mobility is a barrier**, public transportation is insufficient, medical transportation is **unreliable** and the cost of private transportation services are beyond burdensome.

- **People don't get what they pay for in housing;** the cost is high and the quality is less than desirable. Access to health care for those with chronic illnesses is challenging and local resources lack the capacity to meet the needs.

- Educational opportunities for youth and adults are important to Wimauma residents but **insufficient to meet the aspirations of its people** and too many parents don't have options for their children's education, existing public **parks are closed** and children and families have limited opportunities as well childcare before or after school.

- Vulnerable residents with **limited options** are relegated to work for **employers who take advantage** of their situation, while convenient stores sell **unhealthy** and **expired food** at high prices and others benefit from the language barrier.

Figure 3. Children and Parents Walking home from School

Figure 4. Streets Flooding and in Disrepair

Bridges to Health (Puentes de Salud) Survey Summary:

With the assistance of the University of South Florida, a survey designed to capture the experience and perceptions of community residents of the community's quality of life and access to existing and needed resources in Wimauma. The survey was conducted by HSC staff and community stakeholders throughout various neighborhoods of Wimauma. A total of 54 residents were consulted through the survey with a survey tool that consisted of 55 questions. The survey consisted of demographics, perceptions of environment, community resources, health care. Specifically, the sections included questions on the following: housing/ living conditions, perceptions of change in Wimauma, personal agency to change the community, assessment on the existence and need of basic community needs in Wimauma, assessment of the existence/ need of social services and social support, perception of safety in Wimauma, perception of crimes persistent in Wimauma, assessment of existence/ need of adult and child educational facilities, assessment of existence/ need of health services in Wimauma, percentage of chronic illnesses in respondents, preferred clinics for adult and child medical/ dental services, employment status and type, and regular means of transport.

Demographic Overview of Puentes de Salud Respondents
Total 54

72.2% Female
24.1% Male
77.8% Hispanic
13% African American
7.4% White
See appendix for complete table of demographic data

Resident's Perceptions of Community Conditions:

Community and Environment

- Wiimauma residents in **general like their community** (53% reported feeling satisfied or very satisfied) and only 14.8% consider that the community's has declined. Most feel like there is a sense of community in Wimauma among its residents in fact 64.8% reported having some level of regular interaction with neighbors.

- **Wimauma residents are hopeful** about the future and feel like they can make a difference. When asked specifically, 63% reported that they believe that they can influence change in Wimauma and among possible organizations to belong to 42.6% reported being members of religious organizations.

- Wimauma **residents don't feel safe** in their neighborhood at night (63% of respondents reported feeling unsafe). While feeling less threatened during the day (57% reported feeling fairly safe).

- Respondents rated burglary and theft as the highest safety concern (83.4%), followed by drug violence (74%), home break-ins (72%), and alcohol related incidents (71%).

Access to Social Services & Supports

Regarding the availability of social services located in Wimauma more than **60% of respondents agreed that basic services like affordable housing and transportation** are needed but are not available.

Among a list of social supports discussed, residents ranked the need for informal supports from friends, family and church community as most important, followed by counseling, supports for adults with disabilities, family planning and alcohol and drug abuse treatment.

Adult education and training was ranked as the most important among educational services for Wimauma residents followed in ranking by GED, English as a Second Language and parenting education.

Top Community Concerns

1. **Public Safety**
2. **Access to reliable & affordable Transportation**
3. **Access to affordable housing and health care**
4. **Insufficient educational resources for children, youth and adults**
5. **Access to recreational resources for children, youth, families**

Of the 54 residents surveyed, 72% had children under the age of 10, and among them 52.5% ranked tutoring for children as the most important need, job training for youth and summer programs for children, Childcare and afterschool programs were ranked among the top 5.

Health Conditions & Access to Health Care

Top Health Care Needs

1. **Local place to access high quality and affordable basic medical services for children and adults**
2. **Top services Needed:**
   a. **Dental**
   b. **Eye/Vision**
   c. **Annual health exams**
   d. **Nutrition education /information**
   e. **Women's health**

- Respondents reported suffering from chronic illness 16% Obesity, 13% Diabetes 12% (Asthma & High Cholesterol) and 7% Cancer.

- 54% of respondents reported having no insurance coverage, and of the 46% reported to have insurance, 26% had government subsidized coverage.

- Among thirteen types of health care services discussed, Wimauma residents ranked dental, eye/vision and annual health exams at the top, they also reported the need for information about disease, nutrition and women's health care services among the most needed but not available in the local community.

- 26% of residents reported having Emergency Room Visits in the last 12 months, 20.4% had one visit and 3.7% had 3 visits. Residents had accessed general health care services most frequently at the Ruskin health clinic and the Wimauma health clinic, respectively.

Figure 5. Conditions in one of the Many Apartment Complexes in Wimauma

Figure 6. Community Surveys and discussions.

Hispanic Health Chronic Disease Survey

Wimauma has a population of 6,343, of which 74.3% are Latino. To understand the prevalence of disease among the majority minority population in the community, in partnership with the National Council of La Raza, NCLR, a Hispanic Health Chronic Disease Survey was conducted involving 91 Latino residents. In this section we present the findings of the Hispanic Health Chronic Disease Survey related to health care access and the utilization of social supports that residents use to manage their health.

Among the 91 respondents participating in the survey, 89% were Latino and among them 59% were female and 41% male. See attachment __ in the appendix for detailed summary of survey results.

Most Prevalent Chronic Diseases Among 91 Wimauma residents Surveyed

80.7% diagnosed with a chronic disease

Diabetes

Hypertension

Arthritis-related conditions

Burden of Disease:

Overall 80.7% of respondents were told by a doctor that they have a chronic disease. Of these, 3.28% reporting having one chronic disease, 40.3% had two, 13.4% had three and 9% had four or more. (See table Chronic conditions experienced by respondents)

Table 2. Chronic conditions experienced by respondents*	N	Percentage
Hypertension	34	37.4%
Diabetes	41	45.1%
Some form of arthritis, rheumatoid arthritis, gout, lupus, fibromyalgia	10	11%
Depressive disorders (including depression, major depression, dysthymia, or minor depression)	6	6.6%
Heart attack	5	5.5%
Asthma	7	7.7%
Kidney disease (not including kidney stones, bladder infection, or incontinence)	4	4.4%

Table 2. Chronic conditions experienced by respondents*	N	Percentage
Angina or coronary artery disease	5	5.5%
Stroke	0	0%
COPD, emphysema, or chronic bronchitis	3	3.3%
Cervical, colon, or breast cancer	2	2.2%
Atrial fibrillation	0	0%
Other type of cancer	4	4.4%
Hepatitis C	2	2.2%
Liver cirrosis	2	2.2%
HIV	0	0%

**Respondents were asked to select all that apply.*

Weight Management

- Approximately 86% of respondents were either overweight (21.7% or obese 63.9%), however, 64.8% of those who were overweight felt that their health was "excellent", "very good" or "good" but of them, only 33% had discussed their health with a doctor or health care professional in the past 12 months.
- 79% of respondents reporting trying to lose weight in the past 12 months.

Chronic Disease Management

- 78% of respondents living with a chronic illness had not written plan to manage their condition and those with a plan, 22% to manage their condition, 50% always or usually followed the plan, 21.4% follow it half the time and 28.6% rarely follow the plan.
- In terms managing their chronic illness, 12% of the respondents had not had a doctor explain how to manage their illness at their last visit and of those living with a chronic disease, 31% visited the emergency room in the past 12 months for their illness.
- Beyond professional attention, 69.2% reported not having someone to talk about their chronic illness other than their health care professional, however, 3 out of 4 people reported having friends and family who encouraged them to care for their chronic illness.

- About 73% of respondents reported feeling either very confident (35.9%) or somewhat confident (37.5%) in managing their chronic illness and 37.5% reported talking to others with experience of living with a chronic disease.
- Most respondents with a chronic disease were taking medication, 81% of those 84.3% always took them as prescribed, and 7.8% often took them as prescribed. However, 61% of respondents living with a chronic disease responded that they have not been able to purchase a medication because of costs in the past 12 months.

Health Care Access and Utilization

- 54% of respondents reported having health coverage, while 46% did not. However, among those having coverage, 21% reported not having health insurance during a period of time during the last 12 months.
- When selecting a health care professional, 75.8% of respondents considered that language compatibility most important, followed by affordability 50.5% and available appointments 45%.
- The three most important factors preventing respondents from seeing a provider were; Affordability 38.5%, lack of transportation 25.3% and availability of appointment 22%.

Health Information

- About 77% of respondents sought health information from different sources at least once every few months and about 30% at least once a month.
- 74% of respondents preferred to receive health information in Spanish
- 32.6% stated that they experienced difficulties finding health information in Spanish
- When experiencing signs or symptoms of illness, 82.4% sought a doctor, 24.2% went online to seek web based resources, 14.3% asked a pharmacist

Seleccion Sana/Vida Sana/Healthy Choice/Healthy Living Survey

To evaluate the change in attitude or behavior among Latino residents of Wimauma participating in a healthy living and eating education activities delivered through a "community health promoter model", in partnership with the National Council of La Raza and the CSULB Center for Latino Community Health, Evaluation and Leadership Training, a survey of 100 Wimauma participating residents was conducted.

A total of 11 promotores de salud were recruited for this study (91% female, 9% male, average age of 51 years) and most were from Mexico (45%) and the U.S. (27%). Among the community members, a total of 100 adults of Hispanic/Latino origin (79% female, 21% male, average age of 33) participated in the study. Most were born in Mexico (73%) and Guatemala (12%). All participants completed surveys prior to and following their participation. See appendix for detailed report.

Survey Results

Impact of health education and support

100 Wimauma Residents Surveyed

Promotores de salud & Participants of the workshops reported significantly higher knowledge levels regarding nutrition, healthy habits, and physical activity after participation in the "charlas" training.

The following describes the key findings from this assessment:

- Participants reported significantly higher knowledge levels regarding nutrition, healthy habits, and physical activity after participation in the "charla" (workshops).

- Participants' self-efficacy in terms of helping their family eat healthier and engage in physical activity significantly increased following participation in the charla:

  - 98% strongly agreed or agreed with the statement "I think I can convince my family to drink fewer sugar sweetened beverages every day."

  - 97% strongly agreed or agreed with the statement "I think I can help my family find physical activities in the community."

- Participants reported a high level of agreement with intention to help their family eat healthier and engage in physical activity following their participation in the charla.

- Promotores de Salud gained a lot from the trainers and rated the training very high:
    - 82% reported “extremely useful” and 18% reported “very useful” in the training helping them lead their own educational sessions.
    - Promotores de salud reported significantly higher knowledge levels regarding nutrition, healthy habits, and physical activity after participation in the training.

Figure 6. Training Promotores de Salud/ Health Promoters

Bridges to Health Focus Group Summary

Demographic Profile of Focus Groups

33.6% Male

66.3% Female

Average Age: 32.8 Years

Race/Ethnicity: 100% Hispanic

Birth Country: 60.2% Mexico; 13.4% Guatemala; 26.4% US

This section of the report summarizes focus group findings conducted as part of the Wimauma community assessment process. A total of six focus groups were conducted involving 60 residents that represented particular segments of the population including:

- Farm workers (male and female)
- Neighborhood youth
- Parents of elementary school age children
- Health care service providers
- Adults with direct experience accessing health care services in the local community.

The focus groups were conducted over a 3 -month period; May – July, 2014. Specifically, focus groups explored people's experiences in the local community and their ability to access needed health care and other resources.

Theme #1 Safety & Security

Across all the focus groups, participants shared their concerns for the challenges that children and families face everyday. Youth discussed feeling threatened by gun fire often heard at night, walking down unlit and unpaved roads on their way to school, and avoiding youth fights at school, streets and unsanctioned youth gatherings in areas in and outside of Wimauma. Adults and parents echoed the concerns of youth and discussed drug use, gun use and gang activity. They talked about the disruption, stress and insecurity that the violence and general lack of safety in the community is causing them. Parents expressed frustration about their inability to keep their children safe at bus stops for example, or on the street around their home or public parks.

"There is a counselor but no one speaks to them"
Youth Participant

Most participants, expressed concern over the lack of positive police presence. Discrimination is among those issues that some participants described as a threat to their safety. Some participants complained about the closed "sheriff sub-station" while other participants perceived that "police are racists". Youth discussed feeling unsafe at school and unprotected by their teachers. Some students shared their experience with school officials (teachers and administrators), and shared stories of unfair or

maltreatment and offensive racial language and behavior by teachers towards minority students.

Theme#2 –Mobility Challenges

Transportation was one of the top issues shared by all focus groups. Participants young and old agreed that getting around is real problem. Participants discussed the lack of transportation, costs of the limited services and the abuse and exploitation of those in need. One participant shared the need to pay his pastor $70.00 round trip every time he has to go to Tampa for medical care because the medical care is not available to him in Wimauma. Another participant shared how she lost an important medical appointment because the "Medicaid van service" never showed up. "Walking is just about the only way that most people get around that don't have the money to get a car and even walking is dangerous." Participants discussed the challenges of getting around in the neighborhood, particularly getting to and from the local clinics, like Wimauma or Ruskin.

Theme #3: Health Care Access

In all focus groups, participants discussed a variety of factors that are affecting the opportunities to access quality and affordable health care services and agreed that the current services are not adequate. Participants discussed the important need to have a medical service provider in the neighborhood. Most participants knew about a place to go for health care services (i.e. the Wimauma Clinic), but most agreed that the services were limited in scope and inadequate.

Participants shared concerns with the service, treatment and quality of care. Some participants shared the lengths they go to get medical care in other places, like the Ruskin clinic. Lack of basic medical services, such as dental and eye and vision care were among the most discussed among participants. However, participants also discussed the need for drug counseling and mental health services.

Among the barriers to quality medical care, participants discussed the lack of specialized doctors, some expressed concern for medical personnel at local clinics including Ruskin not having the proper experience or training to provide medical services to the community. Other participants talked about the unfair or discriminatory treatment, while others discussed language barriers and the perception among some participants that health care information was inadequately delivered or received.

Theme # 4 Limited Educationall and Recreational Opportunities

All focus group participants agreed that Wimauma lacks many critical services. Youth and adults discussed the need for opportunities for employment and training and shared how the lack of good paying jobs was part of the problem in Wimauma. Some participants acknowledged that there are jobs in the farms but that those jobs don't pay much and the conditions are not good. Some shared the concern for their children and talked about the future for them and its limitations given the lack of opportunities they face today.

In terms of program and services for youth, youth participants discussed how little there is for them to do that is positive. They discussed how they sometimes go to parties that are not supervised because at least it gives them something to do and a place to go. "they don't sell alcohol but there is no security, no chaperones or parental supervision" Youth participants shared that the only options for them are joining one of the few soccer leagues, watching TV or hanging out on the streets, as **"there is no where to go in Wimauma**".

