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Provider Perspectives on Latino Immigrants' Access to Resources for Syndemic Health Issues

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Abstract

Introduction: Latino immigrants to the United States experience disproportionate impacts from the syndemic formed by substance abuse, violence victimization, HIV/AIDS, and mental health (SAVAME). This study characterizes resource access for Latino immigrants living in Philadelphia, as perceived by staff at Latino-serving organizations. **Methods:** An online cross-sectional survey of staff at key Latino-serving Philadelphia organizations assessed access to their organization and citywide access to each type of service (substance use, HIV/AIDS, domestic violence [DV], and mental health) for Latino immigrants. Descriptive statistics for organizational access indicators and citywide access scores across four syndemic domains (availability, accessibility, adequacy, and quality) and by syndemic condition were computed. **Results:** Organizational access and citywide access across HIV/AIDS (mean = 1.94, *SD* = 0.83), mental health (mean = 1.37, *SD* = 0.95), substance use (mean = 1.11, *SD* = 0.74), and DV (mean = 1.49, *SD* = 0.97) services were perceived as far from optimal. Domain scores were highest for accessibility (mean = 1.66, *SD* = 1.03), followed by quality (mean = 1.44, *SD* = 0.79), availability (mean = 1.41, *SD* = .81), and adequacy (mean = 1.24, *SD* = .75). **Conclusion:** Based on findings from a survey of staff working at Latino-serving organizations, this study highlights the lack of support and resources for Latino immigrants, in particular those related to mental health and substance use. Programs and interventions are needed to improve service delivery in Latino immigrant communities.

Keywords

access to care, syndemic, Latino populations, immigrant health, organization

Background

Nationally, substance use disorders, human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS), domestic violence (DV), and mental health complaints disproportionately affect Latinos (Gonzalez-Guarda et al., 2011). These trends hold true in Philadelphia, where since the 1960s, nonprofits have worked to strengthen the Latino community (Ceiba, 2019). However, compared to other Philadelphia racial and ethnic groups, Latinos have the highest rates of new HIV diagnoses and reported mental health diagnoses and the second highest rates of binge drinking and opioid-related mortality (Philadelphia Department of Public Health [PDPH], 2017a).

In 2018, 15.2% of Philadelphia residents identified as Latinos—a 43.3% increase since 2000—and, of them, one in five is foreign-born (U.S. Census Bureau, 2010, 2018). These immigrants are highly diverse: 58.4% originate from Puerto Rico, 14.7% from the Dominican Republic, 7.9% from Mexico, and 19.1% from other countries. North and South Philadelphia concentrate the city's largest population of Latinos. The North community has a larger proportion of Latinos, mostly Puerto Ricans, including thousands displaced by Hurricane Maria (Vargas, 2018). The Latino community in the South is smaller, fast-growing, and mostly Mexican (U.S. Census Bureau, 2015).

The "SAVA and Mental Health" or SAVAME syndemic refers to four conditions facing the Latino community: substance abuse, violence victimization, HIV/AIDS, and mental health (Gonzalez-Guarda et al., 2011). A syndemic perspective recognizes that these co-occurring conditions influence each other and tend to cluster due to socioenvironmental inequities and shared risk factors. Syndemic theory also calls for integrated interventions to address these interrelated conditions (Gonzalez-Guarda, 2009; Singer et al., 2017). The disproportionate burden of HIV, mental health, binge drinking, and opioid-related mortality on Philadelphia Latinos suggests the

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influence of the SAVAME syndemic in the city (PDPH, 2017a). When looking at individual syndemic conditions, Philadelphia Latinos have a new HIV diagnosis rate of 49 per 100,000 and an opioid-related mortality rate of 43.7 per 100,000 (PDPH, 2017a). Of adult Philadelphia Latinos, 29.6% report mental health diagnoses and 22.1% report binge drinking (PDPH, 2017a). While data exist about the influence of specific conditions, such as HIV or opioid use, we are only aware of one study exploring the SAVAME syndemic among the Latino community in Philadelphia. This study with 464 Latino men who have sex with men found that heavy drinking was significantly associated with number of casual male partners. Results from this study also showed that the combination of two or more syndemic factors, such as heavy drinking, homophobic discrimination, and homelessness, was significantly associated with sexual risk-taking among Latino men who have sex with men in Philadelphia (Martinez et al., 2020). Socioenvironmental factors including limited access to culturally and linguistically appropriate health or social services drive the toll of the SAVAME syndemic on Latino immigrants (Gonzalez-Guarda et al., 2011). Immigration status, limited English proficiency, discrimination, and financial constraints all create barriers to services (Derose et al., 2007; Ransford et al., 2011). These factors affect a large number of Philadelphia Latinos: 39.2% of Philadelphia Latinos live in poverty, the highest rate of all racial and ethnic groups (PDPH, 2017a). In 2014, approximately 50,000 Philadelphia immigrants were undocumented, and in 2016, across the greater Philadelphia metropolitan region, there were an estimated 4,700 Deferred Action for Childhood Arrival recipients (Pew Charitable Trusts, 2018). Fear of deportation in a changing policy climate and recent changes to the "public charge" rule for green cards and visa extensions also limit access to health care services (Holder, 2019; Martinez et al., 2015).

