# Sexual and Reproductive Health of U.S. Latinas: A Literature Review

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# Executive Summary

## Sexual and Reproductive Health of U.S. Latinas: Executive Summary

Latinos are a rapidly growing demographic force in the United States and are now the largest minority group in the country. Yet, studying Latina sexual and reproductive health is complicated by several factors—Latinas are heterogeneous in such matters as country of origin, immigration history and level of acculturation. And, like any ethnic group, they differ according to education, income and geographical location. All of these factors have a profound effect on Latinas' health and lives.

Research on Latinas' sexual and reproductive health is necessary to set priorities and inform public policy debates concerning reducing disparities and improving health care access, funding and service delivery. Although several recent reviews address some aspects of this issue, none address it entirely, and the literature has substantial gaps.

This report addresses these gaps by compiling and summarizing key findings in the literature, presenting some basic tabulations of new national data, providing readers with references for further review and highlighting areas where studies are weak or nonexistent. It profiles the demographic characteristics and sexual and reproductive health indicators for U.S. Latinas as a whole, making comparisons with all U.S. women of reproductive age and with comparable non-Hispanic white and black women. It then summarizes some of the research aimed at measuring the influence of such factors as family, peers, partners, acculturation and socioeconomic status on Latinas' sexual and reproductive health outcomes.

The research for this report was undertaken as part of a larger project aimed at initiating discussion about research, public policy and advocacy priorities in Latina sexual and reproductive health. A complementary component of this larger project was to convene a meeting of interested parties in February 2004. A description of that meeting and the resulting action plan is included among the appendices of this report.

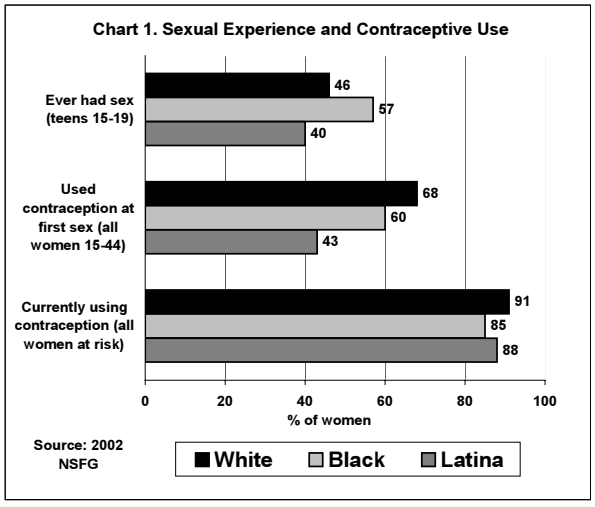
### *Demographic Profile of U.S. Latinas*

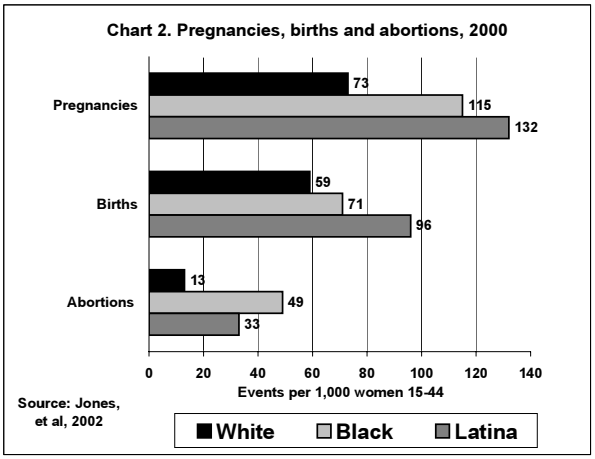
According to the decennial U.S. census and the Census Bureau's Current Population Survey, Latinos are among the fastest growing minority groups in the country. They made up 13% of the population in 2000—almost twice their presence 20 years earlier.

More than two-thirds of U.S. Latinas are of Mexican origin, with smaller proportions from South or Central America, Puerto Rico and Cuba. Half of Latinas of reproductive age are foreign born, and 45% of Latinas have limited English proficiency. Compared with other women of reproductive age, Latinas tend to be disadvantaged in terms of income, education and health insurance status, factors that can negatively affect their health outcomes.

### *Sexual and Reproductive Health Profile*

Data from a range of nationally representative surveys and vital statistics reporting systems indicate that Latinas differ significantly from non-Hispanic whites on many key indicators of sexual and reproductive health and well-being—and often compare poorly; the comparison with non-Hispanic blacks is more complex (see Charts 1 and 2).






• *Sexual experience:* A smaller proportion of Latina teenagers are sexually experienced, compared with their non-Hispanic white or black peers. However, a higher proportion of Latinas say that their first sexual experience was highly wanted.

• *Contraceptive use:* A smaller proportion of Latinas use contraception the first time they have sex, compared with white or black women. Latinas' level of contraceptive use, as well as effectiveness of use, is intermediate between that of white and black women. Compared with white women, Latinas more commonly rely on female sterilization, the injectable and the IUD, while a smaller proportion relies on oral contraceptives or a partners' vasectomy.

• *HIV/AIDS:* Although Latinas represent only 13% of the total U.S. population, they account for one-fifth of Americans with AIDS, and their AIDS case rate is more than six times as high as that of white women.

• *Fertility:* Latinas (particularly, those of Mexican origin) have higher pregnancy rates, birthrates and total fertility rates than white and black women; similar patterns are found among teenagers. In recent years, teenage pregnancy rates and birthrates have fallen dramatically for both black and white adolescents, while Latina teenagers have experienced only modest declines in teenage fertility.

• *Abortion:* Abortion rates among Latinas are considerably higher than those found among whites, but they are lower than those for blacks.

## Key Determinants of Latinas' Behavior

The basic indicators of sexual and reproductive health are important for focusing attention on Latinas' health needs. Yet, in order to best address these needs, researchers must uncover the underlying reasons why Latinas fare better than their peers on some measures and worse on many others. Moreover, researchers must search beneath the broad label of "Latina" to see where problems are at their worst, and also where some groups of Latinas may be pointing the way to solutions.

As yet, most researchers have only scratched the surface of these issues. As this literature review documents, much of our information about these determinants comes from small studies that are far from definitive. Several factors, however, have been identified as important influences determining some types of behavior.

• *Family.* The importance of family structure, parental expectations and communication has been demonstrated to affect many aspects of sexual and reproductive behavior among Latina adolescents. Living in a two-parent home—something that is particularly common for Latinas—may contribute to delayed sexual initiation, as does having parents who disapprove of teenage sex, who set strict rules about dating and who are responsive in talking about sex. These types of family influences among Latinas have also been linked in some studies to lower pregnancy rates, improved communication with sexual partners and consistent condom use.

• *Peers.* Researchers have demonstrated a clear link between what Latina and other teenagers perceive as their peers' attitudes and behavior concerning sex and how they themselves behave sexually; yet, the link probably works in both directions, with teenagers seeking out likeminded friends. Peer influence may also encourage Latinas of all ages to embrace pregnancy and motherhood, as a role that is highly valued in Latino culture.

• *Partners.* Large age disparities between sexual partners are more common in Latinas' relationships than among non-Latinas. Such disparities can put younger Latinas at an increased risk for early sexual initiation, unprotected sex, pregnancy and STDs. Even as adults, a power imbalance within Latina couples has often been found to be a barrier to safer sexual behavior, although gender equality is becoming more common among Latinos and others in the United States.