Adults and parents discussed their concern for the lack of places for their young kids to learn and play safely. Parents discussed the importance that their kids do well in school and shared their understanding that the English language barrier is a real problem. However, many expressed concern with the disconnect between themselves and the schools.

"Entonces donde van todos mis taxes?" Me dijeron que busque por tutores privados para mis niños".

Parent Participant

Among the need of services for children, participants discussed the need for after school programs and summer camps for children other than the migrant population, quality and affordable childcare in the neighborhood and tutoring. Parents talked about the high cost of childcare, $180.00 per month per child reported one participant, and discussed how they had to make arrangements for children that weren't always the best options.

Theme # 5 Vulnerable residents Challenges

Farm workers shared the challenges they face working in unsafe and healthy conditions. One male participant shared ”hay mucho trabajo aqui, unico problema es la violencia” (“there is lots of work here, the only problem is a lot of violence”). Participants reported that theft is a big problem and shared stories of being robbed at local check cashing places. Some participants expressed concern with the growing violent behavior among the youth in the community and the potential of racial violence between Mexicans and African-Americans.

Employers and the business community were discussed by some participants as a threat to them. Farm workers discussed the challenge they face to protect themselves physically but also economically. Participants talked about their exposure to pesticides and their lack of proper training and protection and they discussed their perception that local authorities turn a “blind eye” toward the wrong doing by growers. Women farm workers shared stories about their inability to take bathroom breaks, take protection from the sun, or even take proper care of their children. Both male and female farm workers discussed the challenges with some growers to get paid for their work.

In terms of critical resources important to participants, almost all discussed the need for affordable and quality housing. While youth described the conditions around their homes, adults and parent groups, migrant workers and non-migrant workers discussed the dangers they face living in substandard housing and the health, physical and economic costs that they must pay. Some participants discussed the different means that single mothers, farm workers and in general many residents have to take in order to be able to keep a roof over their head. Participants discussed the need to share a home or mobile home with more people than the housing can accommodate or single mothers rent rooms to men, in households where there are young girls. “Lack of affordable housing is putting many women and children, particularly at risk.”

Figure 8. No Designated Stops to children's homes. Children dropped off on side of road to waiting parents or walk home.

Figure 9. Downing Street unpaved, unlit roads with no sidewalks and ditches.

Recommendations

Data to Drive Community Change

Although, the assessment data presented in this report aimed to inform local residents of the conditions in the community, as a first step in the process of planning community improvements, the need for current neighborhood level data on the social determinants of health became evident.

At the statewide and county level there is a wealth of data resources that can be readily accessed to plan and design improvements at the policy, systems and environment level. However, data on the social determinants of health are limited if not unavailable at the neighborhood level.

Neighborhood level data on the area's social determinants of health can support community and resident groups, institutions, policy makers and health program planners and officials make more informed decisions about the use of limited resources and the design of programmatic interventions.

The data collected should be expanded through additional studies and research that will bring more in depth answers to key community health questions: a) what are the health problems in the community and why those health issues exist; b) which factors create or determine those health problems; c) resources available and to be created to address those problems; and d) what are the health needs of the community from a population-based perspective.

Recommendation:

- Develop a Health Equity Index reflecting data from health and other sectors (a Health Equity Index is a community-based electronic tool that profiles and measures the social determinants, including the social, political, economic, and environmental conditions) that affect health and their correlations with specific health outcomes.

Healthy Place – Healthy People

The forces creating heath disparities at the community level are complex. As the literature on community effects on health disparities demonstrates, there are many factors that contribute to differential health outcomes in a community, that don't necessarily have to do with the race or ethnicity of an individual or their individual characteristics or choices. As expressed by those Wimauma residents consulted, there are many conditions in the local community that are not only obstructing healthy behaviors some are clearly hazardous to your health.

The built environment, safe parks and green spaces, walking and biking paths, affordable housing and places to purchase healthy affordable foods are all "ingredients" of healthy living and of a healthy community. The built environment promotes activity and creates in communities a sense of place and safety.

Recommendation:

- Implement basic quality improvements to the built environment to increase the safety and "walkability" of neighborhood streets, public parks, businesses, and homes.

- Provide public and affordable access to the infrastructure of existing community centers, public parks and green space for use by the entire community for gatherings, education and recreational opportunities.

- Expand public transportation options, increase access and improve use of existing options, as well as support innovative alternative transportation solutions.

Rights and Resources

While health disparities may be attributed to a number of factors, health literacy and access to health information can help special populations gain a better understanding of wellness and prevention. The Internet and other means of electronic communication have become popular tools that are allowing people to take control of their health. However, access to accurate and timely information continues to be a barrier for residents of Wimauma to stay out of harms way, make sound decisions and protect their interests.

According to Healthy People 2010, nearly half of American adults (90 million people) are deemed "health illiterate" that is the inability to read and understand materials related to personal health and navigating the health system. Health illiteracy is an increasing problem among minority and limited English speakers, which contributes to health disparities.

Recommendation:

- With the input of the local community, design and implement a community outreach and education campaign that is culturally and linguistically consistent with the history and experience of the Wimauma residents to:
    - Develop a community social marketing campaign to raise awareness, inform, and educate residents about their rights and protections under the law
    - Publicize and broadly promote existing resources available in the local and greater community
- Design and disseminate broadly a culturally and linguistically competent health literacy community education program that increases the capacity of residents to navigate the health care system and manage their personal health by:
    - Building an infrastructure of local community partners including; faith-based leaders and lay members, government agency personnel and other non-profit human services providers to deliver and promote health literacy education.

Expand Access to Health Care

As documented in 2006 by The Agency for Healthcare Research and Quality Disparities Report, racial and ethnic minorities continue to receive poorer quality of care. Understanding that part of the solution to reducing health disparities includes providing high quality medical care that is physically and financially accessible, and delivered culturally and linguistically appropriate to everyone regardless socio-economic status, ethnicity, race or language.

The Wimauma Community Assessment revealed the challenging nature of receiving affordable, accessible and quality health care in the local community. The barriers to access, receive and pay for medical services increase the health disparities gap in Wimauma, undermine the efforts of existing medical service providers and exacerbate health conditions of residents.

Recommendations

- Establish a community health promotion & navigation model program that trains residents that represent the diversity of the community (culturally and linguistically) to provide basic health, education, screening, personal care management and navigation.

- Create an alternative community-based transportation system that utilizes existing resources and increases affordable transportation options to residents requiring medical services.

- Expand access to health care services by establishing in the local community high quality and permanent facilities that can provide a greater array of medical intervention and prevention services to children, youth, adults, and seniors.

Figure 10. One of few resident Farm Stands selling produce in Wimauma

Figure 11. Community Charlas with Community Resident

Figure 72. Hispanic Services Council Staff advocating at Senator Nelson's office.

Muchas Gracias!

to our funder Allegany Franciscan Ministries for believing, as we do, that change must be driven by those most affected. And thank you too to all the members of Wimauma United and Unidos who believe that they have the power to be agents of change in their community.

We are humbled by your compassion and commitment.

HISPANIC SERVICES COUNCIL

KEY PROJECT STAFF

Amparo Nunez, Director of Puentes De Salud

Liz Gutierrez, HSC Director of Planning and Programs

Diego Mendoza, La RED De Padres Activos. Project Director

Blanca De Ruiz, Community Coordinator

CONSULTANTS

Sara Arias Steele

Cesar Salazar

PROJECT PARTNERS

Hillsborough County Office of Neighborhood Relations

Hispanic Mission Baptist Church

National Council of La Raza

University of South Florida

Wimauma Citizen Improvement League

CONTACT: HISPANIC SERVICES COUNCIL

2902 North Armenia Avenue

Tampa, Florida 33607

813.936.7700

www.hispanicservicescouncil.org

HISPANIC SERVICES COUNCIL
Opportunities Grow Here

APPENDIX

Puentes de Salud/ Bridges to Health Survey

This survey consisting of 55 questions was conducted by the HSC Staff and community stakeholders throughout various neighborhoods of Wimauma to collect information on resident's experiences and perceptions of living in Wimauma. The survey was meant to assess the quality of life and resources in Wimauma, as perceived by residents. The sections included questions on the following: housing/ living conditions, perceptions of change in Wimauma, personal agency to change the community, assessment on the existence and need of basic community needs in Wimauma, assessment of the existence/ need of social services and social support, perception of safety in Wimauma, perception of crimes persistent in Wimauma, assessment of existence/ need of adult and child educational facilities, assessment of existence/ need of health services in Wimauma, percentage of chronic illnesses in respondents, preferred clinics for adult and child medical/ dental services, employment status and type, and regular means of transport.

Survey was collected form 54 respondents, with 72.2% being female and 24.1% being male. In terms of ethnicity, 77.8% were Hispanic, 13% were African American and 7.4% were White. Further demographic data can be seen in the appendix.

Puentes de Salud/ Bridges to Health Survey Findings

Housing

Summary

- Based on the type of housing, the highest average rent of $500-$700 was correlated with people living in mobile homes. Of those who responded, average number of individuals per household ranged form 3-4 or 6 residents, regardless of housing type.

Including yourself, how many people live in your home?

- 16.7% (3, 4, 6 People/ Residence)
- 11.1% (7 People/ Residence)

What type of housing do you live in?

- 55.6% Mobile Home
- 25.9% Single Family Home
- 13% Apartment Complex

Do you Own or Rent?

- 51.9% Own
- 37% Rent

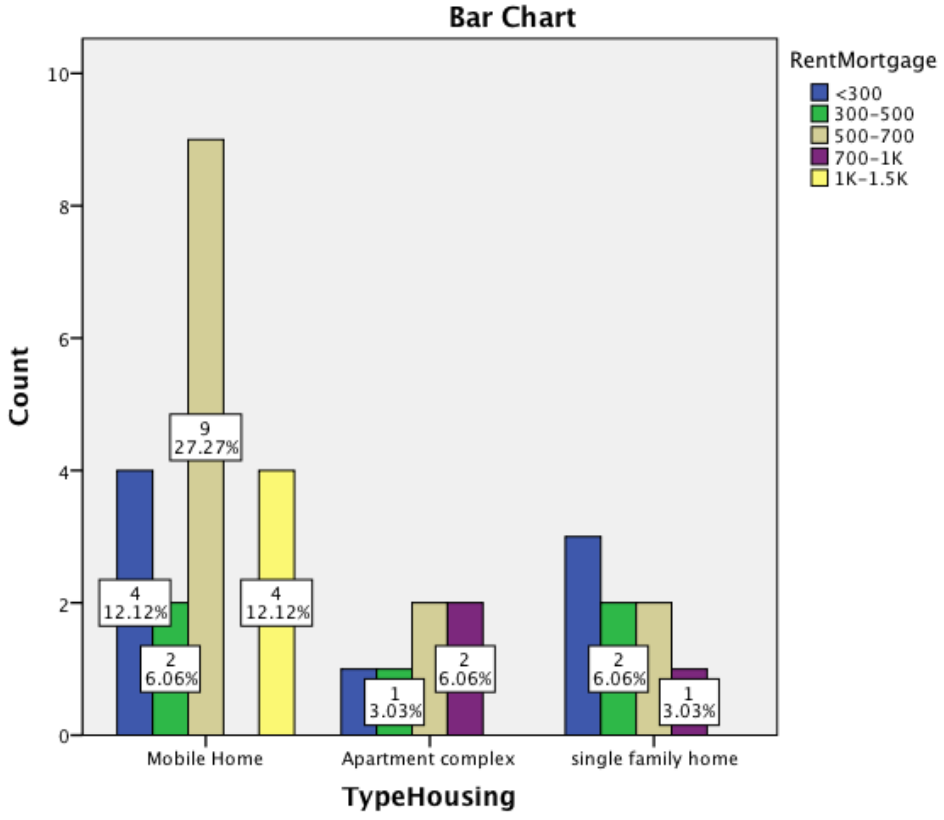
What was the Purchase Price of your Home?

- 24.1% (<50K)
- 9.3% (70K-100K)
- 7.4% (50K-70K)

What is your current monthly rent/ mortgage?

- 24.1% ($500-$700)
- 14.8% (<$300)
- 9.3% ($300-$500)
- 7.4% ($1K-$1.5K)

How much is your monthly mortgage/ rent where you live?



Community Perceptions of Wimauma

Summary

- Based on the past 2 years, community residents were asked if conditions in Wimauma have improved, gotten worse or stayed the same, with 50% mentioning that nothing has changed. The follow-up question gauged the respondents' sense of personal agency in being able to help make changes in Wimauma, including their level of neighborhood engagement, for which we had mixed results.

How satisfied are you with Wimauma as a place to live?

- 37% Satisfied
- 16.7%Very Satisfied
- 16.7% Very Dissatisfied
- 14.8% Fairly Dissatisfied

On the whole, do you think that over the past two years Wimauma has gotten better or worse?

- 50% Same (nothing Changed)
- 33.3% Better than 2 Years ago
- 14.8% Worse than 2 Years ago

How much do you feel you can influence decisions affecting Wimauma?

- 24.1% A Little
- 20.4% A Great Deal
- 18.5% Fair Amount
- 18.5% Not at All

How do you usually get to the grocery store?

- 64.8% Drive own Car
- 16.7% Get a Ride
- 11.1% Walk

How often do you interact with your neighbors?

- 35.2% Regularly
- 29.6% Sometimes
- 20.4% Rarely

What are your Special Talents that you would like to share with others?

- 11.1% Car repair
- 9.3% Cooking
- 9.3% Gardening

What Volunteer Organizations in Wimauma do you belong to?

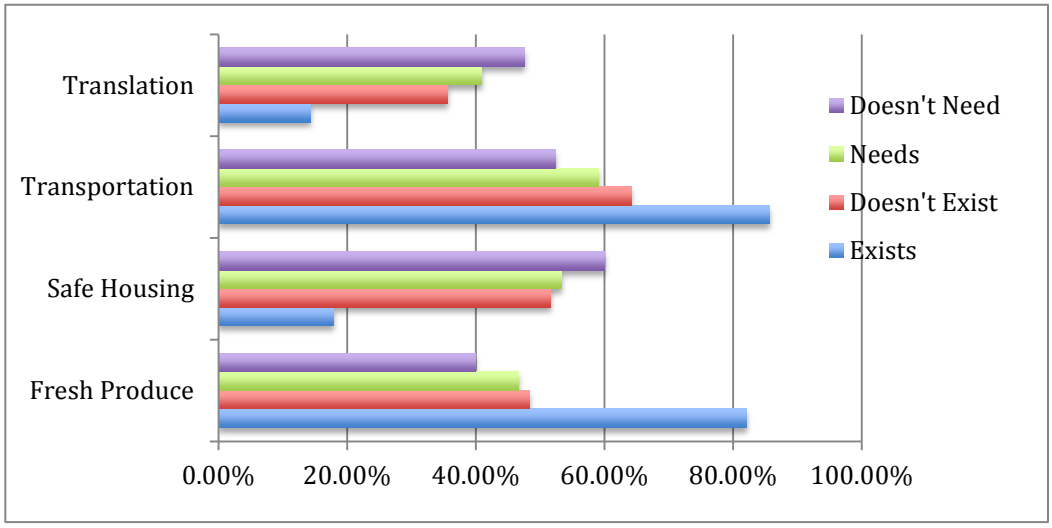
- 35.2% Religious
- 29.6% None

Basic Needs

Summary

- Respondents were asked if the following basic community needs existed in Wimauma and if they were needed or not. Most said safe housing and translation did not exist in Wimauma and expressed a high need of it. While more than 80% mentioned transportation existing, over 60% mentioned it's lack of existence which may be related to where they live and if they have their own means of transportation.

