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Cultural Implications for Public Health Policy for Pregnant Hispanic Adolescents

Cultural Implications for Public Health Policy for Pregnant Hispanic Adolescents

ABSTRACT: This paper examines factors associated with pregnancy among first and second generation Hispanic youth. Birth rates of Hispanic teens are high in both groups although second generation teens have rates of nonmarital births similar to other teens in the United States. Regardless of generational status, Hispanic youth have religious, language, and cultural values that reflect the norms of large families and the value of family ties. The public health system could be used more effectively if there were sensitivity to the importance of cultural norms of Hispanic families, specifically family decision making. This paper explores these issues and provides some suggestions for accessible family planning and maternal health services.

Hispanics constitute the second largest minority group in the United States after African Americans. They represent 8% of the total U.S. population and are expected to become the largest minority group early in the next century. Besides being the fastest-growing minority, they are also the youngest, with a median age of 25.(1)

The estimated fertility rate for U.S. Hispanic women aged 15-44 years is 104.9 per 1,000 live births, 60% above the rate for non-Hispanic women. Mexican American women have the highest fertility rate of any Hispanic group. Their rate is 106.6 per 1,000 live births, compared to 86.6 per 1,000 live births for Puerto Rican women, 49.8 for Cuban American women, and 95.8 for women from Central and South America. Birth rates by age of mother show that the fertility rate of Hispanic women is higher than that of non-Hispanic women especially for teenagers and women age 40 and over. In 1991, 17% of all Hispanic births were to mothers under age 20. The fertility rate for Hispanic teens is 106.7 births per 1,000 women, ages 15-19, compared to 42.7 for nonHispanic teens.(2)

The purpose of this paper is to identify policy areas within the health delivery system that must be addressed to insure that medical services are culturally relevant to the health needs of first, second, and third generation Hispanic adolescents. As migratory patterns no longer are limited to the states that border Mexico and southern Florida, public health providers by considering these factors can enhance the acceptability of their services to this migrant and settling Hispanic population.

Migratory Patterns and Service Needs

As of 1990, more than 20.8 million people of Hispanic origin (about 8% of the U.S. population) were living in the United States.(3) Sixty-four percent of all U.S. Hispanics are of Mexican descent, and the vast majority of all Hispanics live in the southwestern states. About one-third of all Mexican Americans live in Texas, and one-half of all Mexican American immigrant women are 18 years of age and younger. Based on migration and immigration data, the primary health care service needs are in Texas, Arizona, California, Florida, Illinois, and New Mexico.(4) These states experienced an initial influx that is now expanding to many areas of the United States.

In 1989 in Texas, 19,830 births were to Hispanic patients 10-19 years of age, as compared to 16,946 Anglo teenagers and 10,401 black teenagers.(5) Thus, there are linkages between geographic characteristics and the growing needs among Hispanic women for health care, especially in the six states where their population density is highest. The health policies of these states through Medicaid and public hospitals determine available health services.(6) Since Hispanic women tend to have more children than do other Americans, they will experience a greater need for access to prenatal and postnatal care.(7)

Acculturation and Pregnancy

Although research on teenage pregnancy among Hispanics has received little attention, it appears that acculturation may be one factor that contributes to nonmarital pregnancies. Becerra and de Anda's(8) study of cultural differences among 43 English-speaking and 39 Spanish-speaking Mexican American teens who were pregnant and/or parenting demonstrates the impact of acculturation. Spanish-speaking Mexican American teens were less likely to be in school, more likely to be economically depressed, and more likely to be married. Almost half of 13- to 17-year-olds in the Spanish-speaking Mexican American cohort were married, compared to 23% of the Englishspeaking Mexican American sample. This difference was more dramatic in the 18- to 20-year-old age group. In this group, 85% of the Spanish-speaking Mexican American subjects and 62% of the English-speaking Mexican American subjects were married. The authors suggest that the cultural norm of marriage, particularly if the female becomes pregnant, is adhered to more strongly among less acculturated Mexican Americans.