According to access theory, access is defined as the degree of fit between the patient and the health care system and is a broad construct encompassing multiple domains (McLaughlin & Wyszewiansky, 2002; Penchansky & Thomas, 1981). Accessibility refers to location and ease of travel to services (Penchansky & Thomas, 1981). Availability assesses quantity of services with respect to the size of a population (Penchansky & Thomas, 1981). Adequacy refers to services' linguistic or cultural appropriateness, hours corresponding with patient schedules, affordability, and accommodation (Penchansky & Thomas, 1981). Quality refers to service efficaciousness, effectiveness, and efficiency per the latest professional guidelines and client needs (Morrissey et al., 1997).

Purpose

This study examined Latino immigrant access to SAVAME-related services in Philadelphia, as perceived by providers working at Latino-serving organizations. Provider characterization of their organizations was compared across SAVAME syndemic factors (e.g. HIV/AIDS, substance use), demographic focus (i.e., degree to which Latinos represented a priority population for the organization), and syndemic approach (i.e., whether organizations co-screened for two or more syndemic factors). Provider perceptions of citywide access were explored by SAVAME factor, access domain (i.e., accessibility, availability, adequacy, and quality), and organization syndemic focus area. Whereas previous studies have characterized one type of service system, such as HIV providers (Kwait et al., 2001) or mental health providers (Morrissey et al., 1997; Semansky et al., 2009), this study is one of the first to look across sectors related to the SAVAME syndemic for Latino immigrant clients.

Method

Survey and Roster Development

Latino-serving Philadelphia organizations ($N = 43$) were identified through a review of existing resource directories and input from six key informants who worked with Philadelphia Latino immigrants. Inclusion criteria required organizations to (1) provide services to adult Latino immigrants, (2) provide services related to one or more SAVAME factor or specific immigrant needs (e.g. legal, immigration, education, or advocacy support), (3) be located in specified Philadelphia zip codes, and (4) provide Spanish-language services. For this study, the term "Latino immigrants" was used to refer to both immigrants to the United States from other countries and individuals from Puerto Rico due to some similarities in health conditions, behaviors, and sociocultural factors associated with migrating to the U.S. mainland. The survey was pilot tested by partners with local nonprofit experience and refined based on their feedback. Items were created based on access theory (McLaughlin & Wyszewiansky, 2002; Penchansky & Thomas, 1981) and previous studies of health care access (Morrissey et al., 1997; Semansky et al., 2009).

Survey Administration

Between October 2018 and February 2019, researchers contacted organizations by phone and email to identify a staff member who could complete the survey on behalf of the organization. During the outreach process, researchers asked to speak with staff members who were familiar with the organization's services available for Latino immigrants and their organization's collaborations with other organizations. Depending on the size and structure of the organization, this could include a supervisor, director, or service provider. Organizational representatives who agreed to participate were emailed a link to complete a 30–45 min online cross-sectional survey and were offered a US$15 gift card incentive upon survey completion. To improve response rates, organizations that had not yet participated in the survey toward the end of the recruitment period were offered a US$5 pre-incentive, and a subsequent US$10 incentive after survey completion. Participants provided verbal consent by clicking to the next page after presentation of the informed consent. Drexel University Institutional Review Board (IRB) #3 approved study

Table 1. Characteristics of Latino-Serving Organizations in Philadelphia, 2019.