Perception of Basic Needs in Wimauma by Community Residents

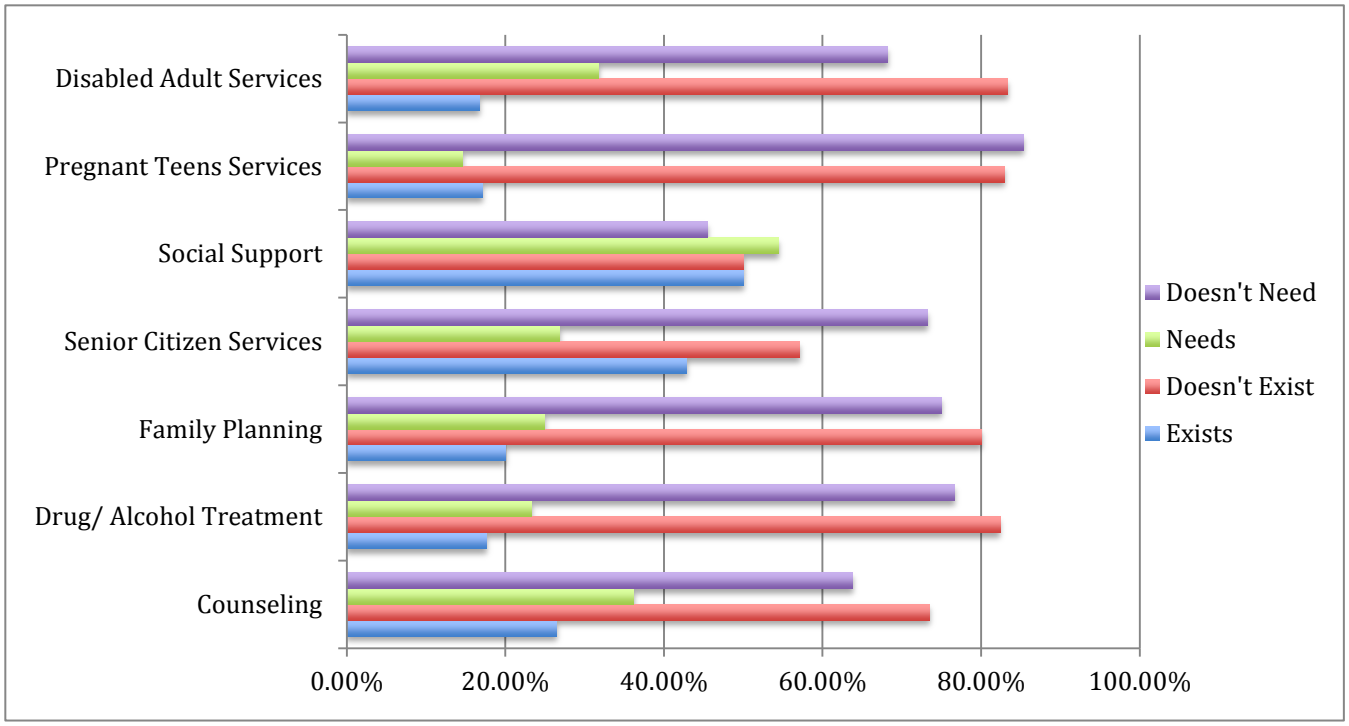


Social Services

Summary

- Respondents were asked if the following social services and social support systems existed in Wimauma and if they were needed. All of the services were seen as lacking in the community (50%-83%), with respondents demonstrating a greater need (>30%) for counseling, social support and services for disabled adults in the community.

Social Services in Wimauma

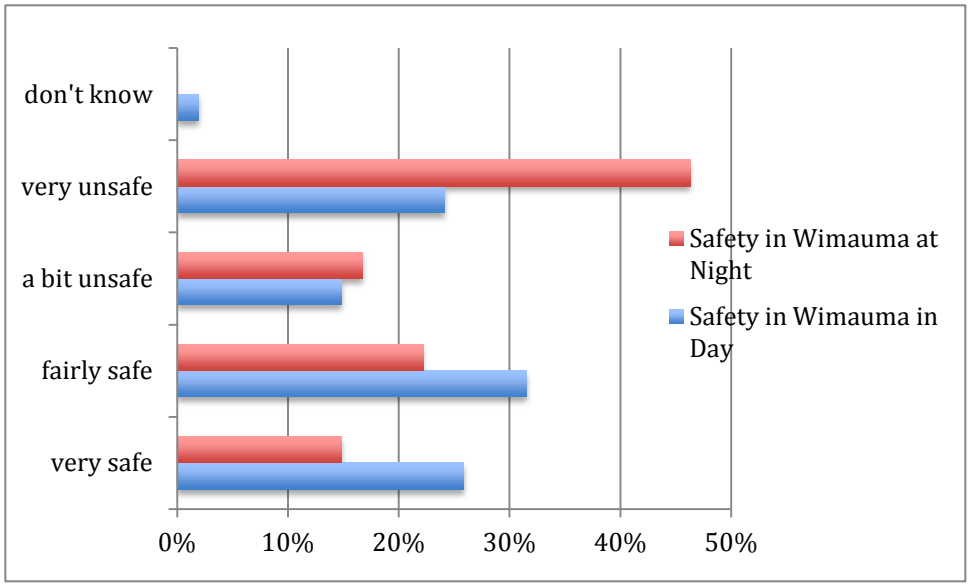


Public Safety

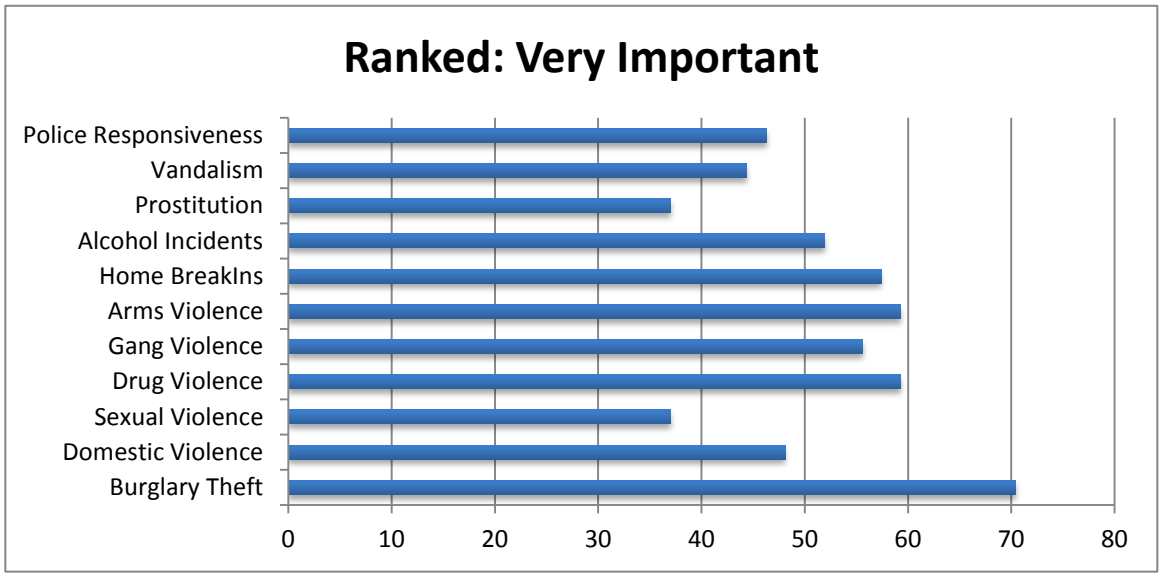
Summary

- In terms of safety in Wimauma, 46.3% of respondents felt very unsafe walking alone at night in Wimauma compared to the daytime. They were also asked which crime issues were relevant to Wimauma, according to level of importance, with burglary/ theft (70.4%), drug violence and arms violence (59.3%) and home break-ins (57.4%) being the most relevant.

How safe do you feel walking along outside during the day/ night in Wimauma?



Safety Issues in Wimauma Ranked Very Important



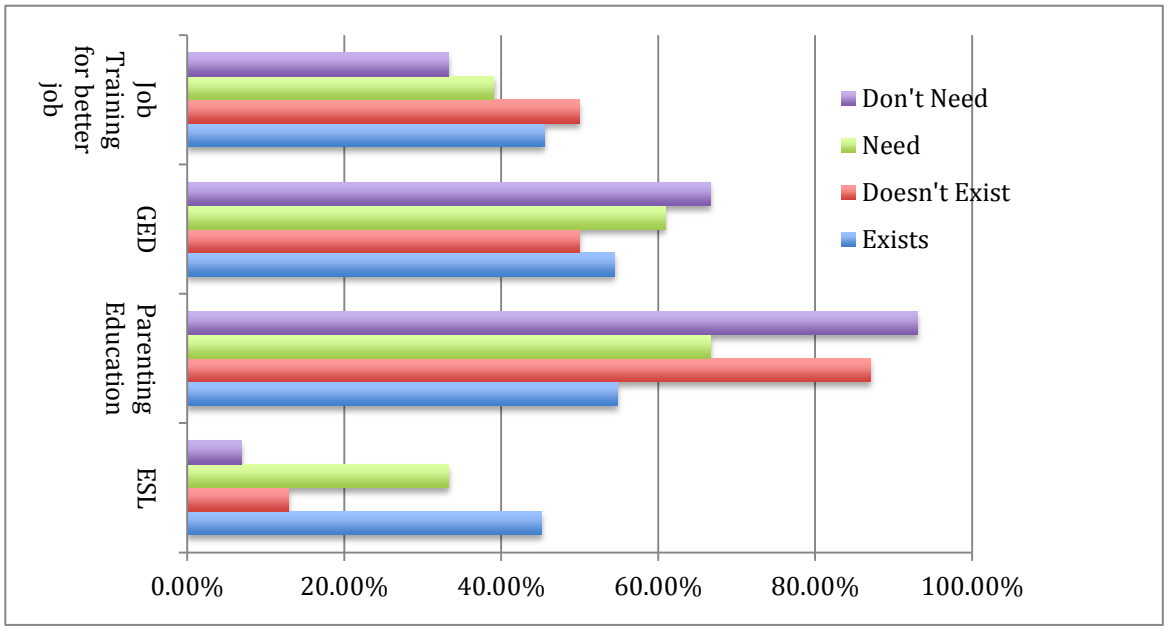
Adult Education

Summary

- Respondents were asked of the following adult educational services, which exist in Wimauma and are the most needed. While all 4 received scores of greater than 55% non-existing in Wimauma, respondents expressed the highest need (>60%) for GED and job training programs.

Do think Adult Education is needed in Wimauma?

- 92% Yes
- 8% No



Child Care/ Child Education

Summary

- In terms of children, 57.4% of our respondents had children, with most of them (44%) within the ages of 6-10 years old attending grades 1-3, with most parents meeting with teachers on a monthly basis. In terms of childcare, 13% chose “Other” and specified they were stay-at-home parents. Less than 7% used any childcare facilities.

Do you have Children?

- 57.4% Yes
- 24.1% No

Do you have a Disabled Child?

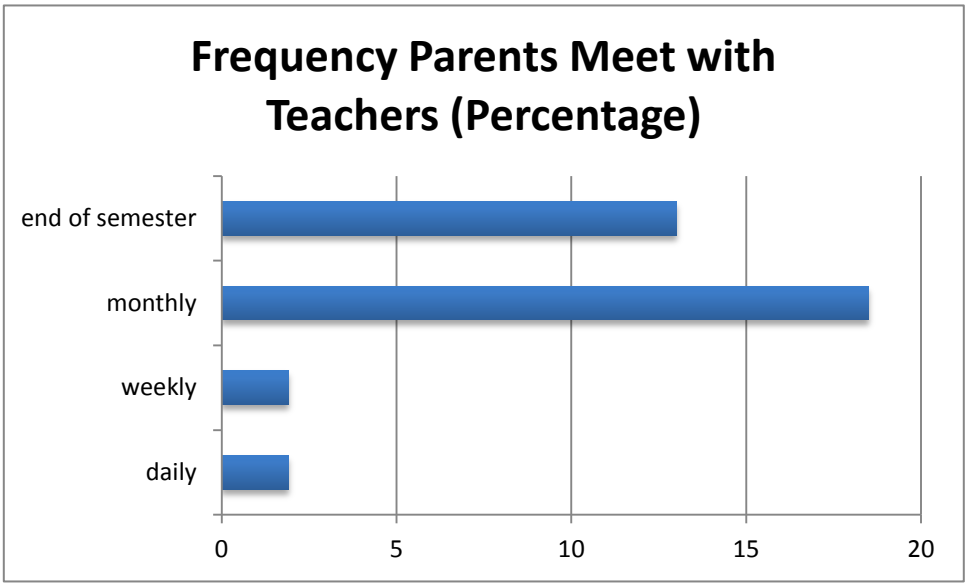
- 42.6% No
- 9.3% Yes

What are the children's ages?