The onset of sexual behavior may also be affected by the degree of acculturation. Among 202 15- to 19-year-old first generation Hispanic teens from the National Survey of Family Growth, 42% were sexually active. Mexican American teens had the lowest rate of sexual intercourse compared to other Hispanic groups. Sexual activity was positively related to not being in school, attending church infrequently, not living with both parents, and being from families with lower incomes. Less than half of all the Hispanic young women claimed to have received formal birth control information. Of this group, the sexually active teens received this information at an older age than did those who were not sexually active.(9) The authors suggest that there were positive associations between stability of family structure, the importance of religious affiliation, and avoidance of sexual activity.

Despite the fact that Mexican American teens have the lowest rate of early sexual intercourse, they also have the highest birth rate among Hispanic adolescents. Mexican American teens are most likely to become pregnant and least likely to terminate a pregnancy.(10) A study of 31,207 live birth and induced abortion certificates in New York City showed that in comparison to white teens, Mexican American teens had the lowest rate of abortions. The author suggests that despite the accessibility of abortion, cultural norms and racial and ethnic attitudes affect utilization.(11)

Acculturated Hispanic teens appear similar in behavioral characteristics to non-Hispanic teenagers who are engaging in risk-taking behaviors. Data from the High School and Beyond Panel Study of 13,061 female high school sophomores showed that 41% of blacks, 29% of Hispanics, and 23% of non-Hispanic whites were willing to consider non-marital childbearing. Across all three ethnic groups, willingness to consider non-marital births was positively related to risktaking behaviors, low socio-economic status, having a single parent, discipline problems in school, lack of future goals, and low self-esteem, especially among white and Hispanic teens.(10) A study of black and Puerto Rican adolescent mothers found that 39% had a repeat pregnancy within a year after the first delivery. Non-use of contraceptives, low educational goals, low reading scores, and traditional sex-role orientation in which positive emotional bonds were anticipated from mothering were factors associated with second pregnancies.(12) Hispanic teens in particular have been found to have greater and more positive expectations about how a baby would affect their lives than have teens from other ethnic groups.(13)

By contrast, a study of 12- to 19-year-old females in Mexico City found that adolescents who did not engage in sexual intercourse accepted traditional family norms, had open communication with their mothers about sexual matters, and expected to continue their education. Adolescents who were sexually active and used contraceptives were knowledgeable about them and had the positive support of their mothers and friends.(14)

Thus, family norms and the effects of acculturation should be considered when developing public health policy that addresses teenage pregnancy. Attitudes about pregnancy, contraception, and abortion are conditioned by cultural norms and should be acknowledged by service systems.(15) Across Hispanic groups, pregnancy may be culturally desired, especially among married women, even if they are teenagers. As such, public policy dilemmas include whether to recognize teen pregnancy and ensure a healthy outcome or attempt to reduce teen pregnancy among Hispanic teens, regardless of marital status.

Value of Children

The value of children among Hispanics has a profound effect on marriage, family planning and school retention. Mexican American families have traditionally desired large numbers of children.(16) Primary health care agencies accustomed to working with the values of the majority population may evaluate the Hispanic's larger family size as an artifact of a contraceptive failure. Sabagh(17) suggests that this assumption may be inappropriate. Instead, Hispanic fertility rates may reflect a positive value associated with larger family size rather than a result of unsuccessful family planning. The worth of children may override contemporary attitudes on family size. Health care providers should acknowledge this attitude and emphasize prenatal care attendance and compliance rather than encourage Hispanic women to have fewer children. Becerra and de Anda(8) suggest that a woman's perception of self as mother and wife is strong in the traditional Mexican American culture, especially among Spanish-speaking teens.(1)

Larger family size is highly correlated with termination of formal education and marriage, especially among first generation Hispanic teens. A study of pregnant Mexican American adolescents and their white and black peers found that Mexican American teens were more likely to be married at delivery/conception, to breastfeed their infants, and to come from larger families.(18) Both school dropout and marriage occurred before pregnancy, which suggests the value of these priorities for Mexican American teens. Nearly two-thirds (64%) of the Mexican American teens were born in Mexico, and almost half were in the United States less than two years. Setzer and Smith(19) found that Hispanic teens, especially married teens, were twice as likely to drop out of school following birth as were black adolescents. While 96% of married Hispanic teens dropped out of school, younger and single Hispanic teens chose to attend a school-based clinic.