Organization Characteristics	All[a] (%)	Substance Use[b] (%)	HIV/AIDS (%)	Domestic Violence (%)	Mental Health[b] (%)	Other[b,c] (%)
Type of organization	$N = 31$	$N = 9$	$N = 6$	$N = 9$	$N = 10$	$N = 11$
Nonprofit (general) or **c**ommunity-based Organization	27 (87.1)	8 (88.9)	5 (83.3)	9 (100.0)	9 (90.)	9 (81.8)
Health care organization	8 (25.8)	5 (55.6)	4 (66.7)	2 (22.2)	3 (30.0)	6 (54.5)
Religious and/or spiritual organization	4 (12.9)	1 (11.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Legal office/legal services	4 (12.9)	0 (0.0)	0 (0.0)	2 (22.2)	0 (0.0)	1 (9.1)
Educational institution	2 (6.5)	1 (11.1)	0 (0.0)	0 (0.0)	1 (10.0)	1 (9.1)
Government entity	2 (6.5)	2 (22.2)	1 (16.7)	1 (11.1)	1 (10.0)	1 (9.1)
Other social services	4 (12.9)	1 (11.1)	2 (33.3)	1 (11.1)	1 (10.0)	3 (27.3)
Primary population served						
Latino immigrants *are the* primary population	9 (29.0)	3 (33.3)	2 (33.3)	2 (22.2)	3 (30.0)	3 (27.3)
Latino immigrants are *one of* primary populations	19 (61.3)	5 (55.6)	4 (66.7)	7 (77.8)	6 (60.0)	7 (63.6)
Latino immigrants served, but *not* primary population	3 (9.7)	1 (11.1)	0 (0.0)	0 (0.0)	1 (10.0)	1 (9.1)
% of clients served who are Latinos						
0–25	2 (6.5)	1 (11.1)	0 (0.0)	0 (0.0)	1 (11.1)	1 (11.1)
26–50	9 (31.0)	2 (22.2)	2 (33.3)	3 (33.3)	2 (22.2)	2 (22.2)
51–75	4 (13.8)	1 (11.1)	0 (0.0)	1 (11.1)	2 (22.2)	1 (11.1)
76–100	14 (48.3)	5 (55.6)	4 (66.7)	4 (44.4)	4 (44.4)	5 (55.6)
% of Latinos who are immigrants						
0–25	6 (21.4)	3 (37.5)	3 (50.0)	1 (11.1)	0 (0.0)	4 (36.4)
26–50	7 (25.0)	1 (12.5)	0 (0.0)	1 (11.1)	3 (30.0)	1 (9.1)
51–75	4 (14.3)	2 (25.0)	2 (33.3)	3 (33.3)	3 (30.0)	3 (27.3)
76–100	11 (39.3)	2 (25.0)	1 (16.7)	4 (44.4)	3 (30.0)	3 (27.3)
Organization location						
North Philadelphia	18 (58.1)	6 (66.7)	4 (66.7)	4 (44.4)	5 (50.0)	5 (45.5)
South/Center Philadelphia	13 (41.9)	3 (33.3)	2 (33.3)	5 (55.6)	5 (50.0)	6 (54.5)
Types of services provided						
Substance use	9 (29.0)	—	5 (83.3)	4 (44.4)	4 (40.0)	6 (54.5)
HIV/AIDS	6 (19.4)	5 (55.6)	—	3 (33.3)	1 (10.0)	6 (54.5)
Domestic violence	9 (29.0)	4 (44.4)	3 (50.0)	—	4 (40.0)	5 (45.5)
Mental health	10 (32.3)	4 (44.4)	1 (16.7)	4 (44.4)	—	4 (36.4)
Other health services	11 (35.5)	6 (66.7)	6 (100.0)	5 (55.6)	4 (40.0)	—
Other social/supportive services	18 (58.1)	6 (66.7)	3 (50.0)	5 (55.6)	5 (50.0)	6 (54.5)
Immigration services, legal services, or advocacy	12 (28.7)	1 (11.1)	2 (33.3)	5 (55.6)	3 (30.0)	4 (36.4)
Number of SAVAME syndemic conditions screened for						
One	16 (51.6)	0 (0.0)	0 (0.0)	2 (22.2)	3 (30.0)	3 (27.3)
Two	2 (6.5)	1 (11.1)	0 (0.0)	1 (11.1)	1 (10.0)	1 (9.1)
Three	7 (22.6)	4 (44.4)	1 (16.7)	3 (33.3)	4 (40.0)	2 (18.2)
Four	6 (19.4)	4 (44.4)	5 (83.3)	3 (33.3)	2 (20.0)	5 (45.5)

Note. $N = 31$, SAVAME = substance abuse, violence victimization, HIV/AIDS, and mental health.
[a] Organizations may provide care for more than one SAVAME condition. [b] Percentages were calculated with the valid percentage. Missing data ranges from 1 to 2.
[c] Other refers to the provision of other health services for conditions outside of the SAVAME syndemic.

documents and procedures and waived documentation of verbal consent (IRB ID: 1804006208).

Measures

Access indicators. The survey included indicators pertaining to language services, costs to clients, hours, and waitlists. The *language services* indicator could range from zero to four (0 = no language services, 1 = phone-based translation, 2 = on-site translation, 3 = bilingual staff, and 4 = bicultural staff—referring to both Anglo and Latino cultures, although there are many subcultures reflected among different Latin American populations), based on the "highest" level of services available. The *Spanish-language written materials* subscore ranged from zero to three (0 = no Spanish-language written materials; 1 = some administrative materials available in Spanish, including consent, complaint, Health Insurance Portability and Accountability Act, or intake forms; 2 = some direct service materials available in Spanish, including website, educational materials, and descriptions of services or how to use services; and 3 =

Table 2. Access Indicators and Organizational Access Ratings ($N = 31$).