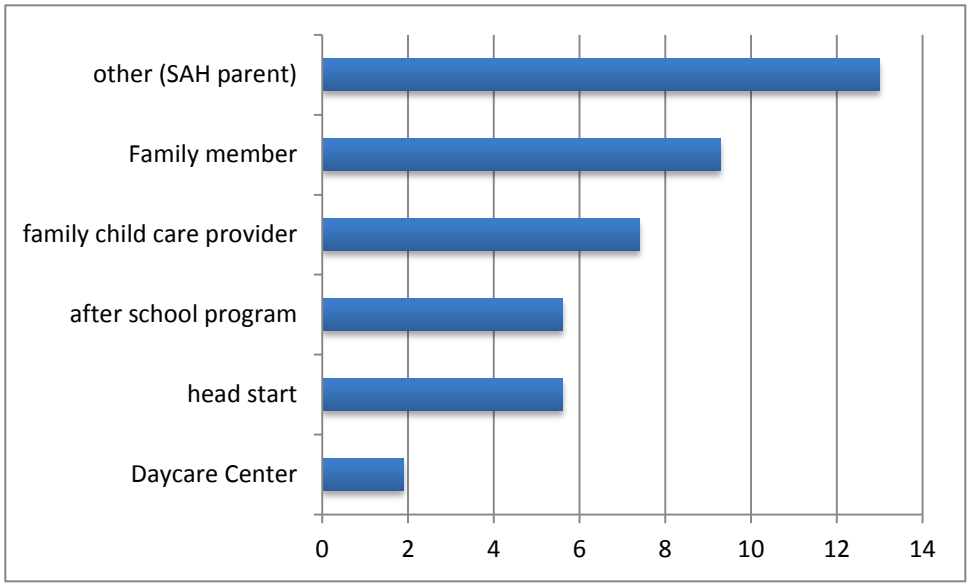
- 44% (Ages 6-10)
- 28% (Ages 5 and Under)
- 24% (Ages 11-17)
- 5% (>17)

What Grade Level does your child attend?

- 43% Grades 1-3
- 29% Grades 4-6
- 19% Grades 7-8
- 10% High School



Who Provides Childcare for you?



Healthcare

Summary

- Perception of Healthcare services in Wimauma by respondent showed that more than 80% of the services were non-existent in Wimauma (except for immunizations), with dental care (83.3%), vision care (71.4%, and annual health exam (73%) among others being considered the most needed by residents. In the past year, only 25.9% have visited the Emergency room and most respondents classified themselves as suffering form obesity (16%), diabetes (13%) and asthma/ high cholesterol (12%). In terms of clinics, adults usually going to Ruskin for both medical (25.9%) and dental (27.8%) services. For children, even though the Wimauma clinic mostly administers pediatric care, less than 3.7% of children attend there. Most children go to Ruskin for medical (20.4%) and dental (24.1%) care. No child attended any dental service in Wimauma.

Has anyone in your household been to the Emergency Room Visits in the Past year?

- 61.1% No
- 25.9% Yes

How many times have you visited the ER in the past year?

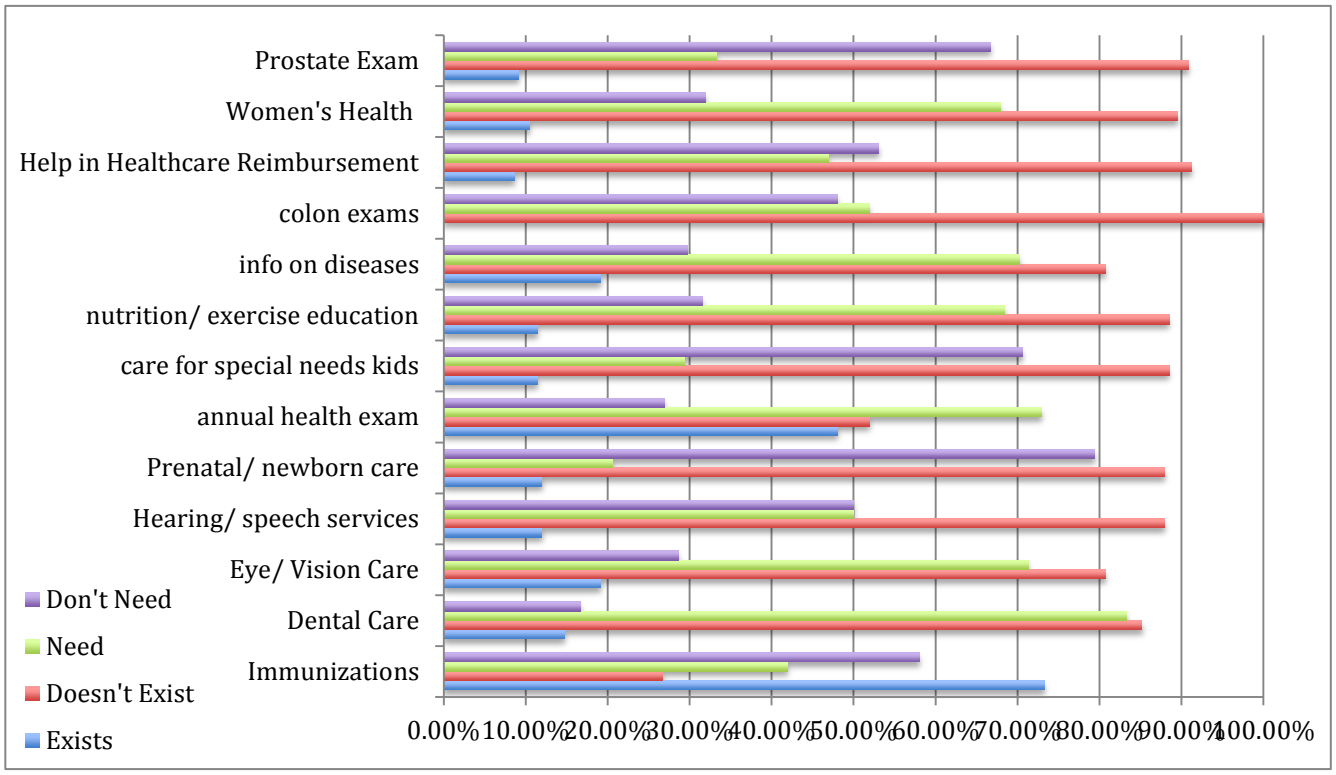
- 20.4% (1 Visit)

- 3.7% (3 Visits)

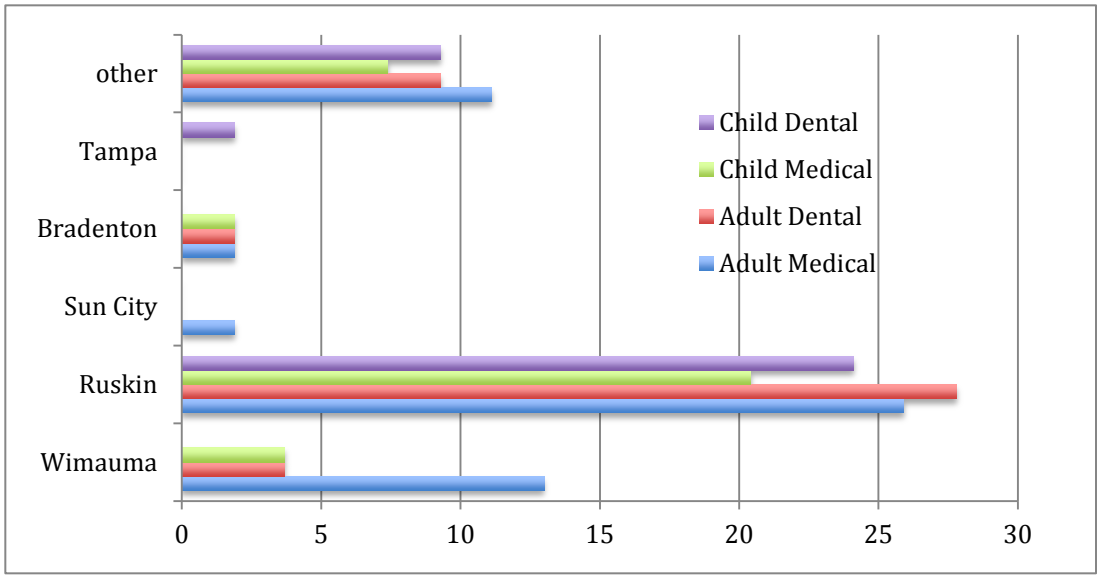
Are you or anyone in your household being treated or suffer from any of the chronic illnesses listed?

- 16% Obesity
- 13% Diabetes
- 12% (Asthma & High Cholesterol)

Health Services in Wimauma



Where do you get your medical/ dental care (Adult and Child)?

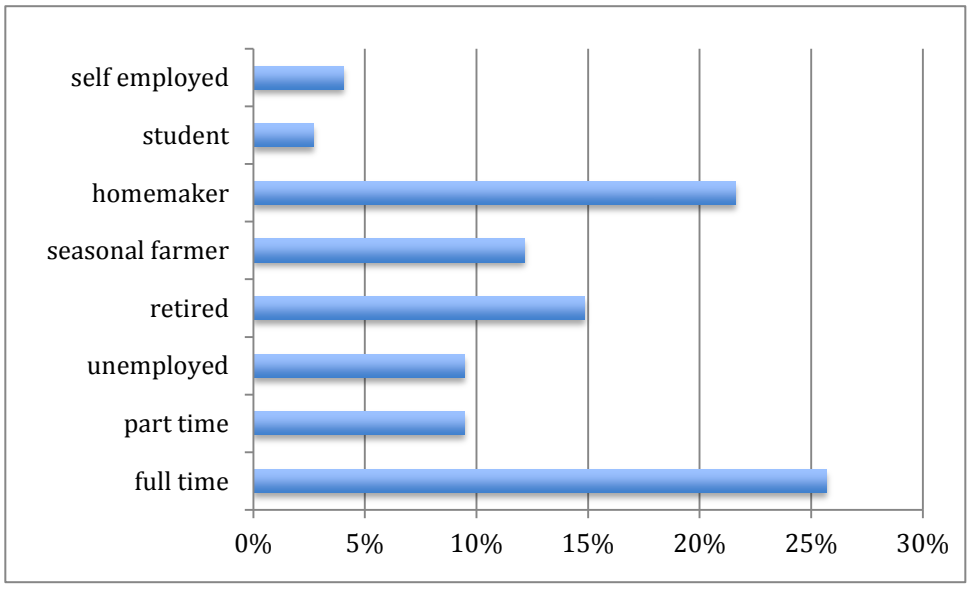


Employment

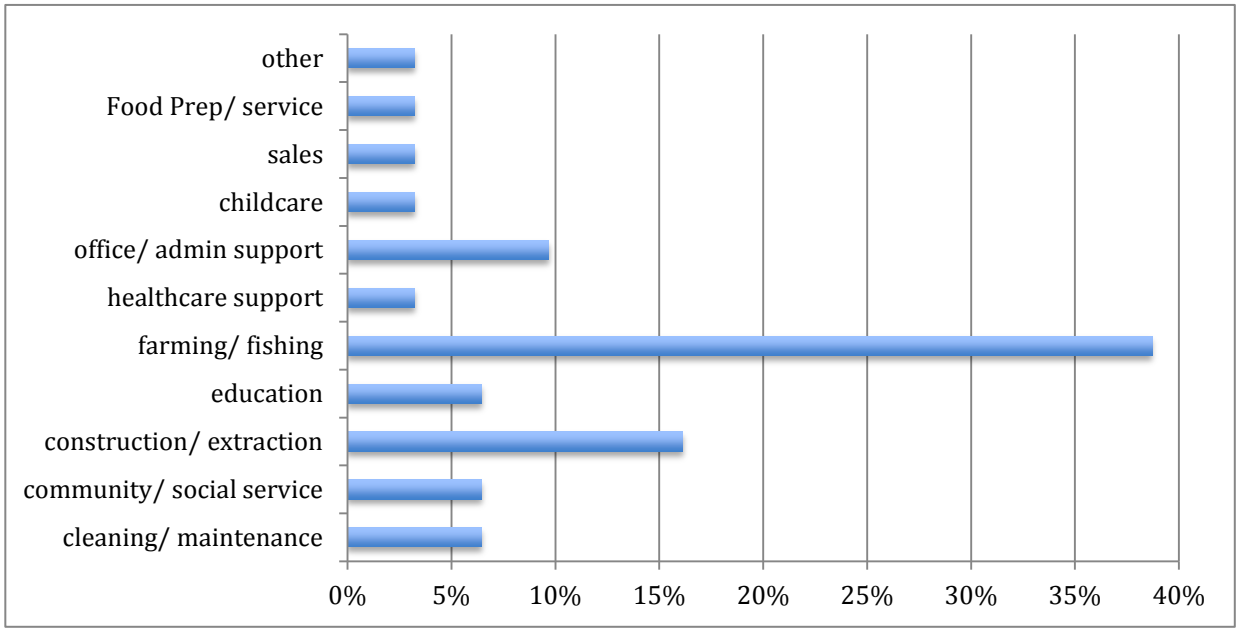
Summary

- Of our respondents, 26% worked full time and 39% worked in agriculture/ fishing industry. In terms of transport 37% drove their own car and 9.3% would get a ride to work.

What is your (and spouses) current employment status?



Where do you work?



How many Hours a week do you work?

- 56% 35-40 Hours
- 41% <35 Hours
- 4% >40 Hours

How do you usually get to work?

- 37% Drive own Car
- 9.3% Get a Ride
- 5.6% (Bus or Other)

How long does it take you to get to work?

- 11.1% Half Hour
- 14.9% < Half Hour

HEALTH CHRONIC DISEASE SURVEY RESULTS

A total of 91 surveys were completed and collected from the Hispanic Services Council in Tampa, FL.

In this section we present the general demographics of the respondents, followed by the results of the chronic disease burden among participants and its relation to obesity. Finally, we present the findings related to health care access, utilization, and the social support and resources that the respondents used to manage their health.

Table 1. Demographics (N=91)	Overall		Chronic Disease		No Chronic Disease	
	N	N%	N	N%	N	N%
Sex						
Male	34	41.0%	26	42.6%	5	33.3%
Female	49	59.0%	35	57.4%	10	66.7%
Age						
18-20	1	1.1%	1	1.5%	0	0%
20-29	5	5.6%	3	4.5%	1	6.3%
30-39	17	19.1%	11	16.7%	5	31.3%
40-49	18	20.2%	12	18.2%	5	31.3%
50-59	18	20.2%	15	22.7%	2	12.5%
60-69	24	27.0%	19	28.8%	3	18.8%
70+	6	6.7%	5	7.6%	0	0%
Hispanic/Latino						
Yes	89	98.9%	65	98.5%	16	100%
No	1	1.1%	1	1.5%	0	0%
Highest Degree or Level of School Completed						
Less than high school	35	39.8%	28	43.8%	2	12.5%
High school graduate or equivalent (GED)	20	22.7%	13	20.3%	5	31.3%
Some College (1-4 years) but no degree	11	12.5%	6	9.4%	5	31.3%
Bachelor's degree (BA, BS, AB, etc.)	15	17.0%	15	23.4%	0	0%
Graduate degree (Master's, Doctoral, or other professional degree)	7	8.0%	2	3.1%	4	25.0%
Annual Household Income						
Less than $10,000	22	25.9%	19	30.2%	1	7.1%
$10,000-$29,000	32	37.6%	23	36.5%	5	35.7%
$30,000-$49,999	17	20.0%	9	14.3%	7	50.0%
$50,000 or more	1	1.2%	1	1.6%	0	0%
I would prefer not to say	13	15.3%	11	17.5%	1	7.1%
Country of Birth						
Mexico	38	46.3%	35	55.6%	0	0%
USA	10	12.2%	8	12.7%	1	8.3%
Other	34	41.5%	20	31.7%	11	91.7%
Number of years living in the US						
Less than 1 year	0	0%	0	0%	0	0%
1-5 years	2	2.3%	2	3.1%	0	0%
6-10 years	15	17.4%	11	16.9%	3	20.0%
11-15 years	6	7.0%	2	3.1%	3	20.0%

15-20 years	11	12.8%	10	15.4%	1	6.7%
20 or more years	52	60.5%	40	61.5%	8	53.3%
Primary household language						
English	13	14.4%	7	10.6%	5	31.3%
Spanish	76	84.4%	58	87.9%	11	68.8%
Other	1	1.1%	1	1.5%	0	0%

Disease burden

Overall, 80.7% of respondents were told by a doctor that they have a chronic disease. Of these, 32.8% reported having one chronic disease, 40.3% had two, 13.4% had three, and 9% had four or more. Table 2 shows that the three major chronic diseases experienced by respondents were diabetes, hypertension, and arthritis-related conditions. The results show that among respondents with a chronic condition, 42.4% reported their health was fair and 10.6% stated that it was poor. Additionally, 60% have lived with their condition for more than five years.

