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An Ethnographic Description of Latino Immigration in Rural Arkansas: Intergroup Relations and Utilization of Healthcare Services *

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ABSTRACT Recent growth of Latino immigration in the rural south resulted in a 337 percent increase in the Latino population in Arkansas from 1990 to 2000 (Broadwater 2001; U.S. Census Bureau 2000). The purpose of this study was to examine perspectives of both the established non-Hispanic resident and new immigrant Latino regarding the “accommodation” processes occurring and the inherent changes both groups experience. This paper describes a rural/urban comparison of two issues: 1) intergroup relations between new Latino immigrants and the established non-Hispanic resident population, and 2) utilization of healthcare services by Latinos. Methods for this study included key informant interviews, participant observation, and systematic open-ended interviews using free-listing questions with residents in three rural Arkansas communities. Although many of the intergroup relations in rural Arkansas were similar to published findings of urban communities, there were also signs of transformations in schools and business development. Access barriers to physicians and hospital services may be mediated more often in rural communities as compared to urban Latino experiences.

The growth of Latino immigration in the rural south is a recent phenomenon. Therefore, the published literature regarding Latinos in rural southern communities is limited (Cravey 1997; Griffith 1995; Hernandez-Leon and Zuniga 2000; Villatoro 1998) and none

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include Arkansas. The ethnographic findings reported here examine both the established non-Hispanic and immigrant Latino perspectives regarding the “collective change” or “accommodation” process occurring where new immigrants settle and the inherent changes both groups experience (Bach 1993:4).

The goals of this ethnographic research were to describe the nature of the experience of Latinos who immigrate to Arkansas to work in rural areas and to define the nature of this immigration experience for local, established non-Hispanics. The research questions of this pilot study were: 1) Who is immigrating? 2) Why are immigrants selecting specific rural communities? 3) How are immigrants integrating into the community? 4) How are individuals from the local community responding? 5) How are the new immigrants interacting with the healthcare community? It was hypothesized that these processes and experiences may differ between rural communities and more urban settings. This paper compares findings from the study conducted in rural Arkansas with those of other published studies of urban Latino immigration in regard to two specific issues: 1) intergroup relations between new Latino immigrants and the established non-Hispanic resident population, and 2) utilization of healthcare services by Latinos.

Background

General Growth in Latino Immigration

The Latino population has more than tripled in six southern states. In Alabama, Arkansas, Georgia, Tennessee, North Carolina, and South Carolina alone, the population increased by 211 percent between 1990 and 2000 (Mayo and Erwin 2003; U.S. Census Bureau 2000). There are indications that some of this growth is “second stage” immigration from Mexican Americans moving from California and Texas to improve their lifestyles and work in a growing industry of this area (Massey, Goldring, Durand, 1994). Hernandez-Leon and Zuniga (2000) presented a case study of an emerging Mexican immigrant community in a small city of the southern United States suggesting that a new array of post-Immigration Reform and Control Act of 1996 destinations are arising as a consequence of the secondary migration of amnestied Mexicans (Gonzales 1997).

The experience in rural Arkansas is practically identical to that described by Hernandez-Leon and Zuniga (2000:49) for rural Latinos in “Carpet City” in Georgia. They noted, “Permanent settlement is a feature of these new destinations as family reunification is taking place in such nontraditional receiving areas.” Also pertinent to this study in Arkansas, Griffith (1995) has shown that poultry plants often recruit new workers through ties of family and friendship.

Latino Immigration in Arkansas

In the past five years, Arkansas has been one of the national leaders in the percentage of Latino growth, with an increase of 337 percent (Broadwater 2001; U.S. Census 2000). In 1990, only one county in Arkansas had a Latino population greater than 1.5 percent of the total population. In 2000, there were 86,866 Latinos (3.2 percent) statewide. According to 2000 census data, 70.5 percent of Latinos in Arkansas were from Mexico and 25.6 percent were of “other” origin, including Central America.

Unlike much of the former immigration patterns for seasonal farm work or into major metropolitan areas (See Chavez, Flores, and Lopez-Garza 1990; Massey and Schnabel 1983; Portes and Rumbaut 1996), 59 percent of these new immigrants in Arkansas settled in rural counties (U.S.Census 2000). Here, they found work in poultry processing plants, other light industry, and timber planting and processing.

Urban Comparison Study—The *Changing Relations Project*

The *Changing Relations Project*, a study funded by the Ford Foundation in 1987 to support a multidisciplinary team of scholars studying the impact of new immigrants into six communities in the United States, provides an urban comparison for this research on rural immigration (Lamphere 1992; Bach 1993). The studies examined relationships and everyday interactions among recent immigrants and longer-term residents in the six neighborhoods to obtain critical information to inform policies for responding effectively to the increasing immigration in our nation. The big-city neighborhoods included Chicago, Houston, Miami, and Philadelphia. The

suburban sites included Monterey Park, California, and Garden City, Kansas. This project used ethnographic descriptions to characterize larger social, political, symbolic, or economic issues (Lamphere 1992). The project produced findings about community conditions that newcomers and established residents face and struggle to overcome together, highlighting the importance of economic restructuring, class and gender, geographical settlement, language barriers, racial stratification, and the role of community control.

