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**THE FERTILITY-RELATED ATTITUDES
AND BEHAVIOR OF HISPANIC
ADOLESCENTS IN THE UNITED STATES**

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Despite these alarming statistics, very little is known about the fertility-related attitudes or behavior of Hispanic adolescents. Until recently, many of the relevant studies either did not include Hispanic adolescents or did not identify them as such. For example, the Johns Hopkins surveys (from which much of our knowledge of adolescent contraceptive use and clinic utilization is derived) did not include a code for Hispanic origin. Nor is it possible to reconstruct this information by coding whether or not the respondents had Spanish surnames, because the study name files were destroyed as part of the research protocol. Similarly, of 14 data sets with individual-level data in the American Institutes for Research Data Archive on Adolescent Pregnancy, only the Current Population Surveys include codes for Hispanic ethnicity (Carr, 1984).

PRELIMINARY REVIEW OF RESEARCH

In order to gain the fullest understanding of what is known or can be surmised about the fertility-related attitudes and behavior of Hispanic teenagers, it is helpful to review four major issues in the literature: (1) the extent of adolescent sexual activity, childbearing and contraceptive use among all U.S. teens; (2) the extent of these behaviors among Hispanic adolescents; (3) theories of minority group differences in fertility; and (4) explanations of Hispanic/non-Hispanic differences in health service utilization.

1. Adolescent Sexual Activity, Childbearing and Contraceptive Use Among U.S. Teens

Over 1.1 million young women under the age of 20 have become pregnant every year during the past several years. This statistic is the result of a number of countervailing trends: an increase in sexual activity, use of more effective methods of contraception, a rise in the number of abortions and a rise in the number of out-of-wedlock births.

In 1979, half of all teenage girls in the United States had had premarital intercourse, a 63 percent increase over the proportion in 1971 (Zelnik and Kantner, 1980). In 1979, the same source reported that 70 percent of 17- to 21-year-old males had had premarital sex. However, between 1971 and 1979, there was a marked improvement in contraceptive use among sexually active teenagers. Almost 70 percent had used some method at last intercourse in 1979, compared with just half in 1971. Over one half of these young women had used the pill, IUD or diaphragm; 25 percent had used condoms or foam; 18 percent, withdrawal; and 6 percent, douche or rhythm. Still, as of 1979, it was estimated that 1.3 million sexually active teenagers were using no method of contraception (Dryfoos and Bourque-Scholl, 1981). In the same year, more than 450,000 teenagers obtained abortions, reflecting the high incidence of unintended pregnancy.

Teenagers' reasons for not using contraceptives vary. In 1976, of the young women who at some time had had unprotected intercourse, about two out of five thought they could not become pregnant, either because they were too young or because they had

intercourse too infrequently. Among those who acknowledged the possibility of pregnancy, the most frequently cited reason for not using a contraceptive method was that the young woman did not expect to have intercourse. Smaller percentages of teenagers said they couldn't obtain a method or didn't know where to get one. Others thought contraception was wrong or dangerous, felt it was too hard to use, or said that their partners objected to using contraceptives (Zelnik and Kantner, 1979).

More recently, researchers have examined why teenagers delay seeking family planning services (Zabin and Clark, 1981). Many teenagers said, "I just didn't get around to it"; others mentioned the fear that their families would find out they had attended a clinic, or concern about pelvic examinations and method side effects. Some young women mentioned the cost of clinic visits or access to clinics as barriers. Studies have shown repeatedly that convenience, lack of "hassle" and confidentiality are key variables in clinic utilization.

The importance of barriers to the utilization of clinic services is underscored by the fact that, of first premarital pregnancies among teenagers, more than one-fifth occur within one month of initiation of intercourse, and more than half occur within six months (Zabin et al., 1979). Thus, it is likely that a decrease in the number of unplanned pregnancies could be achieved if sexually active teenagers could be motivated to utilize services earlier.

Unlike out-of-wedlock births, marital fertility among teenagers has decreased markedly. The rate of pregnancies among

sexually active girls reached a low of 214 pregnancies per 1,000 15- to 19-year-olds in 1978. It then gradually climbed up to 223 in 1981, indicating that more than one in five teenage girls are pregnant each year (Hofferth, 1984). The U.S. adolescent fertility rate is considerably higher than that of most other developed countries, and among young black women and certain Hispanic groups, the rates are among the highest in the world (Westoff, 1983; Ventura, 1983). These fertility rates have been associated in repeated studies with low socioeconomic status and low school achievement (Chilman, 1983; Mott, 1984; Hogan and Kitagawa, 1983; Tanfer and Horn, 1983).

