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Best Practices for Working with Pregnant Latina Adolescents along the Texas-Mexico Border

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Health care professionals need to pay increasing attention to recent developments related to adolescent pregnancy in the United States. The adolescent birth rate during 2007 grew for the second year in a row. In 2006 these births rose for the first time since 1991, showing an increase over the prior year from 40.5 births per 1,000 adolescents aged 15 to 19 to 41.9 per 1,000 adolescents of the same age group (Hamilton, Martin, & Ventura, 2009). The U.S. continues to have the highest adolescent birth rate of economically developed countries. Great Britain and Canada have approximately one-half the rate of the United States (Annie E. Casey Foundation, 2007; Boonstra, 2002; National Campaign to Prevent Teen and Unplanned Pregnancy, 2009).

Disparities continue to widen for pregnant lowincome women and those belonging to ethnic minority groups (Child Trends, 2007; Finer & Henshaw, 2006). Latina women had the highest adolescent birth rate, with 82.2 births per 1,000 adolescent females, in 2003. By way of comparison, adolescents of all backgrounds had a birth rate of 41.7 per 1,000 adolescents, roughly half that of the Latina group. Adolescent females of Mexican origin had the highest birth rate in 2006 at 92.9 per 1,000 for those between 15 to 19 years of age (Martin et al., 2009; Ryan, Franzetta, & Manlove, 2005).

The disparities in Mexico just below the Texas -Mexico border region are even more glaring, with adolescent births along the border *municipio* of Tamaulipas in 2006 reported at 75 births per 1,000 women ages 15 to 19 years. The Mexico overall adolescent birth rate for these same ages was 74 births per 1,000 women in 2007, demonstrating an increase over the 2000 birth rate of 70.1 per 1,000 (Galvan González et al., 2008).

The Latina/o population is the fastest growing overall group in the U. S., increasing 40% from 1990 to 2000. Latina/os are expected to become the majority population group by 2020 (PEW Hispanic Center, 2008). The Latina/o population between the ages of 15 and 19 years is projected to increase nationally by 50% by 2025 (Child Trends, 2003). These statistics indicate a likely increase in the number of adolescent births. Accordingly, the largely Latina female population in the state of Texas between the ages of 15 and 19 years was just under 788,800 in 2000. This group is expected to grow to more than 860,000 by 2010 (Texas Department of State Health Services, 2007 ; Vigness & Odintz, 2007.)

Texas reported the highest rate of adolescent pregnancy in the United States in 2006 reaching 63 births per 1,000 adolescents ages 15 to 19 years old as well as the highest level of repeat teen births, at 24% (Child Trends, 2007; Martin et al., 2007). While the adolescent pregnancy rate in Texas remains high at 63.1 births per 1,000, preliminary data for 2007 show that Mississippi has currently the highest rate at 68.4 births per 1,000 adolescents 15 to 19 years of age (Martin et al., 2009).

Pregnant Latina adolescents are typically poor and at-risk for becoming increasingly isolated, losing friendships, leaving school before completion, becoming dependent on the welfare system, having disruptive parental relationships, and being more likely to have another pregnancy within

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two years of the first (Bailey, Moran, & Pederson, 2007; Boonstra, 2002; Chen et al., 2007; Child Trends, 2007; March of Dimes, 2005). Adolescent births profoundly alter the adolescent mother's developmental course and, in turn, the mother-infant relationship (Black et al., 2006; Mayers, Hagar-Budny, & Buckner, 2008). The children of adolescents are up to three times as likely as the general population to grow up in poverty, experience academic and social difficulties, developmental delays, sexual abuse, and pregnancy during their adolescent years (Boonstra, 2002; Terry-Humen, Manlove, & Moore, 2005).

Poverty and lack of health insurance have long been associated with the inability to receive health care. This problem most always disproportionately affects minority ethnic populations and populations of color long before pregnancy occurs, thus making these women especially vulnerable to pregnancy and birth-related problems (Child Trends, 2007; Gavin, Adams, Hartmann, Benedict, & Chireau, 2004; Hamilton et al., 2007; National Campaign to Prevent Teen and Unplanned Pregnancy, 2007).