• *Socioeconomic status.* Most studies have found low levels of access to and use of health care among Latinas—in part, because Latinas are less informed about

available services; and, in part, because they are more likely to be uninsured and unable to pay for care without insurance. Poverty and poor education, among Latinas aand others, are clearly linked to early sex, pregnancy and childbearing. Less well understood is how race, ethnicity, socioeconomic status, and changing health and welfare policies affect one another and ultimately impact women's access to and use of health care services.

• *Acculturation.* Whether measured by immigration status, generation, language ability, language preference or choice of peers, the concept of acculturation is central to many aspects of Latina health and behavior. A variety of studies have linked greater acculturation among Latinas to better contraceptive use, more trust in contraception, more knowledge about HIV transmission and lower birthrates. Yet, acculturation has also been linked to prenatal stress, early delivery and comparatively low-birth-weight infants. Many studies have focused on understanding why disadvantaged Latina immigrants often have more favorable birth outcomes than native born Americans; although the evidence is still mixed, cultural preferences against alcohol, tobacco and drug use are particularly important. Cultural support for motherhood and male involvement in childrearing may also have an impact.

### *Gaps in the Literature*

Most of the basic indicators of Latina behavior and outcomes, and much of the analysis on the influences behind these numbers, are drawn from large, nationally representative surveys. For adult and adolescent Latinas, the most important source has been the National Survey of Family Growth, which looks at a range of relevant indicators for women of reproductive age. Several other major surveys of adolescents, including the Youth Risk Behavior Survey and the National Longitudinal Study of Adolescent Health, contribute to our knowledge about adolescent behavior. Unfortunately, most of these national surveys are not large enough to look at specific Latina subgroups and, instead, combine data from all Latinas, regardless of such factors as their national origin or level of acculturation.

There have been many smaller studies of sexual and reproductive health and behavior that have targeted Latinas in specific states or communities or among clinic populations. These studies help to provide answers and context to some of the questions that large surveys neglect or are unable to address, such as knowledge and attitudes related to sexual and reproductive behaviors, including HIV prevention. Although these studies cannot represent U.S. Latinas as a whole, because of their size and design, they are valuable and many more such studies are needed.

This literature review includes more than 200 references, demonstrating the breadth of the research that has been conducted touching on Latinas' sexual and reproductive health and behavior. Much more, however, remains to be learned about the determinants of different behaviors and how aspects of ethnicity, poverty and public policy all influence one another. Some of the clearest gaps in information identified in this report include:

- improving data collection efforts;
- evaluating the impact of national health care and welfare policies on access to services;
- understanding how protective aspects of immigrant culture can be leveraged to help others;
- identifying the most important barriers to contraceptive use;
- addressing the needs of adolescents and young women; and
- documenting adult Latinas' experiences with unintended pregnancy and abortion.

Armed with more information on these critical topics, policymakers, advocates and health care providers will be better able to address the persistent disparities in health care access and outcomes that U.S. Latinas face each day.

# Chapter 1
# Introduction

An examination of the literature related to Latina sexual and reproductive health is critical for the development of research priorities and informed public policy recommendations. Not only are Latinas a growing demographic force that must be recognized, but the fact that Latinas are not a homogenous group in terms of countries of origin, immigration history, levels of acculturation—to name only a few areas—makes the study of Latinas both unique and complex.

A recent anthology of articles provides a much needed overview of Latina health in general.[1] It covers a wide range of health problems and issues experienced by Latinas from childhood through old age, but devotes only a limited amount of space to sexual and reproductive health issues, including one chapter on Latina health during the reproductive years.[2] In addition, several government reports have focused on measuring the health disparities experienced by Latinas and other racial and ethnic minorities.[3] Again, little or nothing is included in these reports about variations or disparities in sexual and reproductive health behavior or outcomes as experienced by different minority groups. On the other hand, an excellent review of Latino adolescent sexual and reproductive health is available.[4] But this review is limited to studies focused on adolescents and young adults. Finally, a recent anthology of articles previously published in the *International Quarterly of Community Health Education* highlights case studies from both the United States and Latin America that focus on Latina sexual and reproductive health promotion.[5]

The purpose of this report is to compile and summarize key findings from important studies that have investigated or reported on the sexual and reproductive behavior and health of all U.S. Latinas—adolescents and adults—of reproductive age. Priority for inclusion in this review was given to studies focusing specifically on Latinas and to those that highlight significant differences between Latinas and other U.S. racial and ethnic groups. Priority is also given to peer-reviewed articles published since 1990. This review is not intended to provide an exhaustive discussion of study findings, but instead will highlight some of the key findings and provide readers with references for further review. Finally, the report pays particular attention to areas of policy and programmatic interest where studies are weak or nonexistent.

We begin by painting a statistical profile of U.S. Latinas—including an overview of demographic and socioeconomic characteristics and a summary of key indicators of sexual and reproductive health—using nationally representative census and survey data. We recognize the fact that these summary measures often combine data from a variety of Latina subgroups, but given the limitations of current data collection systems, it is not possible to provide subgroup detail for most national indicators. To supplement the available published data on Latinas, this chapter also includes four tables based on special tabulations of the 2002 National Survey of Family Growth, a nationally representative survey of women aged 15–44.

Subsequent chapters summarize studies that have examined a variety of factors hypothesized to influence Latinas' sexual relationships, contraceptive use, fertility behavior and experience with STDs, such as HIV. The types of factors examined include personal characteristics, family, peer and partner influences, acculturation and socioeconomic determinants, as well as differential access to services and the experiences that women have had with providers when seeking sexual and reproductive health care services, to name only a few of the areas examined by studies cited in this review.

A concluding chapter summarizes some of the key gaps in the research and three appendices provide resources for additional information. Appendix A provides contact information for different organizations involved with Latina sexual and reproductive health. Appendix B provides a complete bibliography of literature listed according to author and date of publication. Appendix C is the text of a published action plan to address Latina sexual and reproductive health.

# Chapter 2

# Profile of U.S. Latinas

## Demographic Profile of U.S. Latinas of Reproductive Age

***Key data sources.*** The principal sources available to describe the demographic characteristics of Latinas are from the U.S. Census Bureau—chiefly the decennial census[6] and the Current Population Survey.[7] Both of these sources provide valuable data about the numbers, ages, nativity and other socioeconomic characteristics of Latinas in the United States. However, few standard publications from these sources provide separate tabulations for reproductive-aged women by ethnicity, so special tabulations or regrouping of published tables is necessary. In addition, these sources may not provide a completely accurate portrait of Latino demographics since there is evidence that some groups—Latinos, in particular—are undercounted in official census tabulations.[8] Finally, it is important to note recent changes in the wording of specific race and ethnicity questions on the U.S. Census, including the allowance for multiple races, as these changes may affect analysis of trend data.[9] While these changes will, in the long run, provide a more complete understanding of the race, ethnicity and ancestry of U.S. residents, they do provide challenges for accurate documentation of trends. An additional source of demographic data for Latinas of reproductive age is the 2002 National Survey of Family Growth (NSFG).[10] Tables 1 and 2 present some key data on Latinas from the NSFG.