Among the results of the *Changing Relations Project*, the findings emphasized that both established residents and new immigrants experience “accommodation,” or collective change, within a community, conflicting with the traditional assumption that only newcomers must assimilate to new surroundings (Bach 1993:4). Economic restructuring that influenced employer-generated increases in immigrant workforces affected group interactions. However, these urban communities often maintained social order in spite of fears of social disorder and fragmentation caused by the immigration and employment changes. Likewise, the findings illustrated that recent immigration in these urban neighborhoods added new complexities to existing inequalities of language, class, race, and wealth. The report suggested that one of the most contested issues in intergroup relations found in all six sites involved the conflict, separation, and tension related to language (Bach 1993:6). With respect to ways individuals are encouraged to interact across group lines, the report indicated that shared activities, local organizations and leaders—often teachers, clergy, social workers, and local women working as ‘community brokers’— “forge ties and ease tension among groups” (Bach 1993:7).

A decade after the initiation of the *Changing Relations Project*, the pattern of new immigrant flow had begun to spread into rural communities previously untouched by the complex neighborhood issues reported by Lamphere (1992) and Bach (1993). Their findings on immigration to urban neighborhoods provide a comparison for examining intergroup relations between the new Latino immigrants and the more established non-Hispanic residents in rural Arkansas communities.

Do newcomers in rural areas coexist with established non-Hispanic residents in what Bach (1993) has characterized as divided social worlds of separation and social distance? Lamphere argues

that these separations and divisions are not “merely a matter of choice, language barriers, or cultural differences too difficult to bridge” (1992:viii), but are patterns supported and created by the corporations, school systems, city governments, and housing corporations. This study will explore similarities and differences between the results from the *Changing Relations Project* and findings from small-town environments by addressing two questions. First, are new Latino immigrants in Arkansas incorporated into local economies, gaining access to higher-paying jobs, and integrated into the community; or are they continually marginalized, finding themselves trapped in low-wage, unstable employment? And second, are opportunities to buy property, own businesses, and perhaps, cross class barriers mediated differently in rural settings?

The same political and economic macro-processes at work in the incorporation of immigrants into the U.S. labor market that influenced the urban intergroup relations at the neighborhood or microlevel (Lamphere 1992; Bach 1993) are also manifested at the microlevel in the patterns of urban healthcare utilization (Chavez, Flores and Lopez-Garza 1992). This leads to the comparison of these initial findings on healthcare utilization in rural communities in Arkansas to some existing studies on healthcare utilization of urban Latino immigrants.

Urban Latino Healthcare Utilization

Studies show that urban Latinos utilize health services at rates below those of the general U.S. population (Chavez, Cornelius and Jones 1985). A comparative study of undocumented immigrants in Dallas and San Diego reported that 41.4 percent of recently immigrated Central Americans in Dallas were covered by insurance as compared to 71.2 percent of the undocumented Mexican interviewees who had lived in the city a longer period of time; approximately half of undocumented Mexican and Central Americans in San Diego were covered by insurance (Chavez et al.1992).¹ In this same study, 41.6 percent of Central American immigrants in Dallas, and as few as 28.1 percent of Central Americans in San Diego, sought care at a

¹ These respondents were interviewed in 1986 prior to the enactment of the Immigration Reform and Control Act of 1986 (IRCA).

hospital. Likewise, in San Diego, 22.2 percent of undocumented Mexicans and only 9.4 percent of undocumented Central American immigrants had seen a physician; while in Dallas, the percentages were 14.6 percent for Mexicans and 10.4 percent for Central Americans (Chavez et al. 1992). The authors suggest these differences between cities are related to the local structure of health services (location, availability, etc.), while utilization differences between documented and undocumented Mexicans and Central Americans were at least partially due to fears and concerns regarding legal status and deportation, as well as less knowledge among undocumented immigrants about managing the social and healthcare systems (Chavez et al. 1992).

A random sample study of Latinas in Orange County, California, reported that 45 percent of the 160 undocumented Latinas used a public health clinic, while 25 percent had used an outpatient hospital clinic, and only 4 percent reported using a hospital emergency room (Chavez, Hubbell, Mishra and Valdez 1997). In this Orange County study, only 21 percent of undocumented Latinas compared to 44 percent of legal Latina immigrants had seen a private physician (Chavez et al. 1997), again demonstrating differences due to legal status.