Unplanned adolescent pregnancies coupled with delayed prenatal care are well-known factors influencing birth risks and infant-maternal relational difficulties (Centers for Disease Control and Prevention, 2008; Child Trends, 2007; Moran, Pederson, & Krupka, 2005; Pajulo, Helenious, & Mayes, 2006). For example, 2006 statistics revealed that 10.5% of babies born to adolescents had low birth weight, compared to 8.3% of the general population (Martin et al., 2009). As of 2004, the latest data available for adolescent prenatal care, expectant mothers under the age of 20 had the lowest percentage of any age group (56.5%) of those who received adequate prenatal care, compared to all age groups (83.2%). *Healthy People 2010*, a major health care initiative, has set the goal of 90% for pregnant women to receive or commence prenatal care during the first trimester by the year 2010 (U.S. Department of Health and Human Services, 2000).

Major health-care programs traditionally focus on preventing unintended adolescent pregnancies; however, less attention is given to ensure that pregnant adolescents have healthier children (Annie E. Casey Foundation, 2006; Boonstra, 2002; National Campaign to Prevent Teen and Unplanned Pregnancy, n.d.). It is equally important to promote physically and emotionally healthy births, especially for those adolescents of color and Latina populations who demonstrate higher rates of disparities in prenatal care attendance and pregnancy risks compared to the non-Latina white population (Chen et al., 2007; Child Trends, 2007; Rothenberg & Weisman, 2002; U.S. Department of Health and Human Services, 2005).

Significant government and private organizations describe adolescent births as "unintended" (Centers for Disease Control and Prevention, n.d.; Guttmacher Institute, 2006; U.S. Department of Health and Human Services, 2005) but definitions of intention, described as pregnancies reported by the mother to be untimed (occurring too early or too late) or unplanned and unwanted at the time of conception, have come under criticism as of late. These definitions do not take into account the socio-cultural factors including family or boyfriend attitudes, or the underlying emotional factors influencing planning. They are based on the mother's retrospective opinion at the actual time of conception and also assume that the woman has made a conscious decision regarding pregnancy (Afable-Munsuz & Braverman, 2008; Finer & Henshaw, 2006).

Curiously, a study by Feldman and Pittman (2008) revealed that even though the predominately Latina Mexican-American adolescent population had a high pregnancy rate, the incidents of pregnancy and birth-related risk factors of those living in the Lower Rio Grande Valley were equal to or lower when compared to the State of Texas and the Nation (see Table 1). This led the authors to ponder what possible cultural factors might be mediating birth risks which could be important to understanding and working with this predominately Latina population.

While recognizing the need to diminish the number of adolescent births, the focus of this paper is on providing health-care practitioners and other related professionals with a culturally based

best practices framework to engage pregnant Latina adolescents and provide them with needed services to ensure healthier births. It is no longer sufficient for practitioners to deal with individual-level variables such as age and income. The cultural context that surrounds the Latina adolescent needs to be understood and integrated.

The next section presents a description of the Lower Rio Grande Valley region on the Texas/Mexico border, the target area of this study. Factors pertinent to the area, including economics, health care, and diseases, are depicted in order for the reader to appreciate the socio-economic environment of the Latina adolescent woman.

The Lower Rio Grande Valley Region: Disparities along the Texas/Mexico Border

The Lower Rio Grande Valley lies in the southernmost part of Texas and encompasses Cameron, Hidalgo, Starr, and Willacy counties. With the exception of Willacy, each county lies along the United States-Mexico border. The counties have an approximate total population of 1,162,030, in addition to approximately 25,000 unauthorized migrants from Mexico and Central America. During winter months, approximately 143,000 retired individuals from the northern part of the United States settle temporarily in the area (Fed Stats, 2008; U.S. Census Bureau, n.d.; Vigness & Odintz, 2007).

The Valley, as it is known to local residents, is an unusual area known paradoxically for its explosive economic growth combined with one of the highest poverty rates in the nation. While it is one of the fastest growing regions in terms of population growth in the United States, with the city of McAllen in Hidalgo County being ranked fourth in the Nation, the lower Valley is one of the poorest and most underserved areas of the United States (Immroth & Lukenbill, 2007; Sethi & Arriola, 2002).

The average annual family income of the region in 2007 was $26,443, with over 35% of the population living below the poverty level — a rate nearly twice that of Texas as a whole. A high unemployment rate of 10.7%, unequal distribution of resources, and poor health care and substandard education abound (Texas Workforce Press Release, 2009; U.S. Census Bureau, n.d.). More than 400,000 individuals live in about 1,500 unincorporated substandard shanty towns known as *colonias* that often lack basic services, such as water and plumbing. Many living in these areas are undocumented, transient migrants who are not easily counted (López, 2006; PEW Hispanic Center, 2007; Texas Department of State Health Services, 2004).