***Number and age distribution.*** Latinos (including men and women of all ages) make up one of the fastest growing minority groups in America. In 1980, they made up 6% of the U.S. population. This percentage rose to 9% in 1990 and to 13% in 2000.[11]

Latinas comprise an even larger share of women of reproductive age. In 2000, there were 61.6 million women of reproductive age (15–44) in the United States. Two-thirds of these women were non-Hispanic white; the rest were women of color. Latinas made up the single largest minority group; 8.5 million Latina women represented 14% of all women of reproductive age. They were followed closely by non-Hispanic black women, with 8.4 million women aged 15–44.[12]

Latinas of reproductive age are, on average, younger than all women of reproductive age. Within this age group, 54% of Latinas are younger than 30 and 46% are aged 30–44. Among the total population of reproductive-aged women, these proportions are reversed: 47% are younger than 30 and 53% are aged 30–44.[13]

***Origin, residence and language.*** Two-thirds (68%) of all Latinos are of Mexican origin, one in seven come from South or Central America, nearly one in ten are Puerto Rican and 4% are Cuban.[14] (Note: this distribution of Latinos by country of origin comes from the 2002 Current Population Survey and is based on a sample. It is somewhat different from the distribution found in the 2000 census, which enumerated 58.5% from Mexico. It is unclear if these differences are due to actual change or to different data collection methods.) Latinos are concentrated in several states, with half of all Latinos in the United States living in either California (31%) or Texas (19%), and an additional one-quarter in New York, Florida, Illinois, Arizona or New Jersey. In New Mexico, although their numbers are not as large as in these other states, Latinos make up 42% of the total population.[15] Among Latinas of reproductive age, 55–69% report being of Mexican origin, depending on age group (Table 1).

Among Latinas of all ages, 38% were born outside the United States and nearly half of these entered the United States after 1990.[16] When considering only Latinas of reproductive age, the percent foreign born rises to 50% (Table 1). Among all adult Latinos (aged 18–64), over 80% speak another language besides English (mostly Spanish) and nearly half (45%) report that that they do not speak English "very well."[17] These are adults who report that they either speak English "well," "not well" or "not at all." According to 2002 Department of Justice Guidance,[18] such persons are defined

as having limited English proficiency (LEP) in the context of health care settings because they may be unable to speak, read, write or understand the English language at a level that permits effective interaction with health and social service providers.

***Socioeconomic status.*** Compared to all women of reproductive age, Latinas are disadvantaged on a number of key indicators. Based on census tabulations, one in four Latinas of reproductive age lives below the federal poverty level, compared with 15% for all women age 15–44.[19] In comparison, perhaps because of different poverty definitions, over one-third (37%) of Latinas of reproductive age in the NSFG reported family incomes below the federal poverty level, compared with 19% among all women (Table 2). Among foreign-born Latinas, the percentage below the poverty level rises to 45%. Educationally, Latinas are also at a disadvantage. Considering only Latinas aged 25 and older, the census reports that nearly half (46%) have not completed high school, compared with only one in five adult women of all races and ethnicities. Similar percentages are found with the NSFG: Some 42% of Latinas have not completed high school, compared with 16% of white women of reproductive age and 25% of black women. Over half (52%) of foreign-born Latinas do not have a high school diploma.

Nationally, based on Current Population Survey (CPS) data, one in three Latinos (32%) has neither private nor government funded health insurance; among foreign-born Latinos this proportion rises to nearly one in two (48%). In comparison, 15% of all U.S. residents lack health insurance.[20] Among Latinas of reproductive age in the NSFG, a similar situation is found—30% have no health insurance, compared with 16% of all women (Table 2); the percentage of foreign-born Latinas with no insurance is 42%.

Issues of poverty, social class, acculturation and ethnic identity are intimately related to health status and outcomes. A number of researchers have examined these issues as related to Latinos, and, although a review of the full scope of these investigations is beyond the mandate of this report, some of these studies are referenced here.[21]

## Sexual and Reproductive Health Profile of U.S. Latinas

***Key data sources.*** Several national data sources allow measurement of key sexual and reproductive health indicators among Latinas. Birth data for Latinas as a group and for major subgroups (Mexican, Puerto Rican, Cuban, Central/South American and other) are collected as part of the national vital statistics reporting system and are quite complete.[22] Information on pregnancy rates is less complete since abortion data are not routinely collected by all states; however, estimates of pregnancy rates for all Latinos are available from both the Centers for Disease Control and Prevention (CDC)[23] and from the Guttmacher Institute.[24] These rates are not available by Latino national origin.

Information on sexual behavior, pregnancy intention status and other reproductive health indicators comes from survey data. However, national surveys typically do not have large enough sample sizes to provide estimates by national origin. A key source for relevant data is the National Survey of Family Growth, a nationally representative survey of women aged 15–44 than includes an over-sample of Latinas and black women. Other national surveys that provide data specific to the sexual and reproductive health of adolescent Latinas include the Youth Risk Behavior Survey and the National Longitudinal Study of Adolescent Health. Finally, there are many smaller, targeted data collection efforts that provide information about the sexual and reproductive behavior of Latinas in specific states or communities or among clinic populations.

### *Sexual experience*

• Latina youth are less likely to be sexually experienced compared with either non-Hispanic white or black teenagers. In 2002, 40% of Latinas aged 15–19 had ever had sexual intercourse (Table 3).[25] In comparison, 46% of non-Hispanic white teenagers and 57% of non-Hispanic black teenagers were sexually experienced (not shown).[26] A similar pattern is found when looking at sexual experience among younger and older adolescents. One-quarter of young Latinas aged 15–17 have had sex, compared with 30% of non-Hispanic white and 41% of non-Hispanic black women aged 15–17. Among older teenagers aged 18–19, 64% of Latinas are sexually experienced, compared with 70% of non-Hispanic white and 81% of non-Hispanic black women aged 18–19. Between 1995 and 2002, all groups experienced a drop in the percentage of young adolescents who were sexually experienced, however, among Latinas, this drop was precipitous—in 1995, 49% of 15–17-year-old Latinas were sexually experienced. This proportion fell to 25% in 2002.

### *Contraceptive use*

• Latinas are less likely than non-Hispanic black or white women to report having used a method of contraception at first intercourse. Among women aged 15–44

in 2002, 43% of Latinas reported contraceptive use the first time they had sex, compared with 60% of blacks and 68% of whites (Table 4). However, these differences appear to be lessening. Among unmarried women of all ages who first had intercourse between 1990 and 2002, 55% of Latinas reported using any method of contraception at first intercourse, compared with 70% of non-Hispanic black and 80% of non-Hispanic white women. In comparison, among women aged 15–19 in 2002, 71% of Hispanic and non-Hispanic black teenagers reported any contraceptive use at first intercourse compared with 78% of non-Hispanic white teenagers.[27]

• Among all women at risk for unintended pregnancy (those who are sexually active and fecund, but not currently pregnant or trying to get pregnant), the percentage of women using no method is highest for non-Hispanic blacks (15%) and lowest for non-Hispanic whites (9%); Latinas fall in between these two groups (12%) (Table 4).[28] These numbers represent an increase among all groups in the percentage of women at risk of unintended pregnancy reporting no current contraceptive use between 1995 and 2002. In 1995, 9% of Latinas at risk for unintended pregnancy were nonusers, as were 10% of similar non-Hispanic black women and 7% of similar non-Hispanic white women.[29]

• Among all Latina contraceptive users, nearly one in six (16%) will experience a contraceptive failure during the first two years of method use. This is significantly higher than the failure rate for non-Hispanic whites (11%), but slightly lower than the failure rate for non-Hispanic blacks (18%).[30]

• Latinas who use contraception are quite similar to non-Hispanic blacks in their choice of methods. Both Latinas and blacks are more likely than whites to choose female sterilization over male sterilization, less likely to choose oral contraceptives and more likely to choose an injectable hormonal method (Depo Provera) (Table 4).[31]

### *HIV/AIDS*

• Although Latinos represent only 13% of the total U.S. population, they represent one-fifth of the U.S. population living with AIDS. For Latinas, the AIDS case rate is 13.8 per 100,000, compared to only 2.2 per 100,000 among non-Hispanic white women. Women represent a steadily increasing proportion of Latino AIDS cases; in 1990, 15% of all Latino AIDS cases were among Latinas. By 2000, this had risen to 23%.[32]

### *Fertility*

• Latinas have the highest fertility rate of any race or ethnic group in the United States. In 2003, the annual fertility rate for all Latinas was 97 births per 1,000 women aged 15–44. In comparison, the fertility rate for all women aged 15–44 was 66; for non-Hispanic Blacks it was 67 and for non-Hispanic whites it was 59.[33] Fertility can also be expressed as the number of children born per women, or total fertility rate (TFR). For all Latinas, the TFR is 2.79, compared to 2.04 for all women, 2.03 for black women and 1.86 for white women.