Table 2. Chronic conditions experienced by respondents*	N	Percentage
Hypertension	34	37.4%
Diabetes	41	45.1%
Some form of arthritis, rheumatoid arthritis, gout, lupus, fibromyalgia	10	11%
Depressive disorders (including depression, major depression, dysthymia, or minor depression)	6	6.6%
Heart attack	5	5.5%
Asthma	7	7.7%
Kidney disease (not including kidney stones, bladder infection, or incontinence)	4	4.4%
Angina or coronary artery disease	5	5.5%
Stroke	0	0%
COPD, emphysema, or chronic bronchitis	3	3.3%
Cervical, colon, or breast cancer	2	2.2%
Atrial fibrillation	0	0%
Other type of cancer	4	4.4%

Table 2. Chronic conditions experienced by respondents*	N	Percentage
Hepatitis C	2	2.2%
Liver cirrosis	2	2.2%
HIV	0	0%

**Respondents were asked to select all that apply.*

Relation of chronic disease to body mass index (BMI)

BMI was calculated from the self-reported weight in pounds and height in feet using the standard formula (BMI= (weight in pounds*703)/((height in inches) ^{2}). BMIs were then categorized into underweight, normal, overweight, or obese, according to international standards established by the World Health Organization. Table 3 shows the values for each category and the percentage of respondents who fall into each category.

Table 3. BMI categories	BMI	N	Percentage
Underweight	<18.5	0	0%
Normal	18.5-24.9	12	14.5%
Overweight	25.0-29.9	18	21.7%
Obese	>30.0	53	63.9%

The categories of overweight and obese were selected to illustrate the following weight management issues: About 86% of respondents were either overweight (21.7%) or obese (63.9%), but only 69% had been told by a doctor that they were overweight. Table 4 shows that 47.1% of those who were obese and 64.8% of those who were overweight felt that their health was "excellent," "very good," or "good." Only 33% of respondents who were obese or overweight had discussed their weight with a doctor or other health care professional in the past 12 months. Additionally, about 79% reported trying to lose weight in the past 12 months.

Table 4. Perceived health status by obesity categories	Underweight	Normal	Overweight	Obese	Total
Excellent	0% (0)	8.3% (1)	5.9% (1)	2% (1)	3.8% (3)
Very Good	0% (0)	16.7% (2)	11.8% (2)	13.7% (7)	13.8% (11)

Good	0% (0)	25% (3)	47.1% (8)	31.4% (16)	33.8% (27)
Fair	0% (0)	33.3% (4)	35.3% (6)	41.2% (21)	38.8% (31)
Poor	0% (0)	16.7% (2)	0% (0)	11.8% (6)	10% (8)

Chronic Disease Management

More than three quarters of respondents living with a chronic illness (78%) had no written plan to manage their condition. Of the 22% who did, 50% always or usually follow it, 21.4% are able to follow it about half of the time, and 28.6% rarely follow it. Furthermore, 12% of the respondents with a chronic illness had not had a doctor explain how to manage their illness at their last visit.

Additionally, of those living with a chronic condition, 31% have visited the emergency room in the last 12 months, and 19% had not seen their doctor in the past 12 months for their chronic disease.

In terms of resources and support, 69.2% reported not having someone to talk to about their chronic illness other than their doctor or health care professional. About three out of four people reported having their family or friends encourage them to do the things that are necessary to take care of their chronic illness and 37.5% had talked to others with experience of living with a chronic illness. Resources are presented in Table 5.

Table 5. Resources and Support	Yes		No	
	N	N%	N	N%
Do you have someone other than your doctor or healthcare professional that you can talk to about your chronic illness?	20	30.8%	45	69.2%
Over the past 3 months, has your family or friends encouraged you to do the things you need to do for your chronic illness?	47	75.4%	17	26.6%
Over the past 3 months, have you talked to neighbors or others who have experience living with a chronic illness?	24	37.5%	40	62.5%
Over the past 3 months, have people at your work, church, or	22	36.7%	38	63.3%

other organization to which you belong shown understanding and support for your chronic illness?				
Over the past 3 months, have you attended free or low-cost meetings that supported you in managing your chronic illness?	14	21.5%	51	78.5%
Over the past 3 months, have you used community resources to help manage your chronic illness?	6	9.2%	59	90.8%

About 73% of respondents reported feeling either very confident (35.9%) or somewhat confident (37.5%) in managing their chronic illness.

Table 6. Confidence in managing chronic illness	Very confident	Somewhat confident	Not too confident	Not at all confident
How confident are you that you can control and manage your chronic illness?	35.9% (23)	37.5% (24)	23.4% (15)	3.1% (2)
How confident are you that you can tell your doctor or healthcare professional any concern that you have about your chronic illness even if he/she doesn't ask?	62.3% (38)	19.7% (12)	14.8% (9)	3.3% (2)
How confident are you that your friends and family can support you in managing your chronic illness?	59.4% (38)	20.3% (13)	12.5% (8)	7.8% (5)

Medications

In terms of medication use, 81% of the respondents took medications for their chronic disease. Of those, 84.3% always took them in the way that was prescribed and 7.8% often took them in the way that was prescribed; results are shown in Table 7.

Table 7. How often does respondent take medication as instructed?	N	Percentage
Always	43	84.3%
Often	4	7.8%

About half the time	4	7.8%
Rarely	0	0%
Never	0	0%

Most respondents took generic drugs (41%) or a mix of generic and brand-name (25.5%) (Table 8). Yet in terms of preference, 19.6% opt for generic drugs, 31.4% prefer brand-name, and 49% have no preference (Table 9).

Table 8. Type of medications taken by the respondents	N	Percentage
Generic drugs only	21	41.2%
Brand-name drugs only	2	3.9%
Both generic and brand-name drugs	13	25.5%
Don't know/not sure	15	29.4%

Table 9. Preference of medication to treat illness	N	Percentage
Generic drugs only	10	19.6%
Brand-name drugs only	16	31.4%
No preference	25	49%

About 61% of respondents living with a chronic disease responded that they have not been able to purchase a medication because of costs in the past 12 months.

Table 10. Could not obtain medication because of cost in past 12 months	N	Percentage
Yes	19	37.3
No	31	60.8
Don't know/not sure	1	2.0

Health care access and utilization

Fifty-four percent of all respondents reported having health insurance, while 46% did not. Table 11 shows that those without a chronic condition were more likely to be without insurance (62.5%). The types of health insurance that respondents had are presented in Table 12. About 21% of respondents who currently have insurance

reported that there was a period of time in the past 12 months when they did not have coverage.

Table 11. Percentage of people with chronic disease who had health insurance	Overall		Chronic disease		No chronic disease	
	N	N%	N	N%	N	N%
Insured	45	54.2%	28	61.3%	6	37.5%
Uninsured	38	45.8%	24	38.7%	10	62.5%

Table 12. Type of health insurance	Overall (total sample)		Chronic disease		No chronic disease	
	N	N%	N	N%	N	N%
Through employer	14	33.3%	10	28.6%	3	50%
Purchased directly from an insurance company	2	4.8%	2	5.7%	0	0%
Medicare	13	31%	13	37.1%	0	0%
Medicaid, Medical Assistance, or any kind of government assistance for those with low income or a disability	8	19%	8	22.9%	0	0%
Other	5	11.9%	2	5.7%	3	50%

As shown in Table 13, when selecting a new doctor or health care professional, language compatibility was the most important factor considered by all respondents (75.8%), followed by affordability (50.51%), and availability of appointments (45.1%).

Table 13. Factors respondents consider important when selecting a new doctor or health care provider*	Overall (total sample)		Chronic Disease		No Chronic Disease	
	N	N%	N	N%	N	N%
Speaks the same language as I do	69	75.8%	54	80.6%	9	56.3%

Treats other patients with the same health condition	20	22%	18	26.9%	2	12.5%
Is available when I need an appointment	41	45.1%	33	49.3%	6	37.5%
A friend or family recommended this doctor	10	11%	7	10.4%	3	18.8%
Appointment costs are affordable	46	50.5%	32	47.8%	9	56.3%
Other	2	2.2%	1	1.5%	0	0%

**Respondents were asked to select all that apply.*

Table 14 indicates that the three most-important factors that prevented respondents from seeing a provider were affordability (38.5%), lack of transportation (25.3%), and availability of appointments (22%).

Table 14. Factors that prevented from seeing a personal doctor or health care professional*	Overall (total sample)		Chronic disease		No chronic disease	
	N	N%	N	N%	N	N%
I don't have a doctor or health care professional who speaks the same language	13	14.3%	12	17.9%	0	0%
I can't get an appointment with a doctor when I need it	20	22%	16	23.9%	3	18.8%
Seeing a doctor or health care professional is too expensive	35	38.5%	23	34.3%	8	50%
I don't have transportation to get to my appointments	23	25.3%	17	25.4%	2	12.5%
Other	6	6.6%	3	4.5%	2	12.5%

**Respondents were asked to select all that apply.*

Health information

About 77% of respondents sought health information from different sources at least once every few months, and about 30% sought health information at least once a month. The preferred sources of information are displayed in Table 15. About 74% of respondents preferred to receive health information in Spanish and 32.6% stated that they experienced difficulties finding information in their preferred language.

Table 15. Sources of information about health*	Overall (total sample)		Chronic Disease		No Chronic disease	
	N	N%	N	N%	N	N%
Doctor or health care professional	79	86.8%	60	89.6%	13	81.3%
Friends or family members	6	6.6%	4	6%	2	12.5%
Online or other web-based resources	22	24.2%	17	25.4%	4	25%
Churches	11	12.1%	7	10.4%	3	18.8%
Books or other printed reference materials	11	12.1%	7	10.4%	4	25%
Health fairs	12	13.2%	7	10.4%	2	12.5%
Newsletter or magazines	5	5.5%	4	6%	1	6.3%
Promotores de salud or community health workers	17	18.7%	12	17.9%	3	18.8%
Television	8	8.8%	5	7.5%	2	12.5%
Curanderas or *curanderos*	0	0%	0	0%	0	0%
Radio	3	3.3%	2	3%	1	6.3%
Other	1	1.1%	0	0%	0	0%

**Respondents were asked to select all that apply.*

However, when experiencing signs or symptoms of illness, respondents usually sought information from the sources shown in Table 16.

Table 16. Sources of health information when experiencing signs or symptoms of a health problem*	Overall (total sample)		Chronic disease		No chronic disease	
	N	N%	N	N%	N	N%
Ask a doctor healthcare professional	75	82.4%	60	89.6%	9	56.3%

Ask a pharmacist	13	14.3%	8	11.9%	4	25%
Ask *promotores de salud* or community health workers	7	7.7%	5	7.5%	2	12.5%
Ask *curanderas* or *curanderos*	0	0%	0	0%	0	0%
Ask a friend or family member	12	13.2%	10	14.9%	1	6.3%
Ask someone else with the same condition	4	4.4%	3	4.5%	1	6.3%
Go online or other web-based resources	22	24.2%	13	19.4%	7	43.8%
Get from a community-based organization	7	7.7%	4	6%	1	6.3%
Other	1	1.1%	0	0%	0	0%

**Respondents were asked to select all that apply.*

Selección Sana, Vida Saludable

Hispanic Services Council Findings 2013

Report prepared by:

Gino Galvez, Ph.D. & Britt Rios-Ellis, Ph.D.

NCLR / CSULB Center for Latino Community Health, Evaluation and Leadership Training

January 8, 2014

Executive Summary

Selección Sana, Vida Saludable is a *promotores de salud*-led program developed by National Council of La Raza's (NCLR) Institute of Hispanic Health (IHH) to target underserved Latinos at risk for obesity. The program uses a culturally and linguistically educational intervention designed to increase knowledge about healthier foods and physical activity, improve attitudes, and increase behavioral intentions to live healthier lives in terms of nutrition and physical activity. To evaluate the goals of the program, the NCLR/CSULB Center for Latino Community Health, Evaluation and Leadership Training developed survey questions to assess demographic information, knowledge of nutrition and physical activity recommendations, and self-efficacy to improve nutrition and physical activity-related health behaviors. The purpose of this report is to describe Tampa, FL findings from *promotores de salud* and community participants.

A total of 11 *promotores de salud* were recruited for this study (91% female, 9% male, average age of 51 years) and most were from Mexico (45%) and the U.S. (27%). Among the community members, a total of 100 adults of Hispanic/Latino origin (79% female, 21% male, average age of 33) participated in the study. Most were born in Mexico (73%) and Guatemala (12%). All participants completed surveys prior to and following their participation. Relevant findings were:

- Participants reported significantly higher knowledge levels regarding nutrition, healthy habits, and physical activity after participation in the *charla.*
- Participants' self-efficacy in terms of helping their family eat healthier and engage in physical activity significantly increased following participation in the *charla*:
    - 98% strongly agreed or agreed with the statement *I think I can convince my family to drink fewer sugar sweetened beverages every day.*
    - 97% strongly agreed or agreed with the statement *I think I can help my family find physical activities in the community.*
- Participants reported a high level of agreement with intention to help their family eat healthier and engage in physical activity following their participation in the *charla.*
- *Promotores de salud* gained a lot from the trainers and rated the training very highly:
    - 82% reported "extremely useful" and 18% reported "very useful" in the training being useful in helping them lead their own educational sessions.
- *Promotores de salud* reported significantly higher knowledge levels regarding nutrition, healthy habits, and physical activity after participation in the training.