Legal and illegal crossings of one of the most heavily transversed borders bring a multitude of social and health problems to an already overburdened and inadequate public services system (Fed Stats, 2008). Many adolescents experience sexual and commercial exploitation due to the heavy business traffic brought on by the North American Free Trade Agreement (NAFTA) and the development of *maquiladoras*, or industrial plants, along the border in Mexico (Annie E. Casey Foundation, 2006; Inter-institutional Attention to Border Minors Program, as cited in Annie E. Casey Foundation, 2006).

Due to the high rate of migration and difficult economic factors, people from each side of the border often utilize health care services on the other side for various reasons, including poverty-related inability to afford health insurance, and the population's strong family ties on both sides of the border. The utilization of health-care services on the United States side has burdened an already over-taxed system (Texas Medical Association, 2008), while the provision of institutionally based resources has increased, in many instances, to replace or substitute for interpersonal resources such as the extended family (Ramírez, 2007).

Diseases in the Texas-Mexico border population are difficult to treat due to the transient nature of the population. Rates of communicable diseases, such as tuberculosis, were 192% higher in the Valley than the State of Texas as a whole in 2001, and autoimmune disorders are a serious concern. Gastrointestinal disorders and rarer diseases, such as dengue and cholera, as well as autoimmune disorders are other health hazards.

Obesity is a major problem for 34% of the Valley population due to a high-fat, low-fiber diet. The rates for type 1 and childhood-onset

type 2 diabetes are high. An estimated eight percent of the population age 18 and over in the Valley in 2001 had diagnosed diabetes compared to 6.2 percent for Texas as a whole (Ryan et al., 2005; Warner & Jahnke, 2003)

All of the counties of the study are designated by the Department of Health and Human Services as Medically Underserved Areas (MUA), meaning that the locale has more than 3,500 individuals per physician, high poverty rates, high infant-mortality rates, and large numbers of live births (Texas Medical Association, 2008; Warner & Jahnke, 2003). Texas leads the nation in the number of people who have no health insurance, and the highest uninsured areas are within the border region (Task Force on Access to Health Care in Texas, 2006).

Due to the serious problems of adolescent pregnancy in the Latina/o population for the mother, the infant, and the society in general, the next section will address the best culturally based framework to assist this population. It is hoped that practitioners will understand the importance of integrating these values into practice so that these young women and their children can be better helped to overcome negative consequences.

Best Practices Framework for a Latina Adolescent Pregnant Population

Petr and Walter (2005) define best practices inquiry as "the process by which an investigator (practitioner, scholar, administrator, or consumer) ascertains the current state-of-the-art approaches, models, and interventions for a given problem and target population" (p. 251). Best practices enhance evidence-based practice by incorporating practitioner experience, social work values, the specific target population, and qualitative research to deepen the knowledge (Burke & Early, 2003; Franklin & Corcoran, 2000; Rubin & Parrish, 2007; Thyer, 2007).

The Council on Social Work Education (CSWE), the accrediting body for schools of social work, through the Educational Policy and Accreditation Standards (EPAS) outlines the need for social work practitioners to be culturally competent (Council on Social Work Education, 2008; Cordero, 2008; Guy-Walls, 2007). Cultural competence involves adapting best practices to the culture of the target population so as to empower and affirm ethnic identities (Lum, 2005).

The best practices framework presented here incorporates the unique social work ecological person-in-environment perspective (Bronfenbrenner, 1979; Germain & Gitterman, 1980) while incorporating the Latina/o cultural context, traditional values, and practice-based experience case vignettes. Though the Latina/o population is diverse, best practices approaches are grouped according to five commonly found cultural values: (a) acculturation and self-identity, (b) *familismo* (familism), (c) *personalismo* (personalism) and *simpatía* (amiableness), (d) religion and genderrole constructs, and (e) traditional and conventional health care.