These findings and other reviews (Chavez and Torres 1994) support the hypothesis that economic and political constraints shape the use of healthcare by low-income, undocumented immigrants in urban areas. There are no comparable studies on Latino healthcare utilization in the rural south. And although immigrants may bring with them cultural differences, Chavez et al. (1992:22) argue that “structural obstacles” like location, availability/timing, transportation, and lack of insurance within the local environment most challenge recent immigrants in seeking healthcare. If there are variations between environments in different cities, then the global and national forces (macro-processes) interacting with local rural (micro-processes) culture, economy, and social structure might also be expected to affect health-seeking behaviors. This study in Arkansas explores how the local rural accommodation processes, and political, social, and economic forces, impact both intergroup relations and healthcare utilization for new Latino immigrants, and how these processes differ from their urban counterparts.

Methods and Data

Communities Selected

Methods for this study included key informant interviews, participant observation, and systematic, open-ended interviews using free-listing questions with residents in three Arkansas counties (Weller and Romney 1988). These Arkansas counties were selected because they were rural counties with higher percentages of Latino population than other rural counties in Arkansas—43.5 percent, 38.6 percent, and 8.3 percent (U.S. Census 2000). The county seats were the primary interview communities for the study. The county with only an 8.3 percent Latino population was selected because it was one of the few counties settled by Latinos that also had a high percentage of African Americans (41 percent). As African Americans are the only other minority group comprising a significant percentage (16 percent) of the state population, it was deemed important to include intergroup relations among all three groups (U.S. Census 2000). All three communities had less than 7,000 people.

Participant Selection

The interview sample was a combination of snowball sampling for many of the Latino interviews (Cornelius 1982); with some reputational case selection sampling (Miles and Huberman 1994:28) assisted by local church leaders, healthcare providers, *parteras* (midwives), schools, and community contacts. This provided an optimal sample to include varying backgrounds and experiences of Latino, non-Hispanic white, and African-American residents. The sample included long-term residents (Latino and non-Hispanic), as well as Latinos who had immigrated as recently as four months prior to their interviews. Only non-Hispanic residents who had lived in the community during the increased immigration process of the past eight years were included. Fifty-three key informant interviews, 43 semi-structured free-list interviews, and 140 structured interviews with non-Hispanic whites, African Americans, and Latinos were collected during 2001 and 2002. Of these 236 interviewees, 44 percent were non-Hispanic whites, 42 percent were Latino, and 14 percent were African American.

Interview Techniques

Fifty-three key informant interviews were done with mayors, hospital administrators, police, physicians, church leaders, priests, nuns, school administrators, teachers, business owners, realtors, farmers, poultry workers, and poultry plant management. Interviews generally lasted from one to three hours and were conducted at sites throughout the community.

Forty-three semi-structured free-list interviews were used to collect all the possible answers to questions regarding certain domains—in this case, regarding immigration, the accommodation process, intergroup relations, and healthcare utilization experiences following settlement into a particular community. An additional 140 structured interviews were completed in the communities, asking the participants to prioritize or rank the lists of 8 to 11 most frequent answers from the free-list interviews (Weller and Romney 1988). The free-list questions are listed (in English) as an appendix. Questions were asked in Spanish for Spanish speakers.

The free-list and key informant interviews were entered into the SphinxSurvey Lexica software program for data and text management. Together with field notes from participant observation in these communities, these ethnographic findings provided the cultural data for characterizing the experiences of newcomers and established residents in the rural Arkansas communities.

Description of the Participants

Latino participants. Although not specifically asked in the interview process (to minimize human subject risks), it is estimated by interviewers based on responses and candid comments that approximately 70 percent of the Latino respondents were undocumented immigrants. About a quarter of Latino respondents could be considered what Saenz and Cready (1999) call “trailblazers” to Arkansas, as they were some of the first Latinos to settle in this area from another state as many as 17 years ago (Hernandez-Leon and Zuniga 2000). Sixty-four percent of Latinos in this Arkansas sample were new immigrants to the United States, never having lived in any other state. Eighty-five percent were foreign-born and immigrated

from Mexico, and 15 percent were from several other Central American countries. Fifty-one percent of Latino participants were male and 49 percent were female. The average age of the Latino sample population was 31.5 years old. Most Latino participants were unskilled workers, although approximately one-third were middle-class, having moved into business or farm ownership.

Non-Hispanic participants. The established, non-Hispanic residents in this Arkansas sample were 77 percent (n=106) white and 23 percent (n=32) African American. All had lived for more than eight years in the town in which they were interviewed; the majority were born there. Forty-five percent of the non-Hispanic residents were male and 55 percent were female. The average age for non-Hispanic residents in the sample was 43 years. The non-Hispanic participants were approximately one-third middle-class, blue-collar workers and two-thirds middle- to upper middle-class professionals.

Findings

The following descriptions characterize the micro-level (local, small-town) environments of the settlement processes for Latino immigrants living in rural Arkansas.

Community Descriptions

Little Mexico. The community referred to as “Little Mexico” is in the southern-most area of the western “chicken strip” area of chicken houses and processing plants that runs from northwest Arkansas straight south to the border with Texas. In 2000, at least 39 percent (2,225) of the 5,765 people were Hispanic/Latino; however, local residents, both Latino and Anglo, believed the percentage was much higher. The majority of these Latino immigrants were from Mexico, with the earliest families arriving approximately 20 years ago. The resident Arkansas community was primarily non-Hispanic of European ancestry (66.4 percent) with less than 1 percent African American or Native American.