Introduction

Hispanics/Latinos receive less preventive care than non-Hispanics/Latinos and are less likely to be reached by mainstream health education, promotion, and disease prevention efforts. Diabetes and overweight are two important health issues that are negatively impacting Latino communities across the United States. To address this growing health disparity, the *Selección Sana, Vida Saludable* project was developed by the NCLR's IHH with support from ConAgra Foods Foundation.

NCLR is the largest national Hispanic civil rights and advocacy organization in the U.S. and works to improve opportunities for Latinos/Hispanic Americans. Through its network of nearly 300 affiliated community-based organizations, NCLR reaches millions of Hispanics each year in 41 states, Puerto Rico, and the District of Columbia. NCLR's IHH is committed to promoting the health and well-being of Hispanics/Latinos by reducing the incidence, burden, and impact of health problems such as obesity and overweight with projects such as *Selección Sana, Vida Saludable*. In particular, the *Selección Sana, Vida Saludable* project expands on NCLR current health and wellness efforts by developing, implementing, and evaluating a culturally and linguistically appropriate evidence-based initiative to reduce obesity risk factors among underserved Latinos in targeted areas in the U.S.

To evaluate the goals of the *Selección Sana, Vida Saludable* project, the NCLR/California State University Long Beach (CSULB) Center for Latino Community Health, Evaluation and Leadership Training (hereafter the Center) was consulted by NCLR to develop survey questions for community member participants and *promotores de salud* (community health workers). The Center worked with NCLR to develop a set of measures that assessed demographics, nutrition knowledge, lifestyle options, and physical activity recommendations. The project was approved by the CSULB Internal Review Board for the involvement of human participants in research. The purpose of this report is to describe data collected from *promotores de salud* and community member participants. Data will be presented to address characteristics and training utility of the *promotores de salud* and changes in the following parameters among community participants following *charla* participation:

- Level of knowledge related to nutrition and physical activity recommendations
- Self-efficacy in terms of behavior change to improve nutrition and level of physical activity
- Intention to improve nutrition and physical activity-related behaviors among participants

Methodology

Recruitment. The *Selección Sana, Vida Saludable* project involved the recruitment and training of *promotores de salud* and the recruitment of community members to participate in an educational session. The aims of the *Selección Sana, Vida Saludable* educational session were three-fold: 1) Increase knowledge regarding how to identify and gather information regarding existing community resources to improve nutrition and physical activity-related behaviors; 2) Learn how to overcome barriers to a healthy lifestyle; and 3) Learn how to participate in community affairs. Across nine sites, community members were recruited by the project coordinators during regular business hours at each site and through existing programs. To assess eligibility and share information about the project, coordinators utilized a screener guide. Community members who expressed interest in the intervention and met eligibility requirements were consented by the project coordinator at each respective site. Community members were given a copy of the consent form which contained information about the study and contact information of the principal investigators at NCLR and the Center. *Promotores de salud* (community health workers) were recruited in the same manner. This study was reviewed and approved by the California State University, Long Beach Internal Review Board.

Survey. Brief paper-and-pencil surveys (i.e., demographic survey, a pre-intervention survey, a post-intervention survey) were developed for p*romotores de salud* and community member participants by the evaluation team in consultation with NCLR and *promotores de salud*. Surveys for *promotores de salud* were administered by NCLR training staff (i.e., train-the-trainer model). Surveys for community member participants were administered by *promotores de salud* at two time points: prior to and following the *charla* (educational session). The surveys were designed to assess changes in knowledge and behaviors regarding lifestyle, nutrition and physical activity following the *Selección Sana, Vida Saludable* educational session for both the *promotores de salud* and community member participants. All survey data were processed and entered into SPSS databases for analysis by the evaluators. The survey questions that were collected at each time point are presented in Appendix A and B.

Statistics. Percentages were calculated to show overall responses to the questions. Where applicable, measures of central tendency, such as the mean and mode, were produced as well as a standard deviation statistic (i.e., SD). Questions on the surveys that asked about specific knowledge were scored "1" if they were correct and "0" if they were incorrect. This enabled us to create composite scores that reflected the number of correct responses for the knowledge items. Furthermore, to examine differences between scores, paired-sample t-tests were conducted. In addition, some questions on the surveys were scaled (e.g., strongly disagree = 1,

disagree = 2, undecided = 3, agree = 4, strongly agree = 5). For these scales, lower scores indicated levels of disagreement and higher scores indicated levels of agreement.

Results

Demographic characteristics – *Promotores de Salud*

Surveys were collected from the Hispanic Services Council site in Tampa, Florida. Demographic information was obtained from 11 adults of Hispanic/Latino origin. The sample consisted of 10 females and 1 male with a mean age of 50.8 (*SD* = 11.3, range 34 - 67). Participants were asked to provide information about their countries of origin. About half reported being born in Mexico (5), about one-quarter reported the U.S. (3), and others reported Colombia (1), Guatemala (1), and Puerto Rico(1).

Promotores de salud were asked to report information regarding their relationship status. Results indicated that most were married (8), some were divorced (2), and fewer were separated (1). On average, participants reported 3.8 (*SD* = 1.9) children per household. In terms of education, *promotores de salud* reported the following categories: elementary school (1); technical school/vocational (2); some college (4); Master's degree (1); and GED (1).

Acculturation. To assess acculturation levels of the *promotores de salud*, five questions from the Short Acculturation Scale for Hispanics (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987) were included. This scale focuses on language preference (English or Spanish) with participants selecting the following responses: Only Spanish (1); Spanish better than English (2); Both equally (3); English better than Spanish (4) and; Only English (5). A composite score was produced to interpret levels of acculturation (i.e., low or high). The mean acculturation score for this sample was 1.9 (*SD* = 0.7), indicating an average response between "Only Spanish" and "Spanish better than English". This finding suggests that on average participants tended to report low levels of acculturation. Please see Table 1 for responses to all acculturation questions.

Table 1.

Frequency of responses for acculturation questions (*N = 11*)

	Only Spanish	Spanish better than English	Both equally	English better than Spanish	Only English
In general, what language(s) do you read and speak?	2	5	4	0	0
In general, what language(s) did you use as child?	8	2	1	0	0
In general, what language(s) do you usually speak at home?	3	5	3	0	0
In general, which language(s) do you usually think in?	5	4	1	1	0
In general, which language(s) do you usually speak with your friends?	3	3	5	0	0

Access to Medical Care. Results demonstrate that 10 out 11 *promotores de salud* reported having regular access to doctor visits. Eight indicated possessing medical insurance and only 1 indicated receiving Medicaid. Seven out ten reported that their children had access to regular doctor visits. Six reported that their children had medical insurance and only 1 reported that their children received Medicaid.

Nutrition and Physical Activity Classes. Prior experience or participation in nutrition-focused or physical activity classes was assessed among the *promotores de salud*. Two out of ten indicated that they had taken part in a prior nutrition class. In regards to physical activity, four out of ten *promotores de salud* had participated in a physical activity class.

Awareness of Government-funded Programs. *Promotores de salud* were asked to indicate if they were aware of the following government-funded programs: 1) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); 2) Supplemental Nutrition Assistance Program (SNAP); 3) Children's Health Insurance Program (CHIP); and 4) The Affordable Care Act (ACA). Most *promotores de salud* reported being aware of WIC (8), SNAP (7), CHIP (3), and ACA (3). Knowledge of government programs is displayed in Table 2.

Table 2.

Awareness of Government-funded Programs (*N* = 10).

	Yes	%
Special Supplemental Nutrition Program for Women, Infants, and Children	8	72.7
Supplemental Nutrition Assistance Program	7	63.6
Children's Health Insurance Program	3	27.3
The Affordable Care Act	3	27.3

Note. Missing data n = 3.

Training Utility. The *promotores de salud* received training to implement the *Selección Sana, Vida Saludable* project. Pre and post assessments of training were completed by all *promotores de salud.* When asked if the training helped them to better understand the barriers to healthier eating and physical activity in the Latino community, 10 reported "very much" and 1 reported "a lot." Additionally, the *promotores de salud* rated their trainers and reported very positive results. About half rated either "extremely prepared" (6) or "very prepared" (5). The training length of time was assessed as well. Five *promotores de salud* reported that the training time was ideal, five reported that it was "a little too long" and one reported that it was "a little too short." Regarding the training being useful in helping them lead their own *charlas*, 9 reported "extremely useful" and 2 reported "very useful."

Educational Materials. The flipchart was rated very highly as well among the 10 *promotores de salud* that answered this question (missing 1 response). All 10 rated the flipchart "extremely helpful." *Promotores de salud* were asked if the educational material were appropriate for use with Latino communities. Specifically, when asked whether the educational materials were designed for the Latino community, 9 reported "yes" and 2 reported "more or less." Lastly, when asked whether the educational content was appropriate for them to carry out their role as community educators, all 11 reported "yes."

Knowledge of Nutrition, Healthy Lifestyle Options, and Physical Activity Recommendations

Nine questions that assessed knowledge of nutrition (e.g., low fat nutrition label), health habits (e.g., increasing intake of vitamins and fiber), and physical activity (e.g., minimum amount of physical activity for adults) were included in the surveys. A score was calculated for every *promotores de salud* based on whether each question was correct (i.e., one point for every correct response). Scores for pre- and post-training were calculated.

A paired sample *t*-test was conducted to determine if there were differences in knowledge scores between pre- and post-training. *Promotores de salud* reported significantly higher knowledge levels regarding nutrition, healthy habits, and physical activity after participation in the training, $t(10) = 4.500$, $p < .001$. Means for all scores are presented in Table 3.

Table 3

Means for Knowledge Score of nutrition, healthy habits, and physical activity questions (*N* = 11)

	Pre Mean (*SD*)	Post Mean (*SD*)
Knowledge score of nutrition, healthy habits, and physical activity questions	6.0 (1.9)	7.6 (2.1)

Note. Scores for each item were summed. Scores ranged from 0-9.

Self-efficacy – Healthier Lifestyle Choices for Self and Family

Promotores de salud reported on their self-efficacy in terms of helping their families eat healthier and engage in physical activity. Self-efficacy was assessed by six statements (e.g., I think I can convince my family to drink fewer sugar sweetened beverages every day). Participants were asked to select their level of agreement with each statement. Table 4 displays responses for each of the items at pre- and post-training.

Table 4

Frequency of Family Self-efficacy Questions for Pre and Post

I think I can help my family increase the number of days of physical activity	**Pre**	**Post**
Strongly Disagree	0	0
Disagree	0	0
Neither Agree nor Disagree	1	0
Agree	5	4
Strongly Agree	5	7
I think I can convince my family to drink fewer sugar sweetened beverages every day	**Pre**	**Post**
Strongly Disagree	0	0
Disagree	0	0
Neither Agree nor Disagree	0	0
Agree	5	4
Strongly Agree	6	7
I think I can convince my family to eat at least one more serving of vegetables every day	**Pre**	**Post**
Strongly Disagree	0	0
Disagree	0	0

Neither Agree nor Disagree	0	0
Agree	5	4
Strongly Agree	6	7
I think that I can use food labels to reduce my family's sugar intake	**Pre**	**Post**
Strongly Disagree	0	0
Disagree	0	0
Neither Agree nor Disagree	2	0
Agree	2	3
Strongly Agree	7	8
I think I can help my family find physical activities in the community	**Pre**	**Post**
Strongly Disagree	0	0
Disagree	0	0
Neither Agree nor Disagree	0	0
Agree	7	5
Strongly Agree	4	6
I think I can use food labels to serve correct portion sizes to my family	**Pre**	**Post**
Strongly Disagree	0	0
Disagree	0	0
Neither Agree nor Disagree	2	0
Agree	3	4
Strongly Agree	6	7

Demographic characteristics – Community Members

Demographic information was obtained from 100 adults of Hispanic/Latino origin. The sample consisted of 79 females (79.0%) and 21 males (21.0%) with a mean age of 33.1 (*SD* = 11.5). Participants were asked to provide information about their countries of origin. Of those that responded (*N* = 99), most people reported being born in Mexico (72.7%), Guatemala (12.1%), U.S. (10.1%), and other countries (5.1%). Figure 1 displays countries reported by the participants.

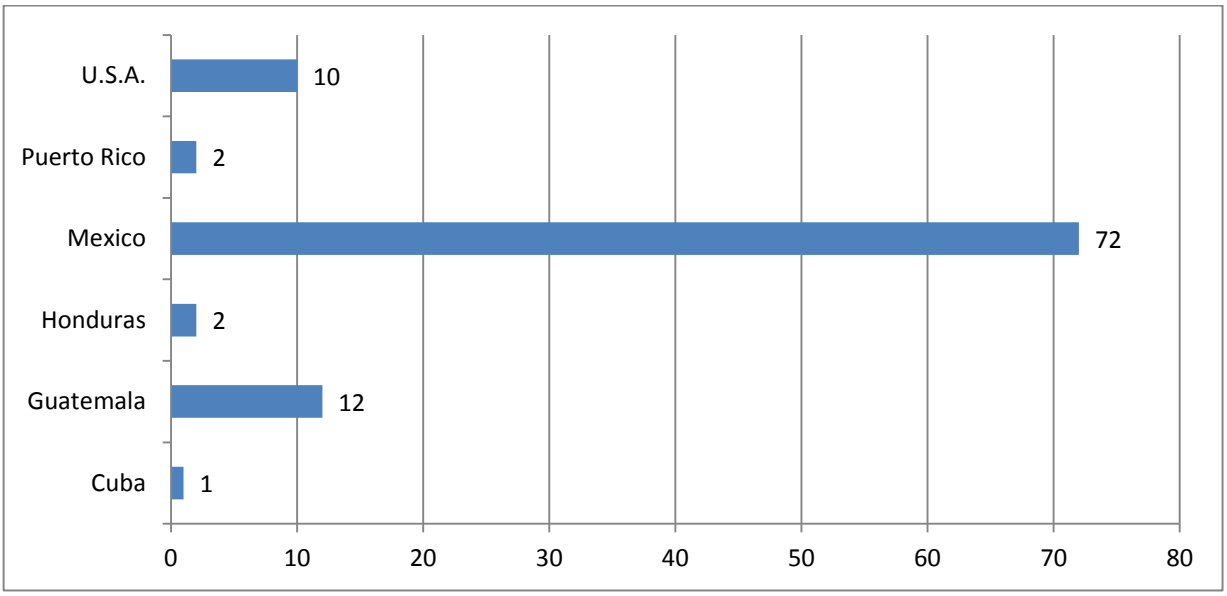


Figure 1. *Participants' country of origin (N* = 99)

Participants were asked to report information regarding their relationship status. Results indicated that 40.0% were married, 1.0% were divorced, 2.0% were widowed, 7.0% were separated, 28.0% were living with a partner, and 22.0% were single. On average, participants reported 2.6 (SD = 1.5, range 0 - 7) children per household. Foreign-born participants had lived in the U.S. for an average of 11.4 (*SD* = 8.8) years. To assess participant educational status, we queried the highest grade of school completed. Over two-thirds (77.0%) reported having below a high school education. Educational status of all the participants is presented in Figure 2.