Access to Health Services

The Monthly Vital Statistics Report of Final Natality Statistics(2) indicates that Hispanic mothers, especially Mexican Americans, usually receive care in the public sector and have fewer health care visits per year compared to white non-Hispanic mothers. Poverty, lack of health insurance, cultural norms and poor knowledge of English are some of the factors that contribute to lack of health care. Hispanics receive most health care from large public hospitals that have rotating staffs. In such settings, patients rarely experience continuity of health care.(20)

In addition, among those who have no insurance Hispanics are three times as likely as non-Hispanics to receive no prenatal care and twice as likely as nonHispanic whites to report using an emergency room as a source of medical care. In fact, on their first visit to contraceptive clinics 7 out of 10 Hispanic teens suspected a pregnancy. In contrast, 4 out of 10 black and 3 out of 10 non-Hispanic white teens suspected pregnancy on their first visit to contraceptive clinic.(21) One possibility for delayed entry into health care is that traditional cultural orientation encourages the use of home remedies first and nonmedically endorsed health providers such as lay midwives and curanderas. Home care or self-care may also be chosen because public health systems are unavailable or too cumbersome.

Another possibility may be the need of the Hispanic woman to obtain permission to receive health care, especially to practice contraception, from an authority source. This is especially true for women who were born in Mexico or who are recent immigrants to the United States (women who may not accept the value system of the dominant inhabitants).(9) Therefore, health policies that do not take into account such cultural values in marketing health care services will have a low rate of success among Hispanic groups.

Finally, it is important to understand how Hispanics evaluate medical services and how they perceive their health needs in relation to the available provider structure. Fatalism may play a role in avoiding health centers. In a review of the "birth cultures" of U.S. ethnic populations, Hahn and Muecke(16) found that among Mexican Americans, conception, pregnancy, birth, and child rearing were commonly understood within a broad framework of religious and cosmic principles. Understanding of health issues includes fatalism; "children come when God is willing," and "sometimes he takes them away."(16) "Moreover, as prayers and vows are important in the matters of health more generally, so they are important also in promotion of conception and in the prevention of problems during pregnancy and following birth."(16)

Within this framework, pregnancy and birth are believed to follow a natural course and are not regarded as inherently pathological. Moreover, when harm occurs, many Mexican Americans explicitly prefer the traditional assistance and healing practices of parteras or lay midwives rather than services provided by medical institutions. Furthermore, within medical settings, traditional Mexican American standards of modesty are severely compromised by pelvic exams and obstetrical care, particularly when performed by male practitioners. Since pregnancy is not regarded as a medical condition, prenatal care in medical settings has not been thought necessary or desirable. Preventive health services, therefore, may not be a priority for this group so that immunizations and birth control are not aggressively pursued.

Ellis(23) in his work on border states, describes this orientation to preventive care as a form of mysticism. This translates into the notion that in the early stages of illness, personal actions are largely irrelevant. Many diseases are left to progress to the most desperate stages before medical intervention is attempted. As a result, for many Hispanic women medical care is usually obtained for acute or emergency conditions instead of preventive care such as pregnancy prevention, maternity, and

well-baby visits.(2) The real benefits of prevention in terms of avoiding an unwanted pregnancy may never be addressed.

The Role of the Health Care Practitioner

At the outset, health practitioners should ascertain the Hispanic client's literacy level. Some Hispanics are bilingual; others speak only English or Spanish or a little of both. When Spanish is spoken, different idioms are used between different subgroups, making communication confusing.(20) However, providing culturally appropriate translated material is not effective if the patient cannot read. Low mandatory educational requirements and lack of educational opportunities in Mexico and Central America, along with a high prevalence of high school drop-out among Hispanic teens in some U.S. regions, increase illiteracy of this group. Providers need to realize that the inability to read is usually deliberately concealed. One way to deal with this problem is to use educational materials that depend on pictures or cultural examples to convey a message.(22)

An associated factor that negatively affects the use of preventive health care by Hispanics is the lack of culturally relevant clinical training for health practitioners. Benefits of culturally sensitive settings pay several types of dividends. First, being more sensitive to cultural mores of migrating and acculturated groups ultimately helps the provider to identify the psychological barriers in the public health system. Second, culturally sensitive settings will attract and retain both patients and staff. Thus, an important clinic responsibility would be to assess the language skills of the staff, specifically whether there is sufficient proficiency in Spanish to develop an initial relationship with the client. Another important responsibility is to assess whether there is available health literature in Spanish to help the less acculturated understand and use the health system appropriately.(20)