• Among major Latina subgroups, women of Mexican origin have the highest fertility rate—106 births per 1,000 women aged 15–44. In comparison, the fertility rate is 62 for women of Puerto Rican origin, 62 for Cuban women and 91 for Latinas from Central and South America.[34] Again, fertility can be expressed using the TFR. The TFR for Latinas of Mexican origin is 2.96, compared to 1.84 for Puerto Ricans, 2.06 for Cubans and 2.73 for Latinas from Central and South America.

• Similar patterns are found among teenagers, with Latinas aged 15–19 experiencing higher birth rates than any other race or ethnic group. In 2003, the birth rate for all Latina teenagers was 82 births per 1,000 women aged 15–19; compared with 650 for non-Hispanic blacks and 27 for non-Hispanic whites. Again, Latina teenagers of Mexican origin have the highest rate—93 births per 1,000 women aged 15–19 in 2003.[35]

• Since 1990, birth rates among Latina teenagers have declined gradually, falling 18% between 1990 and 2003. In comparison, non-Hispanic blacks experienced a sharp decline in teenage birthrates over the same period—falling 44% between 1990 and 2003; and non-Hispanic white teenagers experienced a 35% decline in the teenage birthrate.[36]

• Latinas also have the highest pregnancy rates. Excluding miscarriages, in 2000, Latinas had a rate of 132 pregnancies per 1,000 women aged 15–44, compared with pregnancy rates for non-Hispanic blacks and whites of 115 and 73, respectively.[37]

• The abortion rate for Latinas in 2000 (33 abortions per 1,000 women aged 15–44) was considerably higher than that for non-Hispanic white women (13 per 1,000), but lower than that for non-Hispanic black women (49 per 1,000).[38]

***TABLE 1. Number and percentage distribution of Latinas of reproductive age, by demographic and socioeconomic characteristics, according to age, National Survey of Family Growth, 2002***

| Characteristic | All Latinas 15–44 | | Age | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Number | % | 15–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 |
| **Total number** | 9,106,808 | na | 1,520,611 | 1,632,242 | 1,654,293 | 1,594,677 | 1,447,521 | 1,257,463 |
| **Country of origin** | | | | | | | | |
| Mexico | 5,755,314 | 63.3 | 63.8 | 66.7 | 68.6 | 63.9 | 54.5 | 60.7 |
| Other | 3,335,072 | 36.7 | 36.2 | 33.3 | 31.4 | 36.1 | 45.5 | 39.3 |
| **Immigrant status** | | | | | | | | |
| U.S.-born | 4,560,256 | 50.2 | 71.3 | 58.7 | 43.4 | 46.0 | 43.1 | 36.5 |
| Foreign-born | 4,517,542 | 49.8 | 28.7 | 41.3 | 56.6 | 54.0 | 56.9 | 63.5 |
| **Poverty level** | | | | | | | | |
| 0–99% of poverty | 3,329,049 | 36.6 | 36.2 | 40.2 | 39.0 | 40.3 | 32.2 | 29.3 |
| 100–199% poverty | 2,515,240 | 27.6 | 28.4 | 31.7 | 27.3 | 24.8 | 27.3 | 25.8 |
| 200–299% poverty | 1,505,385 | 16.5 | 22.2 | 10.3 | 15.9 | 14.6 | 16.4 | 21.1 |
| >300% poverty | 1,757,134 | 19.3 | 13.2 | 17.9 | 17.7 | 20.4 | 24.1 | 23.8 |
| **Educational level** | | | | | | | | |
| <high school | 3,833,001 | 42.1 | 72.7 | 35.5 | 40.6 | 36.2 | 27.5 | 39.9 |
| High school/GED | 2,585,672 | 28.4 | 22.1 | 31.7 | 27.0 | 29.2 | 32.1 | 28.3 |
| Some college | 1,871,124 | 20.5 | 5.3 | 28.6 | 19.5 | 22.3 | 26.6 | 20.7 |
| College degree | 817,010 | 9.0 | 0.0 | 4.2 | 12.9 | 12.3 | 13.8 | 11.1 |
| **Insurance in past** | | | | | | | | |
| Private insurance | 3,999,436 | 43.9 | 41.7 | 37.9 | 38.5 | 46.5 | 53.4 | 47.3 |
| Medicaid | 1,667,652 | 18.3 | 25.6 | 20.2 | 20.0 | 18.7 | 11.0 | 12.7 |
| Other | 717,660 | 7.9 | 10.7 | 10.4 | 5.6 | 6.0 | 5.9 | 9.0 |
| None | 2,722,061 | 29.9 | 22.0 | 31.6 | 35.9 | 28.7 | 29.7 | 31.0 |
| **Marital status** | | | | | | | | |
| Currently married | 4,137,972 | 45.4 | 3.9 | 32.4 | 48.6 | 64.2 | 62.3 | 65.0 |
| Currently cohabiting | 1,221,145 | 13.4 | 9.1 | 20.7 | 19.3 | 10.8 | 11.4 | 6.9 |
| Formerly married, not cohabiting | 902,059 | 9.9 | 0.9 | 4.5 | 8.9 | 11.5 | 16.6 | 19.3 |
| Never-married, not cohabiting | 2,845,629 | 31.2 | 86.1 | 42.4 | 23.1 | 13.4 | 9.7 | 8.7 |
| Total | na | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*Note:* na=not applicable.

***TABLE 2. Number and percentage distribution of all U.S. women of reproductive age, by demographic and socioeconomic characteristics, according to race and ethnicity, National Survey of Family Growth, 2002***

| | All women 15–44 | | Race or ethnicity* | | | | |
|---|---|---|---|---|---|---|---|
| | | | White | Black | Latina | | |
| Characteristic | Number | % | | | Total | U.S.-born | Foreign-born |
| **Total number of women** | 61,560,715 | na | 40,420,450 | 8,586,813 | 9,106,808 | 4,560,256 | 4,517,542 |
| **Immigrant status** | | | | | | | |
| U.S.-born | 52,640,879 | 85.7 | 95.9 | 89.3 | 50.2 | 100.0 | 0.0 |
| Foreign-born | 8,818,807 | 14.3 | 4.1 | 10.7 | 49.8 | 0.0 | 100.0 |
| **Poverty level** | | | | | | | |
| 0–99% of poverty | 11,751,380 | 19.1 | 12.7 | 30.1 | 36.6 | 28.6 | 44.6 |
| 100–199% poverty | 12,859,087 | 20.9 | 18.6 | 24.0 | 27.6 | 23.2 | 31.9 |
| 200–299% poverty | 11,262,231 | 18.3 | 18.8 | 18.0 | 16.5 | 19.2 | 14.0 |
| >300% poverty | 25,688,017 | 41.7 | 49.9 | 27.9 | 19.3 | 29.0 | 9.5 |
| **Educational level** | | | | | | | |
| <high school | 13,062,732 | 21.2 | 16.2 | 24.5 | 42.1 | 31.9 | 52.4 |
| High school/GED | 17,244,556 | 28.0 | 27.5 | 32.6 | 28.4 | 31.3 | 25.3 |
| Some college | 17,680,936 | 28.7 | 30.5 | 29.2 | 20.5 | 26.8 | 14.3 |
| College degree | 13,572,491 | 22.0 | 25.8 | 13.7 | 9.0 | 10.1 | 7.9 |
| **Insurance in past year** | | | | | | | |
| Private insurance | 41,725,356 | 67.8 | 76.2 | 55.8 | 43.9 | 55.1 | 32.7 |
| Medicaid | 6,312,202 | 10.3 | 6.2 | 21.2 | 18.3 | 20.5 | 16.1 |
| Other | 3,939,837 | 6.4 | 5.4 | 6.6 | 7.9 | 7.0 | 8.7 |
| None | 9,583,320 | 15.6 | 12.2 | 16.4 | 29.9 | 17.4 | 42.4 |
| **Marital status** | | | | | | | |
| Currently married | 28,326,689 | 46.0 | 50.5 | 25.8 | 45.4 | 37.2 | 53.8 |
| Currently cohabiting | 5,569,791 | 9.0 | 8.0 | 9.4 | 13.4 | 11.7 | 15.2 |
| Formerly married, not cohabiting | 6,095,982 | 9.9 | 9.6 | 12.0 | 9.9 | 9.2 | 10.7 |
| Never-married, not cohabiting | 21,568,252 | 35.0 | 31.9 | 52.8 | 31.2 | 41.9 | 20.3 |
| Total | na | 100 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