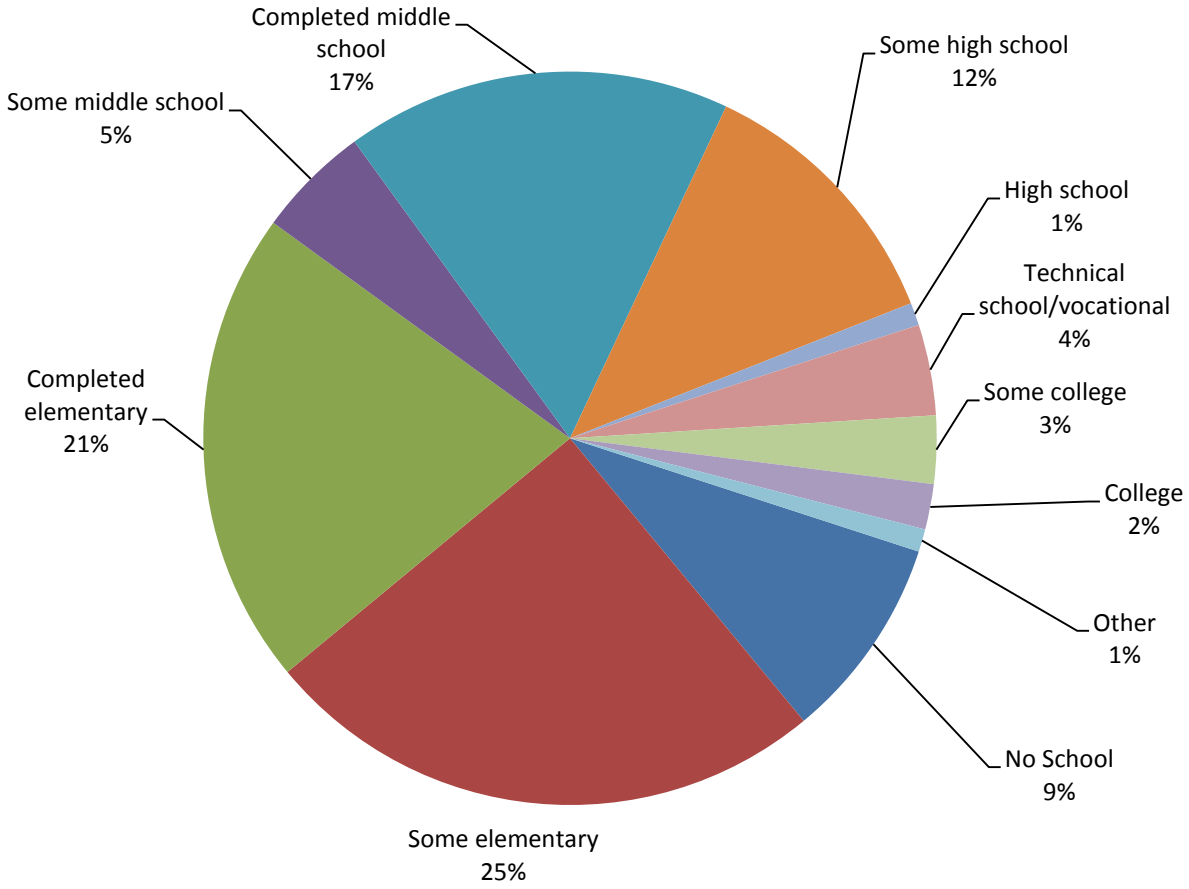


Figure 2. *Educational status of participants* (*N* = 100)

Acculturation. To assess acculturation levels, one question from the Short Acculturation Scale for Hispanics (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987) was included. Participants were asked what language they read and spoke in with the following responses: Only Spanish (1); Spanish better than English (2); Both equally (3); English better than Spanish (4) and; Only English (5). The mean score for this question was 1.5 (Mode = 1.0, SD = 0.8, range 1 - 4), indicating an average response between "Only Spanish" and "Spanish better than English". This finding suggests that on average participants tended to report low levels of acculturation.

Access to Medical Care. Results demonstrate that 66.3% of the participants reported having regular doctor visits. However, few participants indicated possessing medical insurance (13.4%) For those participants that reported having children, 85.7% stated that their children had access to regular doctor visits. Similarly, the majority of these participants (66.7%) reported that their children had medical insurance.

Nutrition and Physical Activity Classes. Prior experience or participation in nutrition-focused or physical activity classes was assessed. Most participants (76.0%) indicated that they had not

taken part in a prior nutrition class. Of those reporting having participated in a nutrition class (*N* = 24), only two reported the number of classes attended which averaged 4.5 classes. In regards to physical activity classes, 80.6% had not participated in a physical activity class prior to their participation in the project. Of the 19 that had participated in a physical activity class, only 2 reported the number of classes which averaged 2.5 classes.

Awareness of Government-funded Programs. Participants were asked to indicate if they were aware of the following government-funded programs: 1) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); 2) Supplemental Nutrition Assistance Program (SNAP); 3) Children's Health Insurance Program (CHIP); and 4) The Affordable Care Act (ACA). The majority of participants reported being aware of WIC (67.7%), 36.4% reported being aware of SNAP, 6.1% indicated being aware of CHIP, and 11.3% reported being aware of the ACA. Knowledge of government programs is displayed in Table 5.

Table 5.

Awareness of Government-funded Programs (*N* = 1587).

	Yes	%
Special Supplemental Nutrition Program for Women, Infants, and Children	67	67.7
Supplemental Nutrition Assistance Program	36	36.4
Children's Health Insurance Program	6	6.1
The Affordable Care Act	11	11.3

Knowledge of Nutrition, Healthy Lifestyle Options, and Physical Activity Recommendations

Nine questions that assessed knowledge of nutrition (e.g., low fat nutrition label), health habits (e.g., increasing intake of vitamins and fiber), and physical activity (e.g., minimum amount of physical activity for adults) were included in the surveys. A score was calculated for every participant based on whether each question was correct (i.e., one point for every correct response). Scores for pre- and post-training were calculated and could range from 0 to 9.

A paired sample *t*-test was conducted to determine if there were differences in knowledge scores between pre- and post-*charla*. Participants reported significantly higher knowledge levels regarding nutrition, healthy habits, and physical activity after participation in the *charla*, $t(99) = 6.906$, $p < .001$, $r = 0.57$ indicating a strong effect size. Means for all scores are presented in Table 6.

Table 6

Means for Knowledge Score of nutrition, healthy habits, and physical activity items (*N* = 100)

	Pre	Post

	Mean (*SD*)	Mean (*SD*)
Knowledge score of nutrition, healthy habits, and physical activity questions	3.83 (2.0)	5.3 (2.3)

Note. Scores ranged from 0-9

Follow-up analyses. To assess any overall differences between the means between pre, post, and follow-up, a repeated measures ANOVA was conducted. Among the sample that had data on each time point (N = 50), the pre-knowledge score mean was 4.2 (SD = 2.1), the post-knowledge score mean was 5.6 (SD = 2.4), and the follow-up knowledge score mean was 7.1 (SD = 2.3). The results indicate that means for knowledge scores significantly increased over time and increased at follow-up indicating that the *charla* experience had potentially resulted in heightened awareness regarding nutrition, health and fitness issues, $F(2, 98) = 31.326$, $p < .001$.

Self-efficacy – Healthier Lifestyle Choices for Self and Family

Participants' self-efficacy in terms of helping their families eat healthier and engage in physical activity were assessed by five statements (e.g., I think I can convince my family to drink fewer sugar sweetened beverages every day). Participants were asked to select their level of agreement with each statement. Table 7 displays responses for each of the six statements.

Table 7

Family Self-efficacy Questions for Pre, Post and Follow-up

I think I can help my family increase the number of days of physical activity	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	3.2	0	0
Disagree	0	0	0
Neither Agree nor Disagree	5.3	3.1	2.1
Agree	36.2	38.1	40.4
Strongly Agree	55.3	58.8	57.4
I think I can convince my family to drink fewer sugar sweetened beverages every day	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	0	0	0
Neither Agree nor Disagree	4.2	2.1	4.3
Agree	46.3	35.1	25.5
Strongly Agree	49.5	62.9	70.2
I think I can convince my family to eat at least one more serving of vegetables every day	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	1.1	0	0
Disagree	0	0	0
Neither Agree nor Disagree	5.3	2.1	4.2

Agree	36.8	33.3	33.3
Strongly Agree	56.8	64.6	62.5
I think that I can use food labels to reduce my family's sugar intake	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	1.1	0	0
Disagree	0	0	0
Neither Agree nor Disagree	3.2	4.2	4.2
Agree	44.1	33.3	25.0
Strongly Agree	51.6	62.5	70.8
I think I can help my family find physical activities in the community	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	2.1	1.0	0
Neither Agree nor Disagree	5.3	2.1	10.4
Agree	50.5	39.2	39.6
Strongly Agree	42.1	57.7	50.0
I think I can use food labels to serve correct portion sizes to my family	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	0	0	0
Neither Agree nor Disagree	5.4	2.1	4.2
Agree	44.1	36.1	27.1
Strongly Agree	50.5	61.9	68.8

Note. Pre n = 93-95; Post n = 96-97; Follow-up n = 47-48

A series of paired sample *t*-tests were conducted to examine difference between pre- and post-*charla* responses. Findings indicate significant increases in agreement for all statements following participation in the *charla.* Table 8 displays means and *t*-test results.

Table 8.

Pre and Post-Charla Family Intention Questions (*N* = 100)

	Pre Means (SD)	Post Means (SD)	*t*-test
I think I can help my family increase the number of days of physical activity	4.39 (0.9)	4.56 (0.6)	1.913^{NS}
I think I can convince my family to drink fewer sugar sweetened beverages every day	4.45 (0.6)	4.62 (0.5)	2.608*
I think I can convince my family to eat at least one more serving of vegetables every day	4.49 (0.7)	4.64 (0.5)	2.012*
I think that I can use food labels to reduce my family's sugar intake	4.44 (0.7)	4.61 (0.5)	2.187*

I think I can help my family find physical activities in the community	4.32 (0.7)	4.55 (0.6)	2.946**
I think I can use food labels to serve correct portion sizes to my family	4.44 (0.6)	4.60 (0.5)	2.468*

Note. * $p < .05$ ** $p < .01$. Strongly disagree = 1, disagree = 2, undecided = 3, agree = 4, strongly agree = 5.

Intention to Change Behaviors – Healthier Lifestyle Choices for Self and Family

We assessed participants' intention to help their families eat healthier and engage in physical activity with six statements (e.g., I will try to use the MyPlate guidelines to serve correct portions to my family) at pre- and post-*charla*, and follow-up. Participants were asked to select their level of agreement with each statement. Table 9 displays responses for each of the six items.

Table 9

Family Intention Questions for Pre, Post and Follow-up

I will try to use serving size information from food labels to decide how much to cook	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	2.0	0	0
Neither Agree nor Disagree	4.1	1.0	4.3
Agree	52.0	43.3	34.0
Strongly Agree	41.8	55.7	61.7
I will try to spend more time doing physical activity with my family	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	0	0	0
Neither Agree nor Disagree	5.1	3.1	6.4
Agree	52.5	36.1	31.9
Strongly Agree	42.4	60.8	61.7
I will try to convince my family to spend less time sitting	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	0	1.0	0
Neither Agree nor Disagree	2.0	1.0	2.1
Agree	52.0	38.1	27.7
Strongly Agree	45.9	59.8	70.2
I will try to use the MyPlate guidelines to serve correct portions to my family	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	0	0	2.1

Neither Agree nor Disagree	1.0	1.0	4.3
Agree	50.5	41.2	25.5
Strongly Agree	48.5	57.7	68.1
I will try to serve portion sizes that will keep my family healthy	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	0	0	0
Neither Agree nor Disagree	1.0	1.0	4.3
Agree	45.9	40.2	27.7
Strongly Agree	53.1	58.8	68.1
I will try to convince my family to eat at least one more serving of fruit every day	**Pre (%)**	**Post (%)**	**Follow-up (%)**
Strongly Disagree	0	0	0
Disagree	0	0	0
Neither Agree nor Disagree	1.0	1.0	6.4
Agree	41.4	34.0	19.1
Strongly Agree	57.6	64.9	74.5

Note. Pre n = 97-99; Post n = 97; Follow-up n = 47

A series of paired sample *t*-tests were conducted to examine differences between pre- and post-*charla* responses. Findings indicate significant increases in agreement for all statements following participation in the *charla.* Table 6 displays means and *t*-test results.

Table 6.

Pre and Post-Charla Family Intention Questions

	Pre Means (SD)	Post Means (SD)	*t*-test
I will try to use serving size information from food labels to decide how much to cook	4.32 (0.7)	4.55 (0.5)	3.564***
I will try to spend more time doing physical activity with my family	4.36 (0.6)	4.57 (0.6)	3.643***
I will try to convince my family to spend less time sitting	4.44 (0.5)	4.56 (0.6)	2.319*
I will try to use the MyPlate guidelines to serve correct portions to my family	4.46 (0.5)	4.56 (0.5)	1.916 NS
I will try to serve portion sizes that will keep my family healthy	4.51 (0.5)	4.58 (0.5)	1.715 NS
I will try to convince my family to eat at least one more serving of fruit every day	4.55 (0.5)	4.6 (0.5)	1.994*

Note. * $p < .05$, *** $p < .001$. Strongly disagree = 1, disagree = 2, undecided = 3, agree = 4, strongly agree = 5

Discussion

The overall results of the *Selección Sana, Vida Saludable* project indicate that the intervention was effective. Broadly, both *promotores de salud* and community member participants reported statistically significant positive changes as a result of participating in the program. Specifically, knowledge of nutrition (e.g., low fat nutrition label), health habits (e.g., increasing intake of vitamins and fiber), and physical activity (e.g., minimum amount of physical activity for adults) were assessed across two time points (i.e., pre- and post-*charla*). Statistically significant mean differences were found between pre- and post-*charla* in which knowledge scores improved following participation in the *charla.* The statistically significant findings were also moderate to strong in terms of effect size indicating that the differences between pre- and post were robust and the program was effective.

Furthermore, we assessed self-efficacy to change and implement healthier practices with family among both *promotores de salud* and community member participants. This area has implications for meaningful behavioral change (e.g., engaging in physical activity, healthier lifestyle for family) and the questions were grounded in concepts derived from the theory of planned behavior (Ajzen, 1991) and self-efficacy theory (Bandura, 1982). We developed a set of statements that aimed to assess self-efficacy and intention (at post only for community members) of the participants in their ability to make healthier choices for themselves and their families (e.g., I think I can help my family find physical activities in the community, I will try to use the MyPlate guidelines to serve correct portions to my family). The results indicated significant increases in agreement for all statements following their participation in the *charla.* Again, these findings are encouraging given that many *promotores de salud* and participants at baseline agreed or strongly agreed with these statements. Statistical tests of effect size were conducted and results indicated that the effect sizes were moderate to large (i.e., strength of the changes between pre and post-*charla*).