In recent years, a considerable amount of research has been undertaken, largely under the aegis of the National Institute of Child Health and Human Development, to study the antecedents of early childbearing, and the consequences for the mother, the father, and the child. National surveys of 15- to 19-year-old women were conducted in 1971, 1976 and 1979 by researchers from the Johns Hopkins University to examine trends in sexuality, contraception, pregnancy and childbearing. In addition, a number of regional and local surveys have focused on such factors as access to service programs, parent-child communication, risk-taking behavior, and contraceptive continuation. Least research attention has been given to institutional studies that might demonstrate which programs are most effective at preventing pregnancy and at providing continuing contraceptive care.

As a result of current research, much is known about the problem of teenage pregnancy, but there is a lack of consensus on

what should be done. It is generally agreed that teenagers need better sex education, access to confidential family planning services, and improved methods of contraception (AGI, 1981). However, some analysts suggest that fertility-related solutions are insufficient, since early maternity results from childhood socialization patterns and perceived or actual lack of opportunity to pursue other life options (Dryfoos, 1983; Chilman, 1983).

Whatever the determinants, teenage childbearing is associated with a number of adverse social, economic and health sequelae for mothers and their children. Perhaps the most serious consequence of teenage childbearing is that many young mothers are unable to complete their educations (Card and Wise, 1978). As a result, they may have difficulty finding employment, and their incomes tend to be lower than those of women who delay childbearing until after age 20 (Suchindran, 1978). Compared with women in the latter group, teenage mothers are more likely to bring up their children in a home with no male present, to receive welfare or be living below the poverty level (Moore, 1978; U.S. Department of Commerce, 1983), and to experience subsequent unintended births (Trussell and Menken, 1978). Furthermore, it has been shown that compared with the children of older women, the children of teenage mothers have inferior academic achievement and are more likely to have to repeat a grade of school (Card, 1978).

2. Adolescent Sexual Activity, Pregnancy, and Contraceptive Use Among Hispanic Adolescents

Far less is known about the fertility-related attitudes and behavior of Hispanic teenagers in the United States than about the behavior of their non-Hispanic peers. What little is known comes primarily from Current Population Surveys, from the Centers for Disease Control surveys of women on the U.S.-Mexican border, and from clinic data. (See Table 1.)

These studies suggest that fertility levels of Hispanic teenagers fall in between those of non-Hispanic blacks and whites. In the 1979 Current Population Survey, for example, never-married Hispanic women aged 18-19 had borne over three times as many children as whites, but only half as many as black women in that age-group (U.S. Department of Commerce, 1980). In 1980, the teenage fertility rate for Hispanics was 82.2 births per 1,000 women aged 15-19, compared with 41.2 for white teenagers and 105.1 for black teenagers (Ventura, 1983). At later ages, however, and among married adolescents, the fertility of Hispanic women surpasses that of black women (O'Connell and Rogers, 1982).

Mexican teenagers had the highest birthrate among Hispanics. However, over half of Mexican adolescents who gave birth were married. Puerto Rican teenagers had the highest rate of pre-marital births (62.4 per 1,000, compared with 41.8 for Mexicans, 6.6 for Cubans, and 27.0 for other Hispanics). The comparable rate for non-Hispanics was 27.7.

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Table 1: Summary of Statistics From Various Sources Regarding Fertility
 Related Behavior of Hispanic Teenagers

Statistic	Hispanics	Blacks	Whites	Sample	Definition of Hispanics	Reference
% women under age 20 who were ever married	25.0%	7.0%	n.a.	Birth registration in 22 states, 1980	Hispanics in United States	Davis et al., 1983
% who were under age 12 at first coitus	31.1%	54.6%	12.5%	421 male students in three northeastern city high school health education classes	Unavailable	Finkel and Finkel, 1975
% who used no contraceptive at last coitus	25.6%	27.1%	20.3%	" "	"	"
Mean age at first intercourse	\bar{x} =15.9	\bar{x} =15.2	\bar{x} =16.2	Clients at New York City adolescent family planning clinic	Predominantly Dominicans and Puerto Ricans	Namerow and Jones, 1981
% with positive pregnancy tests who were referred for abortion	52.0%	52.3%	n.a.			
% who used birth control before coming to clinic	45.4%	51.8%	52.8%	" "	"	"
% using a method at first visit	19.1%	23.9%	31.4%	" "	"	"
% ever pregnant	59.4%	51.3%	39.8%	" "	"	"
% of never-pregnant women whose first visit was for birth control	56.9%	73.7%	76.2%	" "	"	"
% who revisited clinic within 24 months	65.4%	72.0%	68.4%	" "	"	"