There were at least six Mexican stores, four restaurants, a bakery, a tortilla factory, and a car repair business owned and operated by Latinos. One of the largest poultry processing plants in the

United States was located in Little Mexico, and two additional poultry plants were within a 50-mile radius. During the 1980s, when the local, white labor market declined, the processing plant bussed in African-American workers daily. When this was not successful, plant management recruited workers from their plant in Mexico, triggering Latino immigration in the 1990s.

Health services available in Little Mexico included a local 94-bed hospital with a bilingual respiratory therapist and nurse on staff. There was a licensed midwife who understood some Spanish, a local county health unit that provided maternity services (labs and evaluations), 13 to 14 monolingual English-speaking physicians, and a bilingual pediatrician.

Chicken City. The second community, “Chicken City,” is in central, northwestern Arkansas and had a small, yet growing population. In 1990, the population was 1,595, with only 34 Latino residents. In 2000, the population was 2,392, and at least 43.5 percent were Latino (Broadwater 2001; U.S. Census 2000). The Latino population included more Central Americans, primarily from El Salvador.

There were two Latino restaurants, two *tiendas* (Latino stores), a bakery, and a beauty salon owned by Latinos. One 30-acre farm was owned by a Latino. The largest employers in Chicken City were two poultry processing plants—one was a “kill plant” with over 1000 employees; the other processed refrigerated fresh chicken halves, employing about 700 workers. The newest immigrants tended to start at the kill plant and, after they have gained experience, applied for higher paying jobs at the other plant. The latter was considered “better and easier” work.

Local health services included a 41-bed hospital, with a recently added outpatient clinic funded by a federal grant and justified by the documented increase in the Latino population. This grant provided funding to hire a bilingual female family practitioner from Argentina, and they had one interpreter on the hospital staff. Other healthcare services in Chicken City were provided by a bilingual midwife and a county health unit with a bilingual nurse.

Timber Town. The third rural community, “Timber Town,” was in the southern portion of the state within the eastern Mississippi Delta region. The population was 6,442, with 16 percent Latino (1,040) and 35 percent (2,255) African American. Most of the

Latino residents were from Mexico. There were only a few Latino-owned businesses. In response to the settlement of more Latino workers in the area, a new (July 2001) chicken-processing plant opened and planned to hire 150 to 300 workers. Traditionally in Timber Town, most non-migrant Latino workers were employed in the timber industry or as contract agricultural workers (H2A Visas). Because of the agricultural cooperatives and contract labor work, Timber Town had a 20-year history of Mexican workers (primarily male) temporarily in the county for seasonal work. It had only been in the past 15 years that year-round work was available, and the area was drawing new plants to take advantage of the available Latino labor. This community had the smallest proportion of Latinos and the largest number of African Americans of the three communities.

Health services included a 49-bed local hospital and a county health unit. However, because 17.5 percent of the population in the county that included Timber Town was over the age of 65, the Arkansas Department of Health had determined that the county health unit could not afford to include maternity services. Timber Town had no midwife or bilingual physicians.

Although there were minor variations in settlement reception and the nature of the local environment in each community, the variables related to intergroup relations and healthcare services had more similarities than differences. For this analysis, the findings from all three rural communities will be compared to immigration processes and experiences reported from the urban examples in the *Changing Relations Project* and the urban healthcare utilization studies cited above.

Intergroup Relations

Cultural conflict. As Lamphere (1992) and Bach (1993) reported for the urban communities, the Arkansas communities demonstrated little in the way of violent or open conflict in intergroup relations. There were tales of fights between local Latino and African-American highway transportation workers and timber crews, and decisions not to integrate the crews in the future, but these stories were not frequent and seemed to be related to personal problems among group members. There were several forms of “cultural differences” that over one-third of the non-Hispanic residents

interviewed in the Arkansas communities discussed as problematic from an intergroup perspective. Non-Hispanics complained that Latinos play loud music from homes and cars, do not take care of yards or houses in what they considered an appropriate way, fly the Mexican flag in front of homes or stores, slaughter animals in front yards, and keep chickens in town. In response to local complaints, Little Mexico passed legislation to make it illegal to play music after 10 p.m. and to prevent the slaughter and display of any animals in the city limits, prompting a local Latino man to say, “We can’t enjoy our music and our customs.”

Gangs were seen as a potential for intergroup conflict, primarily because many established residents often perceived gang activity as being related to the increase in Latino immigration. Established residents and Latinos in all three communities had narratives related to fears of gangs and drug dealers, or how they had removed the threat by rules or community empowerment.² Carla, a Latina personnel worker at the poultry plant in Chicken City, summarized one of the Latino concerns:

The Hispanics from Texas have a bad rap. Some of them look like they're gang-related. They ruin it for all the Latinos. There was some breaking-in and the Latinos were getting blamed. It turned out to be two white American guys. None of us in town [Latino or white] want any gangs.