Among the *promotores de salud*, the overall the evaluation findings indicate that they gained a lot of useful information from the trainers and rated the training very highly. The overall findings regarding the *charlas* support the effectiveness of NCLR and the community-based organizations in developing and implementing a culturally and linguistically appropriate evidence-based program to reduce obesity risk factors among underserved Latino communities.

Implications. The *Selección Sana, Vida Saludable* project has important public health implications and serves as a model to address health disparities inherent in the growing rate of diabetes among Latinos in the U.S. Interventions that address obesity among Latinos will not only need to address the biological causes of obesity, but will need to address the cultural and contextual implications that influence poor eating and physical activity behaviors. Results of this evaluation indicate that utilizing *promotores de salud* to implement an intervention project

in underserved Latino communities is an effective and culturally-appropriate method to address and curtail the obesity epidemic for Latinos in the U.S.

Limitations. Limitations of this study include the recruitment of participants that reported having engaged in a prior nutrition class (24.0%). These individuals likely had prior knowledge of nutrition and were aware of the importance of physical activity. This limitation was reflected in the generally high degree of agreement with statements regarding self-efficacy at baseline. However, given that the majority of the sample did not possess prior knowledge of nutrition and physical activity, significant differences were still observed between pre- and post-*charla* measurements indicating that the program was highly effective.

References

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50,* 2, 179–211.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37*, 2, 122-147.

Marin, G., Sabogal, F., Marin, B. V., Otero-Sabogal, R., & Perez-Stable, E. J. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences*, *9,* 2, 183-205.

FOCUS GROUP: MALE MIGRANT WORKERS

Date and Location: May 14, 2014 6pm-7:30pm at Bethune Park
Facilitator: Elizabeth Gutierrez, HSC staff
Note taker: Elizabeth Ruiz, USF student
Total Number Participants: 10

Employment

- How long are you typically employed in a year with a farm?
- What months and how many hours per day/ days per week?
- When you are not employed by the farms, what type of work do you typically do/ find?
- Does your job offer retirement benefits/ life insurance? Why or why not?
- Are Vacations provided? Duration?
- How are your hours worked tracked? Are all hours compensated?

Working Conditions

- How would you describe the conditions at the farm? Probes: sun exposure- lack of shades, breaks for water/ snacks/ restroom, Bathroom facilities (cleanliness, location from fields)
- How can family contact you in case of ER situation? Are you allowed to take personal calls while on the job/ during breaks?
- Pesticide use: are there warning signs of its use?
- Transportation to farm/ various farms (how much do they charge, how far is commute, how often do they pick up workers for different farms)
- Perceptions on the crew leaders (individuals assigned to pick up workers from camps/ diff stops)
- If you have a complaint about any of the conditions above or that we haven't mentioned, who can you talk to? Have you heard of anyone who has been reprimanded/ lost their job for speaking out? Labor unions(have they heard of it/ are part of it/ not allowed)

Health Conditions

- Do the farms provide adequate health coverage in case of an accident?
- What health conditions/ treatments have you undergone as a direct result of working in the farms?
- Sick days/ medical leave: employer permission needed?

Living/ Transportation Conditions

- Living conditions in the agricultural camp
    - Probes: who gets to live there, what are the conditions, how much does it cost, how are sleeping arrangements made (by sex, by family), do you feel safe being in the agricultural camps in the day or night?

FOCUS GROUP: FEMALE MIGRANT WORKERS

Date and Location: May 14, 2014 6pm-7:30pm at Bethune Park
Facilitator: Ercilia Calcano, USF staff
Notetaker: Sara Arias-Steele, HSC Staff
Total Number Participants: 10

Employment

- How long are you typically employed in a year with a farm? What months and how many hours per day/ days per week?
- When you are not employed by the farms, what type of work do you typically do/ find?
- Does your job offer retirement benefits/ life insurance? Why or why not?
- Are Vacations provided? Duration?
- How are your hours worked tracked? Are all hours compensated?

Working Conditions

- How would you describe the conditions at the farm? Probes: sun exposure- lack of shades, breaks for water/ snacks/ restroom, Bathroom facilities (cleanliness, location from fields)
- How can family contact you in case of ER situation? Are you allowed to take personal calls while on the job/ during breaks?
- Pesticide use: are there warning signs of its use?
- Transportation to farm/ various farms (how much do they charge, how far is commute, how often do they pick up workers for different farms)
- Perceptions on the crew leaders (individuals assigned to pick up workers from camps/ diff stops)
- If you have a complaint about any of the conditions above or that we haven't mentioned, who can you talk to? Have you heard of anyone who has been reprimanded/ lost their job for speaking out? Labor unions(have they heard of it/ are part of it/ not allowed)

Health Conditions

- Do the farms provide adequate health coverage in case of an accident?
- What health conditions/ treatments have you undergone as a direct result of working in the farms?
- Sick days/ medical leave: employer permission needed?

Living/ Transportation Conditions

- Living conditions in the agricultural camp
    - Probes: who gets to live there, what are the conditions, how much does it cost, how are sleeping arrangements made (by sex, by family), do you feel safe being in the agricultural camps in the day or night?

Female Migrant Worker Experience

- Female bathroom facilities: Cleanliness, locations from fields, is it secure?
- Pregnancy/ sick children: are you allowed to take it easy from heavy lifting/ bending at work if pregnant/ are you allowed medical leave allowances for labor or take sick children to doctor?
- Lifting heavy objects: do you receive help, especially if you are pregnant or much older?
- Is there equal pay in terms of gender at the farms?
- Childcare: what is your awareness of it? Do you use it? What are your perceptions of it in Wimauma?
- Agricultural camps: are they separated by sex or family unit? How secure/ safe do you feel in them in the day/ night? Do the doors lock at night?
- Have you observed cases of harassments among coworkers/ employers?

FOCUS GROUP: PARENTS OF CHILDREN ATTENDING WIMAUMA SCHOOLS/CHILDCARE

Date and Location: May 22, 2014 6pm-7:30pm at Wimauma First Baptist Church
Facilitator: Diego Mendoza, HSC staff
Notetaker: Sara Arias-Steele, HSC staff
Total Number Participants: 14

Education

- What is your perception on the quality of education provided to your child by the schools in he region?
- What opportunities for involvement does the school have for parents to discuss their child's progress/ difficulties?
- Does the school provide accessible tutors/ afterschool programs for children to better understand the subject matter?
- Does the school over special education classes for children of disabilities?If you have a child with learning disabilities, what are your perceptions of the quality of education being provided by the school?

Childcare

- For parents of younger children, what types of childcare services do you use (formal or informal)?What is the typical cost for childcare? Do you use a childcare service targeted specifically to a certain group?
- What are your thoughts on the quality of care of some of these facilities?
- We will be having a focus group with the educators/ teachers in Wimauma. What key issues would you like us to present to them from you?

Focus Group: Youths in Wimauma

Date and Location: June 3, 2014 6pm-7:30pm at Bethune Park
Facilitator: Amparo Nunez, HSC staff
Notetaker: Sara Arias-Steele, HSC staff
Total Number Participants: 10

Recreation Activities

- What kind of activities are there available to youth when they are not in the school, such as after school, summer and winter breaks, etc. (Prompts: parks, educational programs, after school activities, church groups, sports teams, etc.)?
- Are there any specific places in Wimauma that you typically hang out with your friends (what do you do in your leisure time)?
- What prevents you from participating? (Prompts: transportation, cost, peer pressure, lack of interest, have to work, have to take care of siblings etc.)
- What activities would you like to see/ would participate in if it was available in Wimauma?

Perception on School System

- What can you tell us about the environment in your schools where you attend? (Receive tutoring, extra help, adequate counseling, college preparation).
- How do you see the teacher's perception of Hispanic youths (in treatment, in teaching, in helping ect) in comparison with the other children?

Neighborhood Violence Perception

- How safe do you feel in your school or walking to and from school? (School security officers, at bus stops)
- Have you witnessed cases of peer pressure among youths where they are forced to engage in activities that they don't want to (Prompt: such as trying drugs, getting involved in inappropriate activities ect)?
- Have you heard of any gang activity going on in Wimauma?

Community Perception

- If you had the power and money to change something in your community for you, your family and your community- what would it be?
    - What do you see as a barrier to accomplish that?
- Is there anything else about how you live in this community that you want to talk about?

Focus Group: Medical Providers (Suncoast Community Health Center)

Date and Location: June 4, 2014 1pm-3:30pm at Suncoast Community Health Center in Ruskin
Facilitator: Amparo Nunez, HSC staff
Notetaker: Sara Arias-Steele, HSC staff
Total Number Participants: 2 (Laura Resendez, Migrant Outreach Coordinator, and Betsy Martinez, Clinic Administrator)

Medical Services

- What do you think are the social or medical services that people use the most in Wimauma? Why do you think that is?
- Describe the types of services your organization offers?
- How would you rate its impact on the people of Wimauma?
- What do you think are the impediments that keep some individuals from adequately achieving overall good health?
- How have you made your services more accessible/ known to the general public?
- What alternatives/ payment plans do you offer for individuals without insurance?

Focus Group: Resident Users of Medical/ Social Services in Wimauma

Date and Location: June 5, 2014 6pm-7:30pm at Bethune Park
Facilitator: Amparo Nunez, HSC staff
Notetaker: Sara Arias-Steele, HSC staff
Total Number Participants: 14

Medical/ Social Services

- What are you perceptions on the quality of the medical services provided in Wimauma?
    - What do you think are its weaknesses and areas of improvements?
    - Can you access these services without insurance? What do they offer individuals without insurance?
- If you need to visit the health clinic, what type of transportation to you use? How much does it cost?
    - Do you know of other people for whom transportation is an impediment to receiving routine health assessments?
- What types of pharmacies are available in Wimauma? For your medications, where do you go or how to you receive them?
- If you use the social services in Wimauma, how would you rate their quality of care and accessibility?
    - What do you think are its weaknesses and areas of improvements?
    - What type of social services do you use most often?
    - How did you learn about social services?

Wimauma Asset Mapping Findings

DIRECTORY OF WIMAUMA COMMUNITY RESOURCES CONSULTED

Name	Address	Phone Number
Schools		
Reddick Elementery	325 West Lake DR Wimauma Fl	813-634-0809
RCMA Academy	18236 US HWY 301 Wimauma Fl	813-672-5159
Child Care Facilities		
RCMA La Estancia CDC	po box 1744 Wimauma Fl	813-6715285
RCMA Beth El CDC	18234 US HWY 301 Wimauma Fl	813-672-5165
The Learning Canvas	10756 Carloway Hills Drive	813-938-4973
RCMA Balm	14710 Bweet Charlie Cr. Wimauma Fl	813-672-5332
RCMA Wmauma Groves	5316 Sun Paradise Ct. Wimauma Fl	813-672-5322
RCMA Bethune Park	5809 Edina St Wimauma Fl 33598	813-481-4104
RCMA Wimauma Civic Center	5707 Hillsbrough Street Wimauma Fl	813 671 7715
Wimauma Early Education Center	5610 Desoto street Wimauma Fl 33598	813-671-5279
Religious Institution		
Our Lady Of Guadalupe	16650 US HWY 301 S. Wimauma Fl	813-633-2384
Iglesia De Dios Elim	5801 Hickman St. Wimauma Fl	813-477-2884
Prmera Iglesia Bautista Hispana	5701 Camp St. Wimauma Fl	813-634-1569
Beth El Farmworker Ministry Inc	18240 HWY 301 S. Wimauma Fl	813-633-1548
Templo Filadefia	5730 St RD 674 Wimauma Fl 33598	813-634-7467
First Prospect Missionary Baptist Church	6012 Edina St Wimauma Fl 33598	813 633 5600
Mt Moriah MB Church	5909 Vel St. Wimauma Fl 33598	813 785 2875

Health Center		
Wimauma Family Health Center	5121 State Route 674 Wimauma, FL	813-633-2669
Tampa Family Physicians	4874 Sun City Center Fl 33573	813 633 2000
Neighborhood Associations		
The Citizen Improvement League Inc.	P.O. Box 825 5802 Edina St. Wimauma Fl	813-672-4386
County Facilities		
HCFR Wimauma Station #22	1100 7th Street Wimauma Fl	813-671-7711
Wimauma Senior Center	5714 North St Wimauma Fl	813-671-7672
Businesses		
Taqueria Guanajuato	5151 674 St Rd Wimauma Fl	813-650-1971
Simon Computers LLC	16621 HWY 301 S Unit 10 Wimauma Fl	813-465-1144
Annettes Beauty Salon	16621 Hwy 301 S. Suite 201 Wimauma Fl	813-634-5422
LOG Cabin Produce	5214 HWY 674 Wimauma Fl	813-380-5214
Tienda De Los Primos	5616 State Road 674 Wimauma FL	813-633-9458
Turf Keepers Inc	5221 State Road 674 Wimauma FL	813-633-2092
Regions Bank	4892 Sun City Center, Sun City Center FL	813-633-4695
Mr G Wireless (Boost Mobile)	5645 State Road 674 wimauma FL	813-634-2424
Circle K #7169	5133 Hwy 674 Wimauma FL	813-633-9535
La Fruteria Mexicana	5803 State Road 674 Wimauma FL	813-633-8786
Metro PCS	5129 HWY 674 Suite C Wimauma FL	813-938-5883
Jose Fruits & Vegatables	5151 State Road 674 Wimauma FL	813-633-2822
El Mariachi Loco	5640 State Road 674 Wimauma FL	813-633-6777
Garcia Bakery	5805 State Road 674 Wimauma FL	813-633-2848
Wimauma Supermarket	5819 State Road 674 Wimauma FL	813-634-3374

Ana's Mexican Restaurant	5705 State Road 674 Wimauma FL	813-634-3721
Quest Ecology Inc,	735 Lakeview Drive, Wimauma, FL	813-6420799
Amenities		
Canoe Outpost	1800 1 US 301 Wimauma Fl 33598	813-634-2228
Elmiras Wildlife Sanctuary Inc	13910 Seminole Trail Wimauma Fl 33598	813 634 4115
Farms		
Colorfield Farms	8221 HWY 674 Wimauma Fl 33598	813-674-4121
Fox Hollow Farms	2709 County Road 579 Wimauma Fl 33598	813-927-5384
Campground		
Masonic youth Campground	18050 US 301 Wimauma Fl 33598	813 634 1220