Access Indicators	*n* (%)
Language options [a]	
Bicultural staff	28 (90.3)
Bilingual staff	31 (100.0)
On-site translation	11 (35.5)
Phone-based translation	11 (35.5)
Spanish-language written materials available [a]	
Direct service materials	28 (90.3)
Administrative materials	27 (87.1)
Service cost	
All service free/low cost	22 (71.0)
Some services free/low cost or all services sliding fee scale	7 (22.6)
No services free/low cost or unknown/prefer not to answer	2 (6.5)
Service Hours [a]	
Weekdays, business hours only	31 (100.0)
Also some evening hours	20 (64.5)
Also some weekend hours	17 (54.8)
Waitlist [b]	
Yes, for most services	2 (6.7)
Yes, for some services	9 (30.0)
No or very rarely	19 (63.3)
Average length of waitlist [c]	
1 day–1 week	1 (12.5)
2–4 weeks	6 (75.0)
1 month or longer	1 (12.5)
Agreement that to meet Latino immigrant needs, respondents' organizations' services should be [d]	
More affordable [e]	8 (28.6)
In a more easily accessible location	10 (32.3)
Offered across a wider range of days and time [f]	14 (46.7)
More consistent with Latino culture, language, and values	9 (29.0)
Integration of services across syndemic areas [g]	
Good	6 (20.7)
Fair	11 (37.9)
Poor	12 (41.4)

[a]Respondents could select more than one answer, percentages may not add to 100. [b]n = 30. [c]Percentage was calculated for organizations who did have a waitlist and reported length of their waitlist (n = 8). [d]Percentage who reported "somewhat" or "completely" agree versus "somewhat" or "completely" disagree. [e]n = 28. [f]n = 30. [g]n = 29.

both some administrative and some direct service materials). The *service cost for clients* indicator ranged from zero to three (0 = no free or sliding fee scale services, 1 = some services had a sliding fee scale, 2 = some services were free or low cost or all services had a sliding fee scale, and 3 = all services were free or low cost). The *organization hours* subscore ranged from one to three (1 = weekdays during standard business hours, 2 = weekdays plus some evenings *or* some weekend hours, and 3 = weekdays plus some evenings *and* some weekends). The *waitlist* indicators ranged from zero to two (0 = organization had a waitlist for most services, had a longer than 1-month waitlist, or preferred not to answer; 1 = waitlists for some services or a 2- to 4-week waitlist; 2 = no waitlist or a waitlist of 1 day–1 week). Because the access indicator subscores had different possible minimum and maximum values, a *z*-score was calculated for each subscale by using the standard formula $z = (x - \mu)/\sigma$, where x is the raw score, μ is the mean, and σ is the standard deviation. The *z*-scores were summed to create a final score for each organization, with higher scores reflecting greater access. To be included in the overall access indicators score, organizations had to have values for at least four of the five subscores.

Organizational access ratings. The survey also asked respondents to rate their own organization along several indicators of adequacy and accessibility. Questions asked the extent to which respondents agreed that "to truly meet Latino immigrants needs," their organization's services should be (a) more affordable, (b) in a more easily accessible location, (c) offered on a more extended schedule, and/or (d) more consistent with Latino culture. The wording was chosen to emphasize that the question referred to the unique needs that Latino immigrants may experience, including limited English proficiency, lack of insurance, and cultural preferences. These factors have been recognized in the literature as influencing immigrant access to quality health services (Derose et al., 2007; Ransford et al., 2011). The question about "consistency with Latino culture" was similarly chosen to encompass the multiple target

populations served by respondents as well as language preference, sensitivity to immigration status, and other cultural values and preferences that could show up either in individual provider–client interactions or in the organizations' processes. Research has demonstrated that health care services are more effective when culturally adapted to specific groups and when they incorporate cultural context and values (Healey et al., 2017). All items had four Likert-type response options ranging from one (*completely agree*) to four (*completely disagree*). An overall organizational rating was calculated by taking the mean of all items, with possible scores ranging from one (lowest access) to four (highest access).

Citywide access. The last portion of the survey asked respondents to assess the overall Philadelphia Latino immigrant service system across the four syndemic areas (substance use, HIV/AIDS, DV, and mental health) within four domains of access (accessibility, availability, adequacy, and quality). All items had five response options from four (*excellent*) through zero (*poor*). Responses were combined into four separate syndemic access measures (substance use, HIV/AIDS, DV, and mental health) by calculating the mean of responses across the four access domains for each syndemic factor. Responses were also combined into four separate domain access scales (Accessibility, Availability, Adequacy, and Quality) by calculating the mean of responses for all four syndemic factors combined by access domain. Respondents with more than one item missing from any of the scales were excluded. One additional item assessed respondent perceptions of level of integration across services in all four SAVAME syndemic areas, with the same five response options: four (*excellent*) through zero (*poor*). Respondents were invited to provide free text comments on the availability, adequacy, accessibility, quality, and integration of services for Latino immigrants in the City of Philadelphia (e.g., "Do you have any comments about the quality of services for Latino immigrants?").