Best Practices A: Acculturation and Self-Identity: Culture as a Motivator for Health

Issues of migration and acculturation are important to how Latina/os define themselves. Migration may mean a better future for some, yet it leads to losses of social networks and family. An approach that questions and shows genuine interest in the person's migratory or experience as a Latina in the U.S. allows for the telling of the *testimonio* (journey). The *testimonio* allows for the person to work through difficulties related to the migration experience. Many families come separately; usually men migrate alone, bringing families when money is available (Falicov, 1998; Rodríguez, Bingham-Mira, Paez, & Myers, 2007; Vexler, 2007).

Acculturation occurs when the non-dominant group, for example the recently-arrived Mexican person, adapts to the norms of the dominant culture. While the Lower Rio Grande Valley is predominately of Mexican-American origin, there are apparent distinctions made based on socio-economic, racial, and migration differences. Groups with longer histories of residency often see themselves as "higher class" than the newly arrived immigrant. Some individuals even trace their histories back to when the area was officially Mexico. The various groups compete with each other for jobs and social resources. New immigrants often adapt by forming their own

separate sense of community, one that retains traditional values (Bastida, 2001; Bathum & Baumann, 2007). Adding to the diversity of the area are the undocumented immigrants who fall on the "lower rung," avoiding using any public health services for fear of deportation (Pew Hispanic Center, 2007).

Studies have demonstrated that acculturation is often a risk factor for adolescent pregnancy, social maladjustment, psychopathology, and substance use (McHatton, Shaunessy, Hughes, Brice, & Ratliff, 2007; Smokowski & Bacallao, 2007). The importance of developing and maintaining a bi-cultural identity seems to have protective factors that mediate risk factors of acculturation. Positive outcomes have been found for Latina/o adults and youths who maintain a bicultural identity by retaining basic cultural values while integrating aspects of the dominant or new culture (Muir, Schwartz, & Szapocznik, 2004; Schwartz, Pantín, Prado, Sullivan, & Szapocznik, 2005; Smokowski & Bacallao, 2007) . Alternately, adolescents who have acculturated and lost a sense of self-identity show increased risk-taking behaviors such as smoking, drinking, and unprotected sex (Affable-Munsuz & Brindis, 2006; Guilamo-Ramos et al., 2006). Additional conflicts may arise when adolescents adapt more quickly than their parents wish them to or more quickly than their parents adapt. Sensitivity to diverse levels of adjustment within the family will better enable the practitioner to deal with the situation. One young adolescent female living for over five years in a U. S. border city of Texas/Mexico and her U.S. born boyfriend were discussing their relationship with the social worker:

> Rosie complains about her family and says, "They don't trust me to go out alone, they still don't realize that this is not Mexico and things are much different here, like having fun all the time." They both laugh as Rosie says, "My parents have old fashion ideas from Mexico and don't even know English. They hold on to me so tight, they are so afraid of every little thing. I love to really party when I escape and go to the Mexican side of the border and dance and drink without proof." The couple laughingly admits to enjoying risk-taking by not using birth control, as Rosie says, "It makes it more exciting." Rosie is pregnant and she firmly states, "I will have my own baby. I don't care if I am not married, so what."

Best Practices B: Familismo (Familism): Involving the Family

For the Latina/o population, the concept of *familismo* or familism is integral to the culture and includes the immediate and extended family, and others who are not blood related. The family is the basis of Latina/o culture. Compared to the Anglo population, Latina/os tend to be more inclusive of who they consider family (Falicov, 1998; Rodríguez, Bingham-Mira, Páez, & Myers, 2007). *Familismo* adheres to the importance of the family's *colectivismo* (collective) needs and diminishes attention to individual needs (Galanti, 2003; Molina, Zambrana, & Aguirre, 1994; Gurman & Becker, 2008). The family unit involves strong attachments and loyalty. Families perform activities together and all age levels are involved. Living close and frequent interactions are important (Smokowski & Bacallao, 2007; Villareal, Blozis, & Widaman, 2005).

Familismo is a multidimensional construct involving the hierarchical structure of the family, norms and behaviors, attitudes, and identification with the society (Rodríguez et al., 2007). Along with *familismo* is the importance of *respeto* (respect), which encompasses politeness and obedience, especially toward older individuals and those in authority, such as one's grandparents, parents, and teachers (Allen, Svetsz, Hardeman, & Resnick, 2008). Parenting has been described as more authoritative and stricter with more use of physical punishment, but also with more demonstration of affection than in Anglo families (Fontes, 2002, 2007). Fathers are usually seen as providers rather than nurturers; however, this role is changing as adjustments are made to U.S. customs (Behnke, Taylor, & Parra-Cardona, 2008). The Latina/o child has several "mothers," as close female family members or female family friends commonly assume nurturing roles to each others'

children. Leaving home to set up one's own household is not common and is not interpreted as a sign of independence. Many Latina/os remain living with their families until marriage and then move close by.