The plant manager at Chicken City said that the businesses are working to keep out any gang activity within the workplace:

² In both Spanish services at the Catholic Church in Little Mexico on June 10, 2001, following the sermon and communion, one of the Sisters made a special report to the attendees that there were some gang members—mostly from California—trying to sell drugs to kids at the playground and at the school. She asked parents to take extra care with their children 11 years of age and older. She asked them to keep them at home. She stressed, “As a community, we must not let this happen to our children.”

We don't allow it in the plant. They can't wear any bandanas or anything. We've had a few come in here like that. But they have to stop or get out.

Divided social worlds. There was clear evidence of separation and social distance in all of the Arkansas communities, as was reported for the urban communities (Lamphere 1992; Bach 1993). Much of the social division was related to language, which was reported by all groups as a major problem for newcomers and residents alike. Moreover, unlike major cities in the United States with large established Latino populations, virtually none of the established non-Hispanic residents in rural Arkansas were fluent in Spanish, and most commercial businesses, schools, and service providers were not yet staffed with professional bilingual Latinos. Therefore, almost all services, education, commerce, and communication were inaccessible to monolingual Spanish-speaking immigrants without assistance. Due to the language barrier, new immigrants had little interaction with resident non-Hispanics, including teachers, merchants, politicians, etc.

Institutionalized segregation was often evidenced in the poultry processing plants, which followed the pattern for the meat packing industry in Garden City, Kansas detailed by Stull, Broadway, and Erickson (1992). The poultry industry often segregated Latino immigrants from longer-term non-Hispanic residents by creating groups of Latino immigrants on shifts and grouping new employees who were familiar with one another.

School segregation. With regard to segregation within the schools, one school principal in Chicken City pointed out that the Latino and white children played well together in school and were completely integrated until the fourth grade. However, by Christmas vacation of the fourth grade, they had begun to segregate themselves. She hypothesized that the children began having sleepovers and became more active in extracurricular activities that involve parents, carpools, and visiting in each others' homes at that time. The school principal made this observation:

I guess the parents just don't want those other kids to be in their homes. I wouldn't want my daughter

to spend the night at a family's home that I don't know well.

The school districts in these rural communities went from less than 3 percent Latino in the primary grades in 1992 to almost 50 percent Latino in 2001. When Carla moved to Chicken City in 1994, she was in the ninth grade, and was one of only three Latinos in the school—one of the three was her brother. In 1998 she was the first Latino to graduate from the local high school. Carla recalls that:

It was very difficult—the kids called me names and weren't friendly. I would go home and cry and want to go home to California.

Similarly, Cathy, a non-Hispanic resident and nurse in a hospital in Chicken City, said:

The older kids in the high school may be more segregated than the kids that have grown up together. I have a 6th and 8th grader and my kids have Mexican friends. They spend the night together, play ball together, etc. The key is if the kids speak English. The newer the immigrant, the greater the chance they will segregate in school.

Provincial segregation. There was a dialectic involved in this segregation/integration in rural areas of the south that may be unlike the urban cases, creating a new kind of class distinction. These small towns had a classification system that was specific to their provincial nature. There was a common classification of “outsiders” versus “natives.” People who were born and raised in a specific town or its immediate surroundings were considered natives. Non-natives were people that grew up in another area and one could not change this status. Cathy, a white nurse who moved to Chicken City over a decade ago from another town in Arkansas, summarized it this way,

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Some of the discrimination is a simple, rural thing about 'who you know, what you know, who's your family' and the fact that the new folks here aren't 'from' here and so people don't 'know their people.' They do the same thing to new white people. Important questions like, 'did you grow up here? Did you go to school here?' are the first things natives ask.

Class and income moderated this provincial segregation for non-natives.

Ethnic segregation. Another complicating issue experienced by new Latino immigrants was the complex southern historical segregation process based upon perceptions of race or ethnicity. This often translated into perceived and actual acts of implied and blatant discrimination and racism by non-Hispanic residents toward Latino immigrants. Almost half of Latinos interviewed mentioned racial and ethnic discrimination as one of the things that was cause for concern to them. The following statements by Latino poultry processing plant workers and small business owners demonstrated these feelings: "*The North Americans don't show us respect.*" "*They are racist.*" "*They do not integrate us into the community.*" "*La gente es muy cerrada, y no les gustan los cambios*" (the people are close-minded and they don't like changes).

One area in which there seemed to be some difference between non-Hispanic whites and African Americans with respect to Latino immigration issues was more concern by African Americans over employment and possible job losses. This is demonstrated by comments from an African-American nurses' aide:

I don't know any [Latinos] personally or anything. I wonder if we're all gonna' hafta speak Spanish...will they be replacing me with a Mexican aid 'cause she speaks Spanish?