Data Analysis

Data were analyzed using the Statistical Package for the Social Sciences (Version 24, IBM Corp., Armonk, NY, 2016). Responses from one organization with two respondents were merged following discussion and consensus decisions by the research team. Although the recoding mechanism varied by type of question asked, post hoc data decisions were made by the research team to optimize understanding of the organization. Descriptive statistics (percentage, means, and standard deviations) were run on all variables to characterize the organizations participating in the study. To assess variations in access indicators and organizational access ratings by organization type, location, syndemic orientation, and primary client ethnicity, access indicators and organizational access ratings were dichotomized at the median value into high and low categories. χ^2 tests were run to determine whether variations in access indicators and organizational access ratings were statistically significant at the $p < .05$ level. To understand whether respondent perceptions of citywide access varied based on their familiarity with services provided in that area, χ^2 tests were also run to examine citywide access ratings by SAVAME area and by whether the organization provided services related to the syndemic factors or not. Qualitative data from five open-ended survey questions asking for any additional comments related to the four domains of access and the overall coordination of services across the city were organized into matrices that were used to develop themes.

Results

Of the total sample ($N = 43$), 31 organizations responded, for a 72.1% response rate. Respondents ranged from 24 to 65 years and identified predominantly as female ($n = 22$), of Hispanic or Latino origin ($n = 16$), and as U.S. born ($n = 23$). On average, they had worked at their organization for 5.3 years. Twelve respondents (38.7%) spent over half their time on direct service activities. Respondent position titles were split relatively evenly between directors ($n = 9$) and direct service providers including counselors, case managers, advocates, and paralegals ($n = 8$). Respondents were also coordinators ($n = 5$) and senior leadership ($n = 5$). Almost three quarters of respondents spoke Spanish fluently ($n = 23$).

Over 90% reported focusing on Latino immigrants as their primary or one of their target populations. Most organizations provided social services outside the health-related SAVAME conditions ($n = 18$); close to a third of organizations provided mental health ($n = 10$), DV ($n = 9$), and substance use services ($n = 9$); and slightly fewer provided HIV services ($n = 6$). Despite the synergistic nature of these syndemic factors, over 50% of organizations screened their clients for only one syndemic factor. Less than 20% co-screened clients for all four SAVAME conditions ($n = 6$; Table 1).

Access indicators. Organizations reported relatively high levels of adequacy, seen through indicators assessing language options and cost (Table 2). All organizations had bilingual staff, and over 90% of organizations had bicultural staff, defined in this study as staff with backgrounds in both Anglo and Latino cultures. Most organizations also had written materials available in Spanish, with 87.1% offering administrative forms and 90.3% offering direct service materials such as educational pamphlets or information on how to access services. Over 70% provided all services for free or low cost. The accessibility of organizations, based on an indicator measuring service hours, was mixed with 64.5% offering some evening hours and 54.8% offering some weekend hours. A quarter of organizations ($n = 8$) offered services exclusively during weekdays and business hours. On the other hand, close to half of the organizations (45.2%) also saw clients during some evening hours and on weekends (combined). Availability was also mixed; one in three organizations (36.7%) had a waitlist for some or most services, and three quarters of organizations with a waitlist reported a 2- to 4-week wait. These waitlist levels are unacceptable and call

Table 3. Philadelphia Citywide Access Ratings.

Citywide Access Ratings	All Organizations Mean (*SD*)	Organizations Offering Services for This Syndemic Factor Mean (*SD*)	Organizations Not Offering Services for This Syndemic Factor Mean (*SD*)	*p* Value [a]
Substance use				
Availability	1.04 (0.76)	—	—	—
Adequacy	0.92 (0.76)	—	—	—
Accessibility	1.56 (1.25)	—	—	—
Quality	0.95 (0.79)	—	—	—
Overall access	1.11 (0.74)	1.44 (.53)	0.93 (.79)	.093
HIV/AIDS				
Availability	1.89 (0.99)	—	—	—
Adequacy	1.78 (0.94)	—	—	—
Accessibility	1.89 (1.04)	—	—	—
Quality	2.18 (0.95)	—	—	—
Overall access	1.94 (0.83)	2.15 (.91)	1.85 (.82)	.522
Domestic violence				
Availability	1.50 (1.00)	—	—	—
Adequacy	1.34 (1.04)	—	—	—
Accessibility	1.46 (1.14)	—	—	—
Quality	1.56 (1.12)	—	—	—
Overall access	1.49 (0.97)	2.06 (0.95)	1.26 (0.90)	.045*
Mental health				
Availability	1.27 (1.23)	—	—	—
Adequacy	1.23 (1.10)	—	—	—
Accessibility	1.59 (1.21)	—	—	—
Quality	1.39 (1.03)	—	—	—
Overall access	1.37 (0.95)	1.68 (.90)	1.22 (.96)	.224
By access domain				
Overall availability	1.41 (0.81)	—	—	—
Overall adequacy	1.24 (0.75)	—	—	—
Overall accessibility	1.66 (1.03)	—	—	—
Overall quality	1.44 (0.79)	—	—	—