*White and black exclude Latinas. Latinas may be of any race. Women reporting "other" are not shown separately, but are included in the totals. *Note:* na=not applicable.

***TABLE 3. Number and percentage of Latinas of reproductive age, by sexual and reproductive health characteristics, according to age, National Survey of Family Growth, 2002***

| Characteristic | All Latinas 15–44 | Age 15–19 | 20–24 | 25–29 | 30–34 | 35–39 | 40–44 |
|---|---|---|---|---|---|---|---|
| **Total** | | | | | | | |
| No. | 9,106,808 | 1,520,611 | 1,632,242 | 1,654,293 | 1,594,677 | 1,447,521 | 1,257,463 |
| % ever had sex | 86.6 | 40.4 | 89.5 | 94.9 | 98 | 99 | 99.1 |
| % ever had a child | 67.6 | 13.5 | 55.7 | 72.9 | 87.4 | 89.1 | 91.8 |
| **Sexually experienced** | | | | | | | |
| No. | 7,886,712 | 614,760 | 1,461,104 | 1,569,395 | 1,562,192 | 1,433,091 | 1,246,170 |
| % used contraceptive at first sex | 43.2 | 66.2 | 45.9 | 52.6 | 41.3 | 35.8 | 27.5 |
| % used condom at first sex | 25.4 | 49.1 | 30.8 | 35.1 | 21.9 | 14.7 | 12.1 |
| **At risk for unintended pregnancy*** | | | | | | | |
| No. | 6,075,090 | 405,425 | 1,069,946 | 1,202,391 | 1,259,626 | 1,164,878 | 972,824 |
| % use sterilization | 33.8 | 0 | 6.4 | 17.9 | 35.6 | 55.8 | 68.7 |
| % use reversible method | 54.6 | 76.4 | 81.2 | 69.2 | 51.9 | 36.6 | 23.4 |
| % sexually active, using no method | 11.6 | 23.6 | 12.5 | 12.9 | 12.4 | 7.6 | 7.9 |
| **Using a contraceptive** | | | | | | | |
| No. | 5,370,458 | 309,895 | 936,403 | 1,047,692 | 1,103,341 | 1,076,830 | 896,297 |
| Distribution by most effective method used: | | | | | | | |
| % using female sterilization | 33.8 | 0 | 6.4 | 18.1 | 37.1 | 53.7 | 64.2 |
| % using male sterilization | 4.4 | 0 | 0.8 | 2.5 | 3.6 | 6.7 | 10.4 |
| % using implant/IUD | 7.1 | 2.6 | 5.5 | 14 | 6.9 | 5.7 | 4.4 |
| % using injectable | 7.8 | 20.2 | 15.1 | 6.3 | 9.5 | 2.4 | 1.7 |
| % using pill | 22 | 37.8 | 34.6 | 28.5 | 20.5 | 14.8 | 6.1 |
| % using condom | 18.5 | 33.7 | 25.2 | 23.1 | 16.2 | 12.9 | 10.2 |
| % using withdrawal | 3.7 | 5.3 | 8.6 | 4.7 | 3.3 | 0.5 | 1.5 |
| % using all other methods | 2.8 | 0.6 | 3.8 | 2.8 | 2.9 | 3.4 | 1.5 |
| **% using a condom at all** | 24.1 | 39.8 | 36.1 | 29.6 | 20.1 | 14.3 | 16.5 |

*Number at risk for unintended pregnancy excludes women who are currently pregnant, trying to get pregnant, postpartum, noncontraceptively sterile or not sexually active in the past three months.

***TABLE 4. Number and percentage of all U.S. women of reproductive age, by sexual and reproductive health characteristics, according to race or ethnicity, National Survey of Family Growth, 2002***

| Characteristic | All women 15–44 | Race or ethnicity* | | | | |
|---|---|---|---|---|---|---|
| | | White | Black | Latina | | |
| | | | | Total | U.S.-born | Foreign-born |
| **Total** | | | | | | |
| No. | 61,560,715 | 40,420,450 | 8,586,813 | 9,106,808 | 4,517,542 | 4,560,256 |
| % ever had sex | 88.0 | 88.5 | 89.6 | 86.6 | 81.6 | 91.6 |
| % ever had a child | 58.4 | 55.8 | 63.3 | 67.6 | 58.5 | 76.7 |
| **Sexually experienced** | | | | | | |
| No. | 54,189,517 | 35,789,143 | 7,693,099 | 7,886,712 | 3,720,602 | 4,137,100 |
| % used contraceptive at first | 62.6 | 67.8 | 60.1 | 43.2 | 54.9 | 32.4 |
| % used condom at first sex | 35.5 | 38.2 | 33.7 | 25.4 | 33.7 | 18.2 |
| **At risk for unintended pregnancy†** | | | | | | |
| No. | 42,683,183 | 28,754,730 | 5,799,582 | 6,075,089 | 2,804,209 | 3,243,888 |
| % use sterilization | 32.3 | 32.3 | 35.1 | 33.8 | 37.2 | 30.9 |
| % use reversible method | 57.0 | 58.4 | 49.9 | 54.6 | 51.0 | 57.6 |
| % sexually active, using no method | 10.7 | 9.4 | 15.1 | 11.6 | 11.8 | 11.5 |
| **Using a contraceptive** | | | | | | |
| No. | 38,109,185 | 26,061,680 | 4,925,289 | 5,370,458 | 2,473,445 | 2,870,632 |
| Distribution by most effective method used: | | | | | | |
| % using female sterilization | 27.0 | 24 | 38.9 | 33.8 | 35.7 | 32.3 |
| % using male sterilization | 9.2 | 11.6 | 2.4 | 4.4 | 6.5 | 2.6 |
| % using implant/IUD | 2.4 | 1.6 | 1.5 | 7.1 | 2.8 | 10.9 |
| % using injectable | 5.5 | 4.4 | 9.9 | 7.8 | 6.3 | 8.7 |
| % using pill | 30.6 | 34.3 | 22.5 | 22 | 23.4 | 20.6 |
| % using condom | 18.0 | 16.6 | 19.9 | 18.5 | 17.8 | 19.2 |
| % using withdrawal | 4.0 | 3.9 | 2.6 | 3.7 | 4.2 | 3.4 |
| % using all other methods | 3.3 | 3.5 | 2.3 | 2.8 | 3.3 | 2.3 |
| **% using a condom at all** | 23.8 | 21.8 | 29.6 | 24.1 | 22.7 | 25.6 |

†Number at risk for unintended pregnancy excludes women who are currently pregnant, trying to get pregnant, postpartum, noncontraceptively sterile or not sexually active in the past three months.
*White and black exclude Latinas. Latinas may be of any race. Women reporting "other" are not shown separately, but are included in the totals.