Studies have documented that Mexican-American infants have relatively favorable birth outcomes compared to other ethnic groups. These findings have been attributed to family ties of the Latina/o culture that promote close family support and connections to extended support systems (Feldman & Pittman, 2008; Frisbie, Forbes, & Hummer, 1998; Galanti, 2003; Padilla, Boardman, Hummer, & Espitia, 2002; Rodríguez et al., 2007). Latina/o children often attach to several caregivers rather than just to their mothers, perhaps adding to the children's ability to call upon various support persons, such as an aunt or older sister, in times of need (Feldman, 2007). When working with the Latina/o population, the practitioner must give consideration to involving the family members in some important way. While the Latina/o family certainly may display pathology, it is important that the practitioner distinguish between enmeshment and usual Latina/o patterns of closeness.

In the world of the young Latina female she is typically surrounded by family members and extended communities who protect and keep her from harm while simultaneously hindering her adolescent growth by making it difficult for her to learn how to make choices. The family and community support network helps to mediate problems but can also circumvent the adolescent's need to learn at this stage of her life how to make appropriate decisions (Falicov, 1998; Rodríguez et al., 2007). One 14-year-old adolescent commented to her school counselor on her difficulty with family separation issues:

> *"Ay*, if I could just have a moment to myself! They are all over me telling me what to do. Everywhere I go someone in my *familia* is around telling me to be careful. They do everything for me. My mother would not survive if she did not tell me what to do all the time. I love being with my family but I need some time for me and my friends. I don't even pick out my own clothes in the morning-my mother and aunt do it. My boyfriend tells me that I won't get pregnant right after my period. He knows about all this stuff because he is older and he knows what to do."

Best Practices C: Personalismo (personalism) and *Simpatía (*amiableness)*: The Importance of Politeness.*

Personalismo emphasizes using one's personal character and inner qualities in establishing relationships. Warmth, trust, politeness, and respect are emphasized as well as making the other person feel comfortable. It is preferable to remain silent than to make the other person feel bad about some truth. Indirectness is preferred with sensitive issues (Galanti, 2003).

The Latina/o client will try to maintain *simpatía* or harmony and politeness with the practitioner, giving the overt appearance of being passive, resistant, and unmotivated from the viewpoint of a social worker unfamiliar with the culture (Molina et al., 1994; Gurman & Becker, 2008). However, the cultural framework dictates that, for example, a young Latina female should be acquiescent, soft-spoken, and non-confrontational. To be assertive and questioning of someone older or a professional would be a sign of disrespect (Fontes, 2002; Raffaelli & Ontai, 2001). One social worker, unfamiliar with cultural ramifications, tended to pathologize a Latina pregnant adolescent's behavior. The social worker stated:

> "I couldn't understand that girl. She just sat there looking at the floor. She would not even make eye contact. She sat there with her big belly but behaved like a little girl. She knows she is pregnant. She better start talking and telling me what she needs so she can stop wasting time. She is so resistant."

Latina/o clients usually will tell social workers their histories as they become more comfortable and are helped to see that speaking is not disrespectful but helpful to the practitioner. The young woman may use relational terms embedded within a familial framework to describe her situa-

tion. In response to direct questioning, she will commonly respond in terms of "we." Discussing one's personal goals or feelings are intricately related to family goals. Discussing individual needs in terms of oneself is seen as self-centered and unbecoming (La Roche, 2002).

It is important that health professional learn how Latina/os use language. Latina/os frequently speak in *dichos* (sayings) rather than directly confronting an issue. Difficult topics are best handled with allegories and metaphors. Humor can also be interjected to facilitate communication as it helps to minimize embarrassment, brings a sense of lightness to the conversation, and relieves tension (Falicov, 1998; La Roche, 2002). *Confianza* or confidence is built into the relationship as the client feels he/she is being understood. *Confianza* is the building block for social cohesion (Kanaiaupuni, Donato, Thompson-Colon, & Stainback, 2005).