Note. $N = 31$.
[a] *p* Values based on independent samples *t* test.
*Indicates significance at $p < .05$.

for further research to understand which services are subjected to waitlists and whether these include urgent needs. Delayed care for urgent health issues may have negative impacts on the health of Latinos. Comparing the dichotomized access indicators variable did not yield any statistically significant variation by organizational indicators, if Latinos were the primary clients, number of syndemic factors addressed, location or type of organization. However, organizations providing DV services were significantly more likely to have below median access scores (88.9%) than non-DV service providers (45.5%, $\chi^2 = 4.95$, $p < .05$).

Organizational access ratings. Over a quarter of respondents believed their organizations would need to change their services to truly meet Latino immigrant needs across the domains of adequacy and accessibility. Of all scale items, the highest fraction of respondents (46.7%) endorsed that services must be offered across a wider range of days and times to truly meet Latino immigrant needs. The need to have a more accessible location (32.3%), to have a consistency with Latino culture (29.0%), and to being more affordable (28.6%) was also recognized by about a third of respondents.

The resulting overall organizational access rating had high internal consistency (*Cronbach's* $\alpha = .88$). Organizations rated their own access at an average of 2.9 of a possible four (with higher values indicating greater access). Dichotomous organizational access (below or at the median vs. above the median) did not vary significantly by access indicators, if Latinos were the primary clients, number of syndemic factors addressed, and location or type of organization. However, organizations providing mental health services were significantly more likely to have organizational access levels below the median (60.0%) than nonmental health service providers (19.0%, $\chi^2 = 5.20$, $p < .05$).

Citywide access. Respondents reported relatively low levels of service integration across syndemic areas. Most respondents (41.4%) reported poor integration, and no respondents reported *excellent* or *very good* levels of service integration (Table 2). Regardless of division by syndemic condition or access

Table 4. Access by Measure and Type of Organization.

Type of Organization	Access Indicators Mean (*SD*)	Organizational Access Ratings Mean (*SD*)	Citywide Access Mean (*SD*)
Substance use	.80 (1.83)	3.20 (.81)	1.11 (.74)
HIV/AIDS	.89 (1.68)	3.33 (.34)	1.94 (.83)
Domestic violence	−.29 (1.00)	3.06 (.73)	1.49 (.97)
Mental health	−.36 (1.75)	2.52 (.99)	1.37 (.95)

Note. $N = 31$.

domain, respondents reported relatively low levels of systemwide access. Possible scores ranged from a low of zero to a high of four (with high scores indicating greater access), however, average citywide access scores by syndemic condition (e.g., substance use, HIV/AIDS, DV, mental health) ranged from 1.11 (for substance use) to 1.94 (for HIV/AIDS). Scores grouped by access domain (e.g., availability, adequacy, accessibility, quality) ranged from 1.24 (for adequacy) to 1.66 (for accessibility). No SAVAME area or domain access score was significantly different from the others. Respondents reported HIV/AIDS services as having the highest access, followed by DV, mental health, and substance use services (Table 3).

Citywide access scores by syndemic area did not differ significantly based on whether the respondents' organization provided services in each service area, with one exception. Organizations that provided DV services had a mean DV access score of 2.06, compared to the mean score of 1.26 among organizations that did not provide DV services ($t = -2.1$, $df = 26$, $p < .05$). Although the difference did not rise to the level of statistical significance, respondents who provided services related to a syndemic factor did report a nonsignificantly higher level of citywide access for services related to that factor, when compared with organizations who did not provide services for that syndemic factor. Table 4 shows average scores on the access scale, organizational access ratings and ratings of citywide access by type of organization. We found no statistically significant differences in average scores among organizations providing substance use, HIV/AIDS, DV, and mental health services (Table 4).