n.a. = not available

Table 1: (Continued) Summary of Statistics From Various Sources Regarding Fertility
Related Behavior of Hispanic Teenagers

Statistic	Hispanics	Blacks	Whites	Sample	Definition of Hispanics	Reference
% who talked about sex or pregnancy with mothers	19.1%	40.1%	54.2%	359 pregnant teens under age 16 in California pre-natal clinic	Mexican Americans	Lindemann and Scott, 1982
% who used birth control in past	11.1%	39.1%	38.1%	" "	"	"
% nonparents leaving high school before graduation	17.5%	15.7%	11.8%	1980 and 1982 high school and beyond sample of United States sophomores and seniors	Hispanics in United States	Takai and Owings, 1983
% parents leaving high school before graduation	50.5%	31.2%	42.4%	" "	"	"
% sexually active among never-married women 15-19	14.4%	none	27.7%	CDC survey of women on United States-Mexican border	99% Mexican Americans	Holck et al., 1982
% never-married women 15-19 in need of family planning	12.6%	none	25.6%	" "	"	"
% never-married women 15-19 with unmet need	46.6%	none	38.7%	" "	"	"
% of total births to women 15-19	18.6%	26.5%	12.0%	Vital statistics, 1979	Hispanics in United States	U.S., NCHS, 1982b
% of never-married patients who were under age 20 at organized family planning programs	49.1%	n.a.	71.2%	National Health Survey sample, 1979	Hispanic origin	U.S., NCHS, 1982a
Births per 1,000 unmarried women 15-19	39.7%	n.a.	n.a.	Vital statistics, 1980	Hispanics in United States	U.S., NCHS, 1983
Births per 1,000 women 15-19	82.2%	105.1%	41.2%	" "	"	"
% of most recent births to women 15-19 that were planned	18.4%	none	Too few to calculate	1979 United States-Mexican border survey of over 1,000 women	Mexican Americans	Warren et al., 1983
% of never-married women 15-19 currently using contraceptives	6.7%	none	15.7%	1979 United States-Mexican border survey of over 1,000 women	Mexican Americans	Smith et al., 1983

n.a. = not available

Much less is known about sexuality and contraceptive use among Hispanic teenagers than about their fertility. To further complicate the picture, valid data on one behavior of interest, sexual activity among female adolescents, may be particularly difficult to obtain because of the sensitive nature of the subject matter. On the U.S.-Mexican border, only 14 percent of never-married adolescent Hispanic females reported that they had had sex, as compared with 28 percent of Anglo teens (Holck et al., 1982). Such a low rate is suspect, since Mexican American teenagers on the border and in California have higher fertility rates than Anglos (CDC, 1980; Medina, 1980).

It is, of course, possible that only a small proportion of unmarried Hispanic teenagers are sexually active, but that low probabilities of both using contraceptives and terminating unwanted pregnancies keep their fertility rates at levels comparable to those of sexually active non-Hispanic teens. The scant available evidence, however, does not support the hypothesis that Hispanics have lower rates of abortion. At the Presbyterian Hospital in New York, Hispanic teenagers (predominantly Dominicans and Puerto Ricans) and black teenagers are equally likely to elect abortion after a positive pregnancy test (Namerow and Jones, 1981).

There are indications, however, that Hispanic teenagers are less likely than non-Hispanic teenagers to use contraceptives. On the border, for example, never-married Anglo teenagers are more than twice as likely to be currently using a contraceptive

method as are their Mexican American counterparts. (Smith et al., 1983). Whether the measure is current method use, "unmet need" for contraception (Holck et al., 1982), prior use of birth control (Lindemann and Scott, 1982; Namerow and Jones, 1981), or reported method use among males (Finkel and Finkel, 1975), Hispanic teens are at a disadvantage as compared with non-Hispanic black and white teenagers.