## Chapter 3

# Sexual Relationships and Contraceptive Use Among Adolescent Latinas

### National Studies Measuring Adolescent Behavior

***First sex.*** A number of studies have used nationally representative data to explore how young women's first sexual encounters vary by race or ethnicity.[39]

However, for a number of reasons (e.g., variations in survey methodology, sample selection and question wording), different surveys report varying levels of sexual activity among young Latinas and different levels of change in sexual experience over time. The Youth Risk Behavioral Survey (YRBS) reports that, in 2003, 46% of Latina high school students had ever had sex, a drop from 53% in 1995. By comparison, the NSFG reports that 37% of 15–19-year-old Latinas had ever had sex in 2002, a drop from 53% reported in the 1995 NSFG. The YRBS has consistently reported that the proportion of Latinas who have ever had sex is slightly higher than that for whites and somewhat lower than that for blacks.[40] A similar pattern was found in the 1995 NSFG; however, the 2002 NSFG reports fewer Latina teenagers to be sexually experienced compared with either non-Hispanic white or non-Hispanic black teenagers. Further investigation is needed to understand the factors contributing to these trends.

***Wantedness of first sex.*** The NSFG provides information on whether young women's first sex was voluntary and measures the "wantedness" of this experience. Latinas were the most likely to rate their first sexual intercourse as highly wanted.[41]

***Contraceptive use.*** Among sexually active adolescents, condoms are the most common form of contraception used at first sex. In 2002, two-thirds of Latina and non-Hispanic white teenage women reported using a condom at first sex (67–68%) and 85% of non-Hispanic black teenagers did so.[42] Among sexually active adolescents who are current users of contraceptives, hormonal contraceptives are the method of choice—among all teenage women, 53% use oral contraceptives and 14% use Depo Provera[43]; among Latina teenagers, the percentages are 38% and 20%, respectively (Table 3). The proportions using condoms as their most effective method are 27% for all teenagers and 34% for Latina teenagers. These percentages are considerably higher when dual use is factored in—45% of all teenagers use condoms at all and 40% of Latina teenagers do so.

### Determinants of Young Latinas' Sexual and Contraceptive Behavior

Many studies have examined the factors that influence the sexual and contraceptive behavior of adolescents and quite a few have focused specifically on Latinas. Driscoll et al. provide an excellent review of many of these studies along with commentary regarding the different routes and mechanisms through which these factors are thought to influence behavior.[44] We summarize some of their findings related to adolescent sexual and contraceptive behavior among Latinas according to five broad areas of influence (family, peers, partners, acculturation and socioeconomic status) and include references to more recent studies when possible.

***The importance of family.*** Families have a large impact on the behavior of adolescents. Family structure, monitoring of adolescent activities, familial expectations and communication with parents all play a role in shaping how young people behave. A number of studies have found that growing up in a single-parent family puts adolescent girls (Latinas, as wells young women of other race or ethnicities) at greater risk of becoming sexually active than girls growing up in two-parent families.[45]

A relatively high proportion of Latina teenagers come from two-parent families compared with non-Hispanic teenagers of other race/ethnicities. This might help account for the later mean age at first sex among Latinas than among non-Hispanic whites. Among teenagers in Los Angeles, Latinas were less likely than whites to have had sex before controlling for family structure; they were also more likely to be living with

both parents. After taking parents' marital status into account, there was no difference between white and Latina adolescents, suggesting that two-parent families serve to protect Latinas from early sexual involvement.[46] Similar to teenagers from other race/ethnic groups, Latina adolescents from two-parent families are less likely to get pregnant;[47] and those teenagers from in-tact families who do get pregnant are more likely to have an abortion than those in other family situations.[48]

Studies examining the effect of parental monitoring on the sexual activity of Latino teenagers have shown mixed results. Although strict maternal monitoring of Latino and black teenagers was not associated with age at first sex in one study, another study found a significant association between maternal monitoring and a lower lifetime frequency of sexual intercourse and fewer sex partners.[49] Moreover, adolescent Latinos who perceive that their mothers disapprove of teenagers having sex before marriage and whose mothers have rules about dating delay having sex longer than teenagers who perceive their parents as more permissive.[50] Interestingly, Latino teenagers who believe that their own mother had premarital sex are more likely to have experimented sexually than those who thought their mothers remained virgins until they married.[51]

The frequency, quality and topics of parents' conversations with their adolescents are important predictors of teenagers' sexual behavior. Increasingly, researchers have examined the types of communication that occur among Latino parents and children,[52] and some have looked at whether more or better communication is associated with lower levels of sexual activity. For example, parent-teenager communication about sex appears to predict whether virgin adolescents anticipate having sex in the next year or whether they intend to delay sexual initiation. Latino adolescent virgins who see their mothers as responsive when talking to them about sex are more likely to expect to delay sex than teenagers who rated their mothers lower on understanding, openness, skill and comfort in discussing sexual topics.[53] In another study of young Mexican-Americans (aged 11–14), the child's perception of the congruency of parent-child sexual values was the best predictor of absence of sexual activity.[54]

Parent-teenager communication also appears to affect the behavior of sexually experienced teenagers. Teenagers whose mothers were responsive in conversations with them about sexuality were more likely to communicate with their sexual partners about contraception and STDs than those with less encouraging and responsive mothers. Such teenagers were also more likely to use a condom the first time they had sex and to continue to use condoms.[55] Latina teenagers who discussed sex and boys with their mothers were more likely to use condoms than those who did not talk to their mothers about these topics.[56] Moreover, teenagers who discuss with their parents how their peers feel about condoms are more likely to use condoms. These discussions apparently lessen the effect of negative peer attitudes toward condoms on teenagers' condom use.[57] A study examining communication between parents and Latino and black adolescents around sex-related topics found that mothers were more likely to talk to daughters and fathers more likely to talk to sons, but that the level of agreement between parents and children about whether or not a topic had been discussed was relatively low, particularly in families where there was less openness in the communication process.[58]

***Peer influence.*** In addition to parents and other family members, peers and friends become increasingly important as children grow into adolescents.[59] Adolescents often place a great deal of importance on their peers' opinions and may feel pressure to conform to what they perceive as norms in their social circles. Teenagers tend to overestimate the proportion of their peers that have had sex,[60] and those who perceive their peers as sexually active and in favor of not postponing sex are more likely to have ever had sex.[61] In a sample of disadvantaged, primarily Dominican youth in New York City, teenagers' estimate of how many of their own friends and peers had ever had sex was strongly associated with sexual experience.[62] Among Latina adolescents, peer influences seem to be stronger for younger than older teenagers. Young nonvirgins have more friends that they believe are sexually active than do young virgins and are likely to predict their best friend would not be upset with them if they had sex.[63]

Although there is evidence that teenagers' attitudes and behaviors mirror their friends', the direction of the association between perceived peer norms and sexual behavior is uncertain and most likely bidirectional. Youth probably select peers whose behaviors and attitudes match their own; thus, sexually active youth tend to choose peers who are also sexually active. On the other hand, the need to be accepted by a particular peer group may be strong enough that teenagers alter their viewpoints and behaviors in order to belong. A study of sexually experienced racially and ethnically diverse youth found that youth who perceive that their friends engage in risky behavior or will not support their risk-

reduction efforts are significantly more likely to engage in risky sexual behavior themselves.[64]