While Hispanics constitute 8% of the U.S. population, less than 5% of all U.S. physicians and students in medical schools are Hispanic. Barriers due to differences in culture and language could be reduced through the use of Hispanic health care workers who could encourage preventive care.(20)

Future Needs

Policy development for Hispanics, especially for adolescents, has not addressed specific cultural issues. Until the mid-1970s, pregnancy and legitimacy statistics were grouped into just two cohorts, white and nonwhite. The assignment of the Hispanic population to one or the other group was often made in an arbitrary fashion. Major adolescent analyses, including a Johns Hopkins survey that provides a key database on adolescent contraceptive use and clinic utilization, do not include coding for Hispanic origin.(24)

Padilla et al.(25) suggest that epidemiological studies on high-risk behaviors among Hispanics is only beginning to receive attention. One shortcoming of existing data is that there are questions about which baseline data to use for group comparison (e.g., U.S. population, a first generation population, or an unacculturated population). Additionally, the roles of culture, sex-role behaviors, religion, and class have not been fully explored. Although it has been reported in the literature that the prime factor affecting adolescent pregnancy is the use and non-use of contraception, level of acculturation as a factor has not been fully explored among Hispanic teens.(17,18)

Although a strong database is absent, there are clinical tools to effectively reach Hispanic women. Reproductive health programs are uniquely positioned to build rapport with patients based on cultural norms. When communicating with Hispanic patients, health care providers are often communicating either directly or indirectly with the patient's family. Most Hispanic families emphasize interdependence, affiliation, and cooperation. Thus, important decisions are made by the entire family.(20) For example, Bercerra and de Anda(8) indicate that Mexican American mothers were less likely than were the white respondents to live alone because their traditional cultural orientation is less accepting of living alone. Health care providers can also emphasize family togetherness and community resources that empower this population and can ultimately include health care services.

Public policy debate concerning teenage pregnancy centers on primary prevention (delaying onset of sexual activity) versus secondary prevention (increasing contraception among those who are sexually active).(26,27) Greater emphasis on secondary prevention would help teens born in Mexico who marry young and U.S.-born Hispanic teens to delay pregnancies. The potential reduction in teenage pregnancy must begin early in adolescence because of high fertility, marital status, and early onset of sexual activity.(28)

Health care providers must acknowledge generational, religious, and cultural norms among Hispanic teens. The uniqueness of this population must be translated into programs that specifically address not only the teen but also her entire cultural and family systems. Any educational and marketing techniques must therefore build on the strengths of Hispanic culture. Therefore, the following suggestions are offered:

1. Services to Hispanic teens need to be continuous. It is important to assign one person to be responsible for the care of the teen. Because of the need to coordinate many aspects of case management that can be confusing and overwhelming, a continuous management approach to patient care is appropriate.
2. Outreach to family means communication to both the family and the community. Clinic staff may need to provide in-home consultation and visit church and community organizations. While this is time consuming, it will develop the concept of the clinic as a "home" for health services.
3. Innovative strategies for family involvement must be developed. For example, if the goal is compliance with prenatal care, then families must be directly involved in decision making. Family-of-origin techniques are approaches that focus on behavioral change through an understanding of generational family values and behaviors. They are based on the idea that in the family, behavior patterns are transmitted from generation to generation. Thus, family-of-origin techniques are used to help families recognize intergenerational patterns of behaviors. Their therapeutic purpose begins with helping families understand their interconnectedness. In addition to examining dysfunctional patterns within families, these techniques are also used to promote behaviors that lead to healthy outcomes.(29,30)
4. Clinics should consider providing information, referral, and educational linkages to other resources. This may entail activities such as political advocacy, such as encouraging clients to write their Representatives and Senators; it might also entail patient support groups, patients' newsletters, patient bulletin boards and other activities that promote active participation in health care issues.

Finally, it is important that we recognize that programs that address cultural issues take time to develop and may not provide immediate results. This does not imply failure but rather a longer term goal of both trying to improve service usage and reduce barriers to sporadic service.

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