Religious segregation. Rather than integrating newcomers and established residents, the churches created new opportunities to separate newcomers and established residents by building "mission" churches or separate buildings for Latino immigrants. Often,

Protestant congregations created a “mission” church with a separate building and Spanish service for Latino immigrants. They were still considered the same church—they just included two buildings. The Catholic churches tended to offer separate services in Spanish in the same location until a new building was required to accommodate the larger congregations.

These strongly non-Hispanic Protestant communities within the South, known as the “Bible Belt,” also saw a logarithmic rise in the development of Catholic churches. Ten years ago, in Little Mexico, a popular young priest started a Spanish mass in his parish with eight people. Three to five months later, there were over 100 people. In 2001, they had as many as 2,000 Latinos for mass at the two weekly Spanish services in their new building, and offered services at smaller surrounding communities. This same Catholic church had only 80 non-Hispanic white members who continued to worship together in the small, original church building. The priest was proud to report, “*The grass is worn away around the[new] church now – there is real community here.*” However, this “community” included only a handful of non-Hispanic white members. Both Latino and non-Hispanic residents claimed that meeting separately for religious services (Catholic and Protestant) were preferred by both groups and reduced the stress and intergroup conflict because each group wanted their religious service provided in “their accustomed way” and in their native language.

Transcending segregation. As was the case in many of the urban communities (Lamphere 1992; Hagan and Rodriguez 1992; Goode, Schneider, and Blanc 1992), segregation in the three Arkansas communities was often class related, and could be transcended when new Latino immigrants were able to cross barriers to move into middle-class work and social positions. For example, in each of the Arkansas communities, Latino immigrants had become land-owners and/or had achieved management positions in businesses within 10 to 15 years of settling in the community. In these cases, their children became more integrated into school and social activities with non-Hispanic resident children.

As in the *Changing Relations Project*, many of the Latino immigrants in Arkansas remained marginalized, especially the undocumented workers who remained powerless to speak out and were often exploited by plant owners, real estate companies, and

others. However, there was also evidence on the microlevel of a growing middle class of entrepreneurial, bilingual Mexican American and Latino immigrants, some of whom came up the ranks in Arkansas from undocumented migrant workers or tree planters and had been in these towns for more than 10 years. Others were second-stage Latino immigrants from California and Texas. Some of these individuals were major gatekeepers to financing and business for many other Latinos and served as cultural and language brokers between the newcomers and the established non-Hispanic businesses. One non-Hispanic white political leader in Little Mexico pointed out the economic power inherent in these rural changing relations:

In spite of the Southern stereotypes and past inability to be open-minded to diversity, they [Hispanics] have found the population to be non-hostile and maybe embracing. The business community initially was receptive – money generally helps to reorganize people's thoughts. There's a need—and if they look at it, it affects white Anglo farmers who may not like or understand the Hispanics. But they know that [the local poultry plant] has had 100 open jobs for years and will close the plant if they aren't eventually filled.

However, for some residents, integration and the possible increasing power of Latinos was still threatening, as demonstrated by another white politician:

Well, as long as they are illegal, they are fine, 'cause they aren't causing any trouble and they know their place. If they make them legal, they won't have to worry about being deported. The threat of fines and deportation keeps people in line. We'll be overwhelmed if they're all legal.

David Kirp (2000:27) documented this same sentiment for a community in rural Georgia when he summarized their responses: “If

these newcomers can't be kept out, the logic of bigotry runs, at least they can be kept in their place."

In addition to these findings regarding intergroup relations, the following set of findings further explore the impact of the political and economic factors on the healthcare experiences of Latino immigrants in these three rural communities and compare their utilization patterns to urban examples.

Healthcare Utilization

Health insurance. Although almost 26 percent of the Latino sample had lived in the United States less than one year, 48.1 percent stated they had health insurance through work. This necessarily included many of the 70 percent who were estimated to be undocumented. This percentage with insurance is comparable to the urban study population in Dallas in which 41.4 percent of recently arrived undocumented Central American immigrants were covered by insurance (Chavez et al.1992). However, fewer Arkansas Latinos had health insurance than the 71.2 percent reported by undocumented Mexican interviewees who had lived in Dallas for a longer period of time. In San Diego, approximately half of undocumented Mexican and Central Americans were covered by insurance (Chavez et al. 1992). For the almost 52 percent of Arkansas Latino immigrants interviewed without health insurance, there were multiple explanations. As the average age of these respondents was not quite 32 years old, healthcare concerns were not yet a major priority. One nurse who worked with the Latino immigrants in Little Mexico said,

The average weekly net pay is about \$200-\$250 for folks in the plant, so the insurance cost is about 8 to10 percent of their check. The goal of the workers is to garner as much cash as possible, and many of the workers are fairly young.

Full-time poultry processing plant workers theoretically had access to health insurance through the company. Although all workers were required to show a social security card and other forms of identification to be hired, these documents can be "purchased" or "borrowed." If Latino workers did not have legitimate

documents or were not citizens, many were unwilling to enroll in an insurance program. They were fearful of using a false social security number and being discovered and deported, or they realized that the owner of the social security number had already used it some time in the past and, therefore, they would be discovered in this way. A non-Hispanic hospital administrator described an experience:

One [Latina] woman told me that the last name on the insurance wasn't actually her real name, and not the name she wanted to use for her baby. Her husband yelled at her when he found out because he didn't want the hospital to turn them in for the illegal documentation.