***Partner influence.*** The characteristics of young Latinas' partners are often associated with the teenagers' behavior within relationships. A nationally representative study of youth found that while the partners of white and black adolescents were more likely to be similar to them in terms of race, the partners of Latino adolescents were more likely to be of a different race or ethnic group.[65] Differences in age between partners were common among all groups; and the less similar partners were to one another (either because of race/ethnicity or age) the less likely they were to use condoms or other contraceptives. In a study of pregnant Mexican-American teenagers, partners who were less acculturated tended to be older, working and less educated; whereas partners who were more acculturated tended to also be teenagers and were more educated. Young women with less acculturated partners were also more likely to be married to their partners.[66]

Communication between adolescent partners is also important for avoiding risky behavior. However, among Latinas and other young Americans, discussions about sex are rare prior to first intercourse. Erikson provides an ethnographic look at sexual initiation and communication among several young Latino couples in East Los Angeles, illustrating many of the complexities faced by young Latinas around sexual relationships.[67] The effect of greater communication among couples has been demonstrated in a study of mostly Latino adolescents who were incarcerated in Los Angeles. Researchers found that those who communicated with their partners about each others' sexual histories were significantly more likely to report condom use.[68]

A good deal of research has focused on relationships between younger women and older male partners due to evidence that such relationships often put young women at risk for negative outcomes, such as early sexual initiation, unintended pregnancy and STDs. However, there is evidence that older partners play an important role in early sexual initiation, regardless of the sex of the older partner. Preadolescents whose boyfriends or girlfriends were at least two years older were more likely to have had sex than other youths. While this was particularly true for girls, it was also the case for boys.[69]

Studies examining the relationship between partners' age differences and contraceptive use suggest that age disparities put younger Latinas at risk for unprotected sex. Latina teenagers whose first sexual partner was at least three years older were less likely to have used condoms consistently than teenagers whose partners were closer in age.[70] Such behavior puts young women at higher risk for both pregnancy and STDs.

Finally, the issue of partner violence, gender roles and sexual behavior has been explored, at least for Puerto Rican youth.[71] Based on an ethnographic study of about 150 low-income Puerto Rican adolescents in New York City, researchers found that participants were able to justify violence by linking it to norms about gender roles, sexuality and male dominance. The researchers suggested possible interventions that recognize these constructs while developing alternative expectations for interpersonal behavior.

***Acculturation.*** Acculturation refers to the processes and changes that occur as an immigrant group comes into contact with the mainstream culture of their new country. A number of researchers have explored issues of acculturation and ethnic or cultural identity among Latino adolescents.[72] Others have developed scales or proxy measures of acculturation that can be used to investigate the association between acculturation and other behaviors.[73] Although acculturation can be measured in a number of ways, these proxies all have limitations due to the complex nature of acculturation, and the fact that these processes may be affected by individual differences, and the level, rate or type of contact with the mainstream culture, as well as age or life-stage of the immigrant. Bearing in mind these difficulties, we review some of the studies that have attempted to examine the association between proxy measures of acculturation and behavior. Whether a person is foreign-born (first generation) or native-born, is a common proxy measure. More refined measures classify native-born persons into those whose parents are immigrants (second generation) or U.S.-born (third and higher generations).[74] There is evidence that second and third generation Latino adolescents become progressively more oriented toward American culture as their orientation toward Latino culture diminishes, but does not disappear.[75] Facility in the host country language is another marker of acculturation. In general, English language ability is highly positively correlated with length of residence in the United States and with generation. Language preference is a related acculturation measure. A preference for English indicates a stronger attachment to U.S. culture and thus a higher level of acculturation. Additional proxy measures of acculturation include, but are not limited to, language of pre-

ferred media sources such as TV, radio, newspapers and the ethnicity of friends, coworkers or schoolmates.

Several studies looking at the relationship between level of acculturation and adolescent sexual activity suggest that more acculturated Latinas are more likely to be sexually experienced, but are also more likely to use contraceptives than less acculturated Latina adolescents.[76] Other studies have found different results. Among California high school students, immigrant Latinos were more likely to be sexually active and less likely to use contraception than U.S.-born Latinos.[77] In New York City, level of acculturation was not associated with ever having had sex among Latino Dominican junior high students.[78] These disparate findings suggest that there may be differences according to national origin and immigrant background, as well as across the various situations in which immigrants and their offspring live in the United States. More generally, these findings suggest that the relationship between acculturation and sexual or reproductive behavior is complex and that our measurement of acculturation is still very imperfect. A challenge for the field is to develop better measures for acculturation and to ensure that these measures are included in future research.

***Socioeconomic status (SES).*** The relationship between SES and age at first sex among adolescent Latinas is not entirely consistent. Among young females in California, low family income was associated with the intention to have sex within the next year among Mexicans but not among black, non-Hispanic white or Southeast Asian girls.[79] However, among urban students, low SES was associated with becoming sexually active for Latinos, as well as for black and white students.[80]

The lower mean SES of Latinos appears to explain a proportion of the difference in contraceptive use at first sex between Latino and non-Hispanic white teenagers. For example, controlling for differences in parents' educational attainment narrows the gap in contraceptive use at first sex between Latino and white teenagers. However, even after accounting for SES, Latinos are still only about half as likely to use contraception, thus additional factors must explain the differences in contraceptive use between Latinos and whites.[81] Parental education and welfare status have little or no effect on the gap in consistency of condom use between adolescent Latino males and others.[82] Latinos are markedly less likely to consistently use condoms than are either whites or blacks and SES is apparently not the primary reason for this difference.

Among young Latinas in New York, maternal education was associated with rating the use of birth control as important.[83] Whether this attitude then translates into a higher use of contraception among young women with more highly educated mothers is not clear.

***Community.*** Finally, the idea that certain aspects of one's community can be protective against negative social or health outcomes has been discussed, particularly for Latinos. In a study of adolescent birth rates by zip code in California, the researchers identified communities that had lower birth rates than expected, given area poverty levels, and compared these areas with communities with similar poverty levels and high birth rates.[84] They found that cultural norms and social capital distinguished the low birth rate areas from the high birth rate areas—the zip codes with low adolescent birth rates had a higher percentage of residents of Latino descent, stronger social networks and more ties to their countries of origin. Further research is clearly needed to better understand these protective mechanisms and to develop ways to promote them in other areas.

## Chapter 4

# Sexual Relationships and Contraceptive Use Among Adult Latinas

### Sexual Relationships Among Adult Latinas

The lack of information on sexual attitudes and behaviors among adult Latinas was recognized over a decade ago.[85] Since then, a number of researchers have examined Latinas and the constellation of forces that shape their sexual attitudes, behaviors and relationships. In response to the growing numbers of Latinas affected by HIV/AIDS, particular emphasis has been placed on investigating issues of gender and power among Latino couples.

In examining psychosocial theories for reducing risky sexual behavior, Amaro emphasizes the need to incorporate a gender perspective and summarizes a variety of studies—some that ignore discussion of gender roles and some that have demonstrated the importance of gender and cultural differences in mediating sexual behavior, particularly among Latinos.[86] More recently, Amaro and Raj suggest that, in addition to a gender perspective, understanding the dynamics of oppression and how it affects female autonomy is critical to the relationship of power to sexual risk.[87] Pulerwitz et al. developed a Sexual Relationship Power Scale and tested it using a mostly Latina sample.[88] Women found to have high levels of relationship power using this measure were five times as likely as those with low levels of power to report consistent condom use.