Hispanic teenagers also appear to be less likely to utilize preventive services. Nationally, seven out of ten of their first visits to contraceptive clinics are for suspected pregnancy. The corresponding figures for non-Hispanic blacks is four out of 10, and for non-Hispanic whites, it is three out of 10 (AGI, 1981). Even when Hispanic teenagers have come in for contraceptives, they have been more likely than blacks or whites to accept the least effective methods (such as condoms or foam) at both first and last visits (Namerow and Jones, 1981).

A major study to identify the barriers to contraceptive and clinic use faced by Hispanic young people was recently completed at the Center for Population and Family Health (Darabi, 1984). Preliminary findings suggest that the best word to characterize these barriers is "fear" --- fear that parents will find the method; fear that the clinic will tell parents about the visit; fear of what will happen in the clinic; and fear that someone the teenagers know will see them there.

An important caveat in this discussion is that the nature of available data has often precluded separate tabulations for various Hispanic subgroups; as a result, teenagers from very

different countries and of strikingly different backgrounds are lumped together as Hispanics. Furthermore, few authors have examined the sources of reported differences between Hispanic and non-Hispanic teens, or correlates of the fertility-related behavior of Hispanic youth.

3. Theories of Minority Group Differences in Fertility

From the foregoing section, we may conclude that Hispanic teenagers are particularly reluctant to use contraceptives. Why should this be the case? The most obvious hypothesis is one that was presented earlier: Hispanic adolescent females may be less likely to have sex, and thus less likely to need contraception. Sexual activity is thus a key variable to be measured. Once Hispanic young women are sexually active, what might account for differences in their use of contraceptive methods? Although these questions have not been addressed directly in the family planning literature, several hypotheses are suggested by studies of ethnic differences in the fertility of adult women, and by studies of ethnic differences in health care utilization.

One persistent issue in the literature is the degree to which ethnic differences in fertility are due to differences in socioeconomic status, rather than to specific ethnic group norms. Socioeconomic status, as measured by occupation, education and income, can influence fertility in numerous ways. A woman's educational level affects her desire for children and choice of life-style, as well as her knowledge of methods of fertility regulation. Her education and occupational status determine the

economic value of her time and influence her age at marriage, duration of marriage, and fertility-related attitudes. Undoubtedly, ethnicity and socioeconomic status interact in their influence on each of these variables.

As has been pointed out, with the exception of Cubans, Hispanic women have higher birthrates than non-Hispanic women in the United States. Differences in socioeconomic status or opportunities explain some, but not all, of these fertility differentials. The addition of other background characteristics improves the explanation. One study (Jaffe et al., 1980), for example, has shown that after age, education and income are controlled for, Puerto Rican fertility is almost on a par with that of non-Hispanic whites, and the fertility of Central and South Americans is 15 percent lower. Only the birthrates of Mexican American women and women from Spain remain substantially higher. Among low-fertility groups, such as Cubans, age at marriage is the major determinant (Gurak, 1978).

One team of investigators (Bean and Swicegood, 1982) has paid particular attention to the effect of education on the fertility of Mexican American women. They have found not only that fertility declines markedly with higher levels of education for these women, but also that the bivariate relationship is stronger than that for non-Hispanic white women. The strongest negative relationship between education and fertility was found among the younger Mexican American women. The authors suggest that this is because younger women have had greater access to

resources and opportunities than the older women had (Bean et al., 1983).

Religion is another variable that is frequently suggested as a determinant of higher Hispanic fertility. However, one study (Andrade, 1980) found only a mixed and generally weak association between the two variables. By contrast, another (Sabagh, 1980) found a moderately strong correlation between religiosity and number of children for Catholic Mexican American women raised in the United States, even after controlling for age, socioeconomic status and acculturation. Interestingly, there was not much correlation between these variables for women raised in Mexico.

The third category of variables used to explain Hispanic/non-Hispanic fertility differences consists of culturally determined group norms, such as sex role attitudes and desired family size. Mexican Americans, for example, are said to have values promoting "familism," that is, a preference for traditional roles for women and large families (Andrade, 1980). Other authors suggest that while Mexican Americans do have larger family size desires, their other fertility-related attitudes are not necessarily more traditional than those of non-Hispanics (Darabi et al., 1983).