Public and private healthcare. The majority of Latino respondents (52.5 percent) in the three Arkansas rural communities had used a public health clinic for themselves or a family member, which is higher than the 45 percent of undocumented women in the Orange County, California study (Chavez et al.1997). The percentage of rural Latino immigrants using a local hospital (53.3 percent) was higher than the reported hospital usage for undocumented immigrants in the urban study of Central American immigrants in Dallas (41.6 percent) or San Diego (28.1 percent) (Chavez et al.1992). Likewise, this percentage for local rural hospital usage was more than twice as high as the 25 percent outpatient and 4 percent emergency room use reported for Latino immigrants in Orange County (Chavez et al. 1997). A hospital administrator from one of the Arkansas communities reported that 90 percent of the Latino births in their hospital used emergency Medicaid to cover the costs. More of the respondents in these rural Arkansas communities also reported having seen a private physician (55.7 percent) compared to undocumented (21 percent) or legal (44 percent) Latina immigrants in the Orange County study, or in San Diego (22.2 percent of Mexicans, 9.4 percent of Central Americans) or Dallas (14.6 percent of Mexicans, 10.4 percent of Central Americans) (Chavez et al. 1997; Chavez et al. 1992).

The urban Latino studies, as well as these findings from rural Arkansas, clearly demonstrated the economic and political

constraints shaping the use of healthcare by low-income undocumented Latino immigrants and suggested that differences in the local cultures and social structures affect health-seeking behaviors (Chavez et al. 1992; Chavez and Torres 1994). For example, the relatively high proportion of Latinos in Arkansas who sought health services by a local private physician, regardless of insurance status, may reflect variation in healthcare utilization for Latino immigrants that settle in rural communities as compared to urban settings. The physicians and hospitals in these rural communities may be more accessible than in large cities. These rural medical practices, even those operated by for-profit systems from larger cities, were more likely to afford patients the ability to pay over time, make partial payments, and barter for services than would be likely in urban practices. The physicians in small towns often knew they were the only source of healthcare in the vicinity and perhaps felt ethically compelled to provide care knowing they could not refer patients elsewhere.³ These high utilization figures may also be indicators of the high number of job-related injuries. Further research is needed to explore these issues.

The local county health units in each community, were regionally positioned and fairly accessible to all uninsured Latinas regardless of language abilities or legal status. The primary access barrier was time related—transportation on weekdays and time off from work. This was somewhat mediated for some women by the midwives.

Maternity care. Maternity care was one of the primary interactions Latinas had with the healthcare community. At the time of this research, there were no bilingual physicians offering obstetrical care in any of these communities. The bilingual midwife in Chicken City said that she attended 10 home births in 1995. In 2001, she was averaging 60 per year. Seventy to eighty percent of these were Latinas. She also served as an interpreter for women

³ In one community, a relatively new physician refused to care for a local worker injured on a work-related accident. The patient appeared at the clinic door about 5 p.m. with an obvious trauma to his head, and the physician said his clinic was closed. The community was incensed by this lack of care and compassion and the physician was no longer in practice and had moved away within 6 months.

having hospital births. Both this midwife and the one in Little Mexico often served as gatekeepers to other healthcare services for Latinos. Although midwives may also be available in urban areas, the ability of these small-town midwives to integrate themselves among all of the existing healthcare services, as well as into the local Latino community, in a relatively short time may be one of the reasons new Latino immigrants had higher utilization of physicians, hospitals, and public health clinics than their urban counterparts.

Although a high proportion of Latinos in Arkansas reported utilizing physicians, hospitals, and public health clinics, this was not to say that adequate medical care was accessible to all. Men working in Timber Town reported injuries that did not get immediate treatment. Latinos working for private owners of individual chicken and egg-laying farms (as opposed to poultry processing plants) had the fewest benefits, with no workmen's compensation or insurance, and could not easily leave their remote locations outside of town to seek care. Referrals of Latinos to tertiary healthcare institutions in larger cities for more serious health concerns were particularly problematic because they had so many difficulties navigating the unfamiliar urban landscape and medical system, and continued to face language barriers. Many times the priests, rural church volunteers, or midwives had to accompany the Latino families for these referrals to serve as bilingual "navigators" if the family could not purchase these services from other Latinos.

The longer Latinos are in Arkansas and the older the population grows, the more likely it is that they will experience increasing health problems. The repetitive nature of the plant work is also likely to cause increasing health problems (Griffith 1995; Stull, Broadway and Griffith 1994; Cravey 1997; Voices and Choices 2000), with no allowances made for sick or injured employees. According to the midwives and Latino employees, the response from most plant managers was, "*if they can't do the job, they'll have to leave.*"

Conclusion

Intergroup relations between new Latino immigrants and the established non-Hispanic resident population in rural Arkansas were similar to experiences of more urban communities in that there was

little violent or open conflict, language and communication was a significant problem for newcomers and established residents, institutionalized segregation was demonstrated in the work places and churches, and differential power structures of historically segregated class and race/ethnicity continue. However, intergroup relations in these Arkansas communities also showed signs of transformations.