A number of studies illustrate empirically the dynamics of gender, power and acculturation as they impact Latina sexual behavior and suggest that an imbalance of power within relationships among Latino couples often leads to barriers to safe sex practices.[89] For example, Marin et al. describe significant differences between Latino men and women in numbers of partners, with many men reporting multiple partners and few Latinas doing so, based on a random probability sample of unmarried adults in San Francisco.[90] In a series of focus groups with Latinas in the Northeast, female participants described men's unwillingness to use condoms and their own inability to influence sexual decisions or behaviors with their partners.[91] Another series of focus groups with migrant farmworker Latinas in central California provides an insightful view of the strategies used by immigrant Latinas to hide their sexuality and avoid unwanted sexual advances by coworkers, while at the same time exploring new freedoms that may put them at risk for unprotected sex.[92]

However, the dynamics of gender roles, culture and empowerment as they relate to sexual behavior and negotiation are extremely complex and may vary widely among Latina subgroups, according to national origin, immigrant status, age and other background characteristics. Gil compares sexual negotiation dynamics among women living in Puerto Rico with Latinas from Mexico and Central America living in Los Angeles.[93] Although both groups scored low on a summary "negotiation index," when looking at individual behaviors, Puerto Rican women were much more likely to report initiating sex and controlling when certain sexual practices would occur, compared with the Californian Latinas. He concludes that interventions designed to reduce risky sexual behavior must consider the wide variations among Latinas and that simply relying on empowerment models fails to recognize the dynamics of women's personal lives. Another study, based on a series of in-depth interviews with each partner of sexually active Latino couples in Los Angeles, looks at power dynamics from both the male and female perspectives.[94] In this study, both men and women reported having the power to make decisions in certain areas of the relationship, and, although most participants agreed that men typically initiated sexual encounters, women were seen as the ones who suggest use of condoms or other contraceptives; both sexes reported that reproductive decisions should be made jointly. The authors suggest that the relatively high level of power to negotiate sexual practices expressed by these Latinas may reflect the acculturation process and may reveal changing attitudes related to gender roles within Latino relationships. It may also reflect the wide range of practices found among different Latina subgroups

identified in other research.

Finally, variation in the findings from studies of gender roles among Latinas may also be related to a general shift toward more egalitarian gender role attitudes over time among the general U.S. population. An analysis of gender role attitudes using the General Social Survey (a nationally representative annual survey of adults) from 1974 to 1994 found that, in general, Latinas held more traditional gender role views than whites, and blacks held more egalitarian views than either Latinas or whites.[95] However, over the two decades examined, gender role attitudes have become more egalitarian among all women and the differences between racial and ethnic groups have lessened so that, in the most recent time period studied, the difference between Latinas and whites was nonsignificant.

## Contraceptive Use Among Adult Latinas

The majority of studies on contraceptive use among Latinas examine the behavior of adolescents. Studies that have considered the entire range of reproductive-aged Latinas include analyses of the National Survey of Family Growth (NSFG).[96] Such analyses are useful because they provide national data on the contraceptive behavior of Latinas, as compared with non-Hispanic white and black women. However, few analyses using the NSFG focus specifically on Latinas, so the data are used primarily to highlight differences and similarities among racial and ethnic groups, but not to further our understanding of the determinants of that behavior.

Most sexually active Latinas who are not seeking to become pregnant use some form of contraception. In 2002, 88% of Latinas at risk of unintended pregnancy were current contraceptive users (Table 4).[97] This is slightly lower than the percentage of users among non-Hispanic white women (91%), but higher than among black women (85%). Among Latinas using any method, more than one in three (34%) use female sterilization. Another 4% have partners who have been sterilized. Latinas are similar to non-Hispanic black women in their strong preference for female sterilization over male sterilization, which may reflect more traditional gender roles. Among Latinas and black women, nearly all users of sterilization chose female sterilization, whereas among whites, more than a third of women relying on sterilization have a partner who is sterilized.[98] Latinas are also similar to non-Hispanic black women in their use of oral contraceptives, with slightly more than one in five (22–23%) users choosing the pill; among whites more than one in three (34%) use oral contraceptives. About one in five Latina method users (19%) rely on condoms as their primary method, similar to women from other groups. However, more Latinas (8%) and blacks (10%) choose the three-month injectable, compared with whites (4%). Finally, Latinas are much more likely than either non-Hispanic whites or blacks to use long-acting methods (mainly the IUD; 7% versus 2%) (Table 4).

Little is known about the contraceptive choices of different subgroups of Latinas. The NSFG, even though it oversamples Latinas, does not have a large enough sample size to report variation by national origin (except for Mexican origin versus other Latino origin). Some research has addressed the high prevalence of female sterilization among Puerto Ricans, both in Puerto Rico and in the United States.[99] One study showed that similarly high rates of female sterilization were found among first generation immigrants from Puerto Rico and women living in Puerto Rico (41%–45%).[100] Puerto Rican women who are second generation and higher had lower sterilization rates that were very similar to those of all American women (19%). A comparison of three Latina subgroups in the United States found that Puerto Rican women had higher sterilization rates (23%) compared with Cuban-American women (15%) or Mexican-American women (15%).[101] The same study found that Mexican- American women were more likely to use oral contraceptives compared with the other two groups, but the survey did not ask about any other methods.

Latina contraceptive users are significantly more likely to experience an unintended pregnancy during the first two years of method use than non-Hispanic whites, but less likely than non-Hispanic blacks. However, effective use of oral contraceptives is particularly difficult for both Latinas and blacks. Data from the early 1990s show that during the first two years of method use, one in five Latinas and blacks (19–20%) experienced a failure, compared with only one in ten (11%) white pill users.[102]

In order to better understand variation in contraceptive behavior and experiences, a number of studies have looked at women's attitudes toward contraception, decision-making around contraception, relationship dynamics around contraception, and experiences with different methods and contraceptive providers; some include separate analyses for Latinas. For example, a nationally representative study of low-income women in the mid-1990s compared English-speaking and Spanish-speaking Latinas to whites and blacks on a variety of measures.[103] Overall, Latinas were much less likely than the other groups to agree with state-

ments indicating that contraception matters in pregnancy planning; one does not need partner approval of contraception; and contraceptive use does not spoil sex. Spanish-speaking Latinas were the least likely to agree with these statements. Latinas were also less likely than whites or blacks to report being very satisfied with their current contraceptive method or to have rated their last contraceptive visit very positively. Another small study explored relationship dynamics and condom use among clinic clients in Miami.[104] Latinas were less likely than blacks or whites to report feeling comfortable talking with their partners about sex or condom use, though they were more likely to report that use of birth control was a joint decision (fewer reported that they made this decision on their own).

Few interventions have focused on improving contraceptive use among adult Latinas, and those that do exist typically target HIV-prevention behavior.[105] One intervention was designed to address communication difficulties within Latino couples by involving couples in a series of information and education sessions. The study found that both the intervention group (couples who received three comprehensive sessions) and the comparison group (couples who received one basic session) improved their consistency of condom use and increased their use of effective contraceptives between baseline and follow-up.[106] The authors conclude that simply bringing Latino couples together for a single community-based, culturally appropriate session may have served to help couples adopt protective behaviors and that such an approach might be a more cost-effective way to improve use.

A number of studies focus on barriers to contraceptive use among Latinas (or among all women, with breakdowns by race and ethnicity), including barriers related to personal and relationship characteristics;[107] barriers related to women's experiences with side effects from methods or their perceptions of method safety;[108] and structural barriers such as