Andrade also cites several studies suggesting that Mexican American women have had extensive, but ineffective, experience with contraceptive use. She suggests that this may be the result of low levels of information regarding sex and reproduction, and feelings of modesty that impede both correct use of contraceptives and utilization of gynecologic services. This suggestion

is disputed in a study of Mexican American couples in Los Angeles (Sabagh, 1980), in which it is argued that Mexican Americans are effective users of modern methods of contraception, and that their high fertility is intentional.

4. Health Care Utilization by Hispanics

Barriers that prevent access to contraception are another plausible cause of low levels of contraceptive use. Thus, the literature on health care utilization is relevant to our search for explanations of lower rates of contraceptive use among Hispanic teens. This literature yields a number of theories to explain the lower preventive health service utilization rates of minority populations in general, and the particularly low rates of Hispanics. (See, for example, Dutton, 1978; Berkanovic and Reeder, 1974.)

Once again, the argument centers on the degree to which socioeconomic status differences account for differences in the dependent variable, in this case, health service utilization. Proponents of the socioeconomic status hypothesis generally argue that minority groups' underutilization of services is the result of their lesser likelihood to be able to pay for care or to be covered by health insurance. Proponents of the minority status hypothesis suggest that membership in a minority group affects utilization because of shared traits, values or expectations (Berkanovic and Reeder, 1974). These include hypothesized differences in perceptions of, and reactions to, health

institutions, interpretation of symptoms, and exposure to different sources of information.

In addition, some authors have described special institutional barriers faced by Hispanics and other minority groups, including actual differences in treatment and quality of services, as well as linguistic barriers and preferences for indigenous sources of care.

It is likely that a combination of financial, cultural and institutional barriers best explains Hispanic underutilization of services. This is confirmed by studies such as one that was undertaken to explain why a majority of Hispanic women in California receive late or no prenatal care (Medina, 1980). The underutilization was attributed to lack of awareness of the existence or the importance of prenatal care services; lack of motivation to use the services; ineligibility or inaccessibility; and a shortage of Hispanic service providers.

SUMMARY OF RESEARCH ISSUES

From the foregoing section, it can be seen that knowledge regarding sexual behavior, pregnancy, contraception and child-bearing among Hispanic adolescents is quite limited. From Current Population Surveys, we know that birthrates among Hispanic teenagers (predominantly Mexican Americans) fall between those of non-Hispanic whites and blacks. We know very little about the correlates of these rates, however, or the extent to which Hispanic and non-Hispanic or intra-Hispanic differences are

artifacts of differences in age, marital status or socioeconomic status.

At issue here is the meaning of culture as a determinant of fertility-related attitudes and behavior for adolescents. Numerous articles have been written about the importance of traditional family values and virginity to Hispanics, who are frequently stereotyped as members of a high-fertility group influenced by machismo, authoritarian values, and rigid adherence to Catholicism. Few of these essays are data-based, however, and fewer still address the ways in which these values are transmitted, or their varying importance to Hispanics from different countries. As a result, many important questions are left unanswered.

The need for an examination of differences among Hispanic subgroups is especially problematic, since few national data sets include large enough numbers of Hispanics other than Mexican Americans to permit such analyses. One is then faced with the dilemma of choosing between two unsatisfactory alternatives: using only Mexican American subsamples in analyses of the effects of Hispanic ethnicity, or postponing all such research until larger and more heterogeneous Hispanic samples are available. Despite its limitations, the former alternative is preferable, as long as conclusions drawn from analyses of Mexican Americans are not generalized to cover all U.S. Hispanics. At the same time, it would be important to encourage analyses of regional data and service statistics, which currently provide a rich, and largely untapped, source of data on other Hispanic subgroups.

As planners and evaluators of adolescent clinical and outreach services, we are keenly aware of the need for baseline information on the Hispanic clientele. Such data would be immensely useful to providers of similar programs nationwide. Furthermore, the promotion of scientifically rigorous research on Hispanic adolescents has relevance beyond the needs of this particular ethnic group. The apparent reluctance of many Hispanic teenagers to utilize family planning services, and the high birthrates of Mexican American and Puerto Rican teenagers, makes this a particularly challenging area of investigation. Hispanic teens seem to be an extreme population on many of the variables of interest. If we can understand the determinants of childbearing among this population and their attitudes toward the utilization of preventive services, then we will be closer to realizing the potential for reduction of pregnancy among teenagers in general.

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