Best Practices D: Religion and Gender Roles: Reframing Rigid Constructs to Assets

According to the PEW Forum on Religion and Public Life (2008), Catholicism is the dominant religion for 68% of the Mexican- American Latina/o population, though Protestantism is growing rapidly. The Catholic religion was imposed upon the inhabitants of Mexico by European Spanish conquerors and friars during the 16th century. Mexican-American families often practice a blend of Catholicism from indigenous and European-based beliefs (Lujan & Campbell, 2006). The Catholic Church has a strong influence on how Latina/os live though many may not attend regularly. *Fatalismo* or fate is a large part of the belief system, so that a person feels that he/she has little control over life's events.

Best practices include an understanding of religious factors on the Latina/o family and how these influence values related to self-concept, sex, dating, promiscuity, and motherhood. Family codes are centered on religion and honor. Historically chastity of unmarried women was one way a family could achieve honor. Socialization of females, while emphasizing femininity, stresses the importance of remaining a virgin until marriage. High value is placed on chastity, and violation brings shame to the woman and to her family. The main purpose of a female is to have children through marriage. While females are seldom taught about sex, they are often warned, threatened, and made fearful of any sexually related encounter with a male. Parental messages stress the importance of not having sex, but little instruction is given about how to prevent sexual involvement (Guilamo-Ramos et al., 2007; Raffaelli & Ontai, 2001). Pregnant adolescents often hide their pregnancy for months and do not obtain adequate prenatal care, placing themselves and the child at risk (Ryan et al., 2005).

Simultaneously, young men are expected to be sexually adept. Traditional gender role constructs serve to form Latina/o roles. *Machismo* or male dominance, power, and sexual prowess are emphasized for sons, while *marianismo* or female submissiveness, reticence, and repression of sexual feelings are stressed for daughters. Paradoxically, at the age of 15 the young Latina has a *quinceañera*, usually a large, elaborate party which represents an entrance into womanhood, where she is encouraged to look attractive, feminine, and appealing yet may still not be allowed to date (Davalos, 1996). These constructs, compounded with the value of motherhood as being primary, the lack of knowledge, and the belief in *fatalismo* ("if it is going to happen, it is my fate") strongly influence the decision for an adolescent to have a child or do without protection. Young Latina are often at a loss about sex and are given little information from their parents (Cruz-Janzen, 2001; Guilamo-Ramos et al., 2007; Guilamo-Ramos et al., 2006). A 15-year-old adolescent commented to the school nurse:

> "My mother would not let me go to a school party. She said she would kill me if I ever talked to a boy alone. She says I shame the whole family and my grandmother in Mexico because I am boy-crazy. But I had a big *quinceañera* and she let me wear a sexy strapless gown and then she tells me to button my blouse all the way up because guys will want to "get me." She said guys cannot control themselves. She says she is going to send me to Mexico to a convent. Tell-

ing me that sex is bad is not true. I need to know more than that!"

When dealing with a Latina adolescent, it is of maximum importance to help the adolescent and her family communicate about sex, recognizing that it is difficult and not in their usual nature. Values related to "if you talk about it, they will do it" and "sex is just for after marriage" need to be reframed to also include discussions of sexually transmitted diseases. Latina/o parents wish for greater communication regarding sex with their adolescent children but find these discussions difficult (McKee & Karasz, 2006; Raffaelli & Ontai, 2001; Vexler, 2007).

Though motherhood is the traditional purpose of a female's life in the Latina/o culture (Falicov, 1998, Rafaelli & Ontai, 2001), a pregnancy out of marriage usually brings shame to the adolescent and to her entire family. However for many adolescents with few goals or opportunities, fewer reasons exist to delay pregnancy (González-Garza, Rojas-Martínez, Hernández-Serrato, & Olaiz-Fernández, 2005). This has been found frequently in Mexico where poor young women have little or no potential to break out of rigid class structures. For these women, pregnancy is seen as an effort to achieve a rise in some social status, recognition of being an "adult," and means of attaining stability (Díaz-Sánchez, 2003).