First, because of the limits of space, resources, and lack of opportunities for segregation (only one primary, middle, and high school, and no private alternatives), there was evidence of increasing integration of Latinos and non-Hispanic children in schools when language was not an issue. This was most evident for Latino students born in the United States, and families where Latinos were able to cross the boundaries between newcomers and established residents.

Secondly, for bilingual Latino immigrants, especially those who had legal residency status, there were opportunities to mediate traditional boundaries and increase their economic power through providing gate-keeping opportunities for language and cultural brokerage between monolingual English speakers and the monolingual Spanish-speaking Latinos. This new Latino middle-class was also positioned to compete directly with many non-Hispanic established businesses and was increasingly competing for both Latino and non-Hispanic customers.

Finally, the inherent nature and history of the rural south played a role in intergroup relations that varied from many of the urban community studies. Unlike cities with multi-ethnic populations of various classes where thousands of foreign-born individuals and families move in and out frequently, Southern small-town populations are generally less experienced with the rapid movement and settlement of large numbers of people from outside locations. This is exacerbated by a history of racial segregation and discrimination that marginalizes ethnically different people. Growing concerns by non-Hispanic residents related to perceived challenges from this growing Latino population were clearly illustrated by a comment from a 44 year-old non-Hispanic white woman in Little Mexico, "*I worry that I'm being swallowed up in a culture that isn't mine.*" More specific discussion regarding how these issues impact African-American residents and intergroup relations with Latinos will be a topic for another paper.

Access to healthcare services was another area that varied from urban experiences. Although transportation and language were major concerns, there were indications that access barriers to some services by new Latino immigrants were mediated in rural communities as demonstrated by greater use of physician and hospital services. However, the generally poor rural infrastructure may be challenged to provide for the needs of growing newcomer populations in remote rural areas without insurance and high job-related health problems (Voices and Choices 2000; Cravey 1997; Stull et al.1995).

At the outset of this article, I posed several questions. Are new Latino immigrants in Arkansas incorporated into local economies, gaining access to higher-paying jobs, and integrated into the community; or are they continually marginalized and finding themselves trapped in low-wage, unstable employment? Are opportunities to buy property, own businesses, and perhaps, cross class barriers mediated differently in rural settings? The answer to these questions is a qualified "sometimes." Yes, there were definitely signs that newcomer Latinos were being incorporated into local economies at every level; however, barriers still existed and discrimination was still a factor. And yes, there were more opportunities to buy property and own businesses in these small towns than existed in almost any urban center used as comparison. However, many workers were unable to transcend class and power barriers. In addition to language and immigration status, there were other important variables to mediating class and economic barriers, such as the length of time the Latino immigrants had lived in a community and length of time the residents in a town had exposure to newcomers settling in their area.

These findings offered initial insights on the rural immigration experiences of Latinos in the rural south, but they also created more questions and directions for future research to continue exploring the accommodation processes of new groups of people to small-town communities. For example, additional qualitative and survey research is needed to explore why some immigrants are able to prosper and begin to acquire social and economic capital in these small towns while others remain poor and powerless. With regard to the impact of the immigration experience on health, there is a need to further explore the hypothesis suggested here that local healthcare

services are more easily accessed and utilized by documented as well as undocumented Latino immigrants in rural areas as compared to urban areas. Finally, for applied social scientists and those within the public health arena, these findings demonstrated opportunities to research multiple health concerns impacting Latino immigrants in rural and underserved communities, including maternal and child health; occupational safety, hazards, and reporting; and ethnic health disparities relating to the morbidity and mortality from preventable and treatable diseases such as cancer and diabetes.

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Appendix. Freelist Questions.

A. Established residents:

1. Please list all of the reasons you can think of for Hispanics/ Latinos to leave their cities and towns in their country of origin.
2. Please list all of the reasons you can think of for Hispanic/Latino immigrants to come to [this town] in Arkansas.
3. Please list all of the things and qualities that you like about the Hispanic/Latino immigrants living here in [town].
4. Please list all of the things that you don't like, or are problematic for you in having the Hispanic/Latino immigrants here in [town].
5. Please list any reasons for concern you have about changes that are happening or will happen here in [town] because of the increased immigration of Hispanics/Latinos.

B. Newcomers:

1. Please list all of the reasons that you can think of for leaving your country of origin.
2. Please list all of the reasons that you can think of for coming to [this town] in Arkansas.
3. Please list all of the things and qualities that you like about living here in [town].
4. Please list all of the things and qualities that you don't like or that are difficult for you living here in [town].
5. What type of medical services have you used here in Arkansas? When you are sick, where do you go for help?