Qualitative analysis of the 15 responses to the open-ended questions provided insight into areas of need and barriers to access quality services among Latino immigrants. Four main themes emerged:

(a) The need for additional linguistically and culturally congruent services across service areas, particularly in mental health and DV. One respondent reported, "there are basically no [DV] services for [limited English proficiency] Latinos," while another added that "many non Latinx employees also need better cultural humility for better interactions with clients." Others said, "mental health services are all around hard to obtain . . . this wait time is even longer if you do not speak English" and commented on "A lack of knowledge on how to treat immigrants for mental health."

(b) Insufficient capacity to meet demand. Study participants emphasized the need for more funding, resources, and capacity building for service providers. One participant commented on the "poor adequacy due to lack of funding and resources" and observed that "the places that exist with excellent services don't have capacity to respond to the demand."

(c) The importance of addressing social determinants of health. Comments stressed the difference in access for undocumented immigrants, "because of legal documentation, insurance, etc." and emphasized that social determinants of health impact access for Latino immigrants (e.g., income, housing, Americans with Disabilities Act accessibility). For example, respondents noted that "availability depends on . . . immigration status, health insurance, [. . .] access, because people need to prioritize work for survival . . . ." Others noted "trauma in immigrant communities is different than in regular communities."

(d) Beliefs as barriers, particularly for mental health. A study participant noted the lack of "awareness of [the] need of mental health [for example]" and "the myth [that] only crazy people need [it]."

Discussion

This study explored access to SAVAME-related services among Latino immigrants in Philadelphia, as perceived by providers working at Latino-serving organizations. Given the focus on Latino immigrants, an assessment of adequacy—the extent to which services meet Latino immigrant needs and wants—was fundamental. While specific access indicators suggest that many organizations address linguistic and cultural barriers at some level, organizational access and citywide access ratings by providers indicate that there is much room to improve. Compared to the other three access domains (i.e., availability, accessibility, quality), adequacy of SAVAME services ranked lowest. Nearly half of providers reported that services should be offered across a wider range of days and times. Despite potential desirability bias and possible concerns about positively representing their organization, 29.0% of respondents said that their organization should be more consistent with Latino culture, language, and values to truly meet Latino immigrant needs. Qualitative comments strongly underscore the need for equitable language access, though they acknowledge other necessary elements to respond to Latino immigrant needs. Responses such as "many non-Latinx employees also need better cultural humility for better interactions with clients" and concern about a "lack of knowledge around how to treat immigrants for mental health" also demonstrate the need for improvements in provider training and cultural competency.

Initially, the research team hypothesized that despite the prevalence of bilingual service providers, there was a need for bicultural service providers who could better relate to Latino immigrants. Although 90.0% of participants reported that their organizations had at least one bicultural staff member, comments left on the survey indicate concern about the level of culturally congruent services, especially for potentially sensitive conditions like those of the SAVAME syndemic. Respondents' comments indicated the importance of language access, location, and hour concerns but also highlighted important cultural elements of access to care. These included the differing ways trauma may impact and present for immigrants, stigma surrounding certain syndemic factors, such as poor mental health, and care options that incorporate a variety of medical, religious, and mental health perspectives. Concerns about language options and provider communication difficulties are supported in the literature, particularly for immigrant populations (Ku & Matani, 2001; Ransford et al., 2011).

While adequacy plays a central role in health care delivery for Latino immigrants, availability and accessibility also must be considered. Respondents rated the accessibility of SAVAME services highest among access domains; however, a mean score of 1.66 of a possible four points indicates significant room for improvement. When considering availability via waitlist indicators, over a third of organizations were described as having a waitlist, and seven organizations reportedly had waitlists of over a week. These figures demonstrate capacity limitations and the need for service expansion. Especially for time-sensitive conditions, this delay in care may significantly impact the health of Latino communities. As a baseline study, this survey did not account for specific criteria that programs may put in place due to funding requirements or organizational priorities about which clients are eligible for services. Criteria such as insurance status, poverty level, documentation, and paperwork may mean that some Latino immigrants experience longer delays or are unable to receive services and suggest that actual delays in the ability to access services may be longer than these results suggest.

We hypothesized that there would be differences in access between organizations in North Philadelphia, an area with a more established Latino population, compared to South Philadelphia, where Latinos are a newer population and more likely to be foreign-born. However, the data suggest that perceptions of limited access are pervasive in both areas and point to the need for redesigning services to better meet Latino immigrants' needs across the city.

In addition to providing insights into access domains to improve, this study uncovered that a syndemic orientation in the provision of services is not frequent. One tenet of syndemic theory is that, given mutual interactions and shared determinants across syndemic conditions, prevention and treatment of these interrelated issues should be integrated (Centers for Disease Control and Prevention, 2009). Our findings suggest that co-screening clients for several of the SAVAME conditions is not the norm; only 19.2% of organizations ($n = 6$) co-screened for all four syndemic factors while over half of organizations only screened for one condition. This variation demonstrates that the system can conduct screenings across SAVAME syndemic factors and suggests that the system can further its ability to holistically identify and address these interrelated health conditions. Provider education may help foster increased understanding of the importance of adopting a syndemic orientation for improved client care, as would changes in funding structures aimed at promoting syndemic approaches and organizational collaborations to better respond to the SAVAME syndemic. The nearly 80.0% of respondents reporting *fair* or *poor* integration of services across SAVAME conditions in Philadelphia suggests that even for organizations that screen for multiple syndemic conditions, a higher level of coordination across services areas is needed.