Best Practices E: Traditional and Conventional Health Care: Learning to Accept the Unfamiliar

Importantly, cultural barriers account for many Latina/os avoiding and/or not desiring conventional health care. Family migration and acculturation status influence the ability to access and use health care services. Recent immigrant Latina/os have a lower rate of using public health services than who?. Reasons for this include language difficulties, lack of funds or insurance, illegal status, and fewer social support systems to facilitate health delivery. Additionally, health delivery systems focus more in recruiting and serving longer-term residents than in serving the recently arrived immigrant group. (Aguilera & López, 2008; Padilla & Villalobos, 2007; Pew Hispanic Center, 2007).

Best practices working with the Latina adolescent pregnant population may include integrating the *curandero* folk system with the dominant Western treatment (Clark, 2001). Oftentimes it is more comfortable, usual, less expensive, and less shameful for a Latina/o person to see the *curandero* who uses herbs for medicinal purposes (Gomez-Beloz & Chavez, 2001). Mental health services are even less frequently accessed for reasons of fear of being seen as "crazy" (Fontes, 2007; La Roche, 2002; Padilla & Villalobos, 2007; Sullivan & Rehm, 2005).

Understanding and working with the Latina/o population, and specifically the pregnant Latina adolescent, involves an understanding of the cultural meaning attributed to health and the cultural context surrounding the person. Because of a collective (*colectivismo*) shared expectation that the family will take care of those in need, the family is the usual provider of support to deal with health care issues. The family commonly expects to be included in the health care treatment and decision-making for the individual member (Aranda, Villa, Trejo, Ramírez, & Ranney, 2003).

The pregnant Latina adolescent female who does not share that she is pregnant with her family has enormous difficulties assessing health care due to a myriad of confusing legal issues, inability to know how to negotiate the health care system, and shame attributed to being pregnant. Shame is a prevalent issue for Latina/os and may affect self-disclosure (De Hoyos & Ramírez, 2006; Fontes, 2002). Culture dictates that personal family issues are to be kept within the family and not to be shared with strangers. The adolescent finds herself in a dilemma in which she may have to attend to health care on her own, while simultaneously feeling that she is being disloyal to her family.

While it is not always easy to engage the adolescent in health care, treatment can be facilitated when the practitioner makes the client aware that he/she is familiar with the different health care options available and used by many Latina/os. For example, a sixteen-year-old Latina told her health care person:

"Wow, you know about that stuff?! Great! So you don't mind that I see my

curandero? Great! He knows and I know not to take anything that could hurt my baby. He tells me it is up to my doctors to tell me what to take. He helps me be calm and I have been talking to him for years. I would not ever stop. I am glad I don't have to hide it from you."

Conclusions

Working with the pregnant Latina adolescent means working along with the family when at all possible. Family connectedness, an important value to the Latina/o culture, has served as a protective factor when based on trusting relationships. In general, adolescents who communicate openly with their families about sex are less likely to engage in risky behavior; however, studies have demonstrated that Latina adolescents seldom discuss sex with their mothers. Pro-fertility values and the presence of an extended family-support network may indirectly account for the rise in adolescent births. Latina adolescents, who are poor, have difficulty in school, and engage in risky behavior often see having a child as a way to improve their situation. It behooves practitioners to understand the values of the Latina/o culture and its views on motherhood in order to help these young women find reasons to delay early childbearing or to help them have healthier pregnancies and better relationships with their children. The Latina/o population growth is increasing at a rapid rate and practitioners need to be prepared to understand and deal with Latina/o cultural values.

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Table 1: *Adolescent Pregnancy and Birth Risk Data: 2003-2005*

	USA	Texas	Rio Grande Valley
Adolescent Birth Rates (per 1,000 adolescents) for<20 Years Old	10.4 (2003-05)	13.7 (2004)	16.2 (2004)
1st trimester prenatal care for <20 Years Old (2004)	69.1%	70.4%	69.2%
Preterm births at <37 weeks for <20 Years Old (2004)	14.3%	13.9%	13.5%
Fetal deaths for <20 Years Old (2004)	9.2%	.62%	.71%
Low birth weight or <2500 grams for <20 Years Old (2004)	11.8%	10.6%	7.5%
Maternal weight gain>44 pounds for <20 Years Old (2004)	25% (2005)	15.8%	9.1%
Maternal weight gain<15 pounds for <20 Years Old (2004)	n/a	9.3%	19.8%

Sources: Child Trends, 2007; PEW Hispanic Center, 2007; Texas Department of State Health Services, 2004; U.S. Census Bureau, 2004; Martin et al., 2007.
Note: Contains the latest available data