When looking across the four SAVAME conditions, mental health organizations were significantly more likely to perceive their access as below the median access level reported by all organizations than were organizations that did not provide mental health services. This suggests that mental health organizations in Philadelphia need additional attention and strengthening to meet the needs of Latino immigrants, which is consistent with conversations between the authors and community partners and qualitative comments on open-ended survey questions. As one respondent describes, "... the places that exist with excellent services don't have capacity to respond to the demand."

While examining citywide access scores, no respondents assessed access as *very good* or *excellent*. Although respondents whose organizations provide services related to a syndemic factor tended to provide slightly higher access ratings for that factor on average, even they indicated large room for improvement in the system. Research to characterize resource access for Latino immigrants across all four SAVAME conditions in Philadelphia is important and timely, especially given recent developments at the local and national level. At the national level, policy changes in immigration enforcement, family separations, and asylum processes since 2016 have potential mental health impacts of stress and trauma on Latino immigrants in the United States (Sacchetti et al., 2019; U.S. House of Representatives, 2019). Recent trends in immigration enforcement, anti-immigrant climate, and xenophobic rhetoric have resulted in high levels of fear, uncertainty, and discrimination for Latinos in the United States (McGinty et al., 2020; Radford & Noe-Bustamante, 2019). These events have ramifications in Philadelphia, with families seeking asylum in local churches (Gammage, 2018) and protesting U.S. Immigration and Customs Enforcement activities (Gammage & Oppenheim, 2019; Oppenheim, 2019). Recent events related to police brutality and violence against people of color and the COVID-19 pandemic represent additional stressors that will likely exacerbate the SAVAME syndemic among Latinos and other racial and ethnic minorities in the United States (Koran, 2020; Lopez et al., 2020). Some evidence suggests that COVID-19 is resulting in reduced access to HIV treatment (Stover et al., 2020), increases in DV (Taub, 2020), and exacerbation of mental health and substance use problems (Monteiro et al., 2020;

Panchal et al., 2020). Conversely, disparities in SAVAME factors are likely to increase susceptibility and vulnerability to COVID-19 among Latinos (Substance Abuse and Mental Health Services Administration, 2020**).**

In Philadelphia, these recent traumas coexist with ongoing gun violence and substance use epidemics. Although gun violence happens throughout the city, there are concentrated areas of gun violence particularly in North Philadelphia in areas with a high density of Latino immigrants (City of Philadelphia, 2019). Simultaneously, the PDPH has cautioned about an uptick in hepatitis C cases associated with injection drug use (PDPH, 2017b). This upswing could predicate an increase in new HIV cases (Schaefer, 2019), indicating the need to pay attention to interrelated SAVAME conditions. These national and local events highlight the importance of using a syndemic perspective and focusing on Latino immigrant resource access to advance public health.

Limitations

Several limitations must be noted. Accurate representation of Philadelphia Latino immigrant–serving organizations depends both on successful identification of all relevant organizations and on the degree to which respondent knowledge and attitudes reflect those of their organization. Although the roster was vetted by key informants to limit the exclusion of important providers, inclusion criteria limited Philadelphia organizations by zip code. This means that organizations not located in or near zip codes with a high density of Latino immigrants may have been excluded. Similarly, crisis services provided at hospitals and private doctor's offices were also excluded. All data were provided via self-report, with no independent validation of responses. Respondents may have been susceptible to social desirability bias or other pressures to positively represent their organization. Since this exploratory study characterized syndemic resources broadly, questions did not distinguish immigration status or country of origin. Since legal status has implications for which services an individual qualifies for, access likely looks different for undocumented immigrants. Finally, it is important to note that the findings are not intended to be generalizable to other geographic areas or populations.

Conclusion

By using a syndemic lens and considering multiple access domains, this study offers a new perspective on access to SAVAME-related services in a large urban setting and suggests specific areas for improvement. Baseline findings indicate Philadelphia's need to bolster culturally and linguistically appropriate services and to incorporate a syndemic perspective on client care to reduce the disproportionate impact of SAVAME. These findings may be used by organizations to consider service redesign and interorganizational collaboration and may serve to evaluate future interventions promoting resource access among Philadelphia Latino immigrants. Future work should incorporate community perspectives and investigate which factors drive low adequacy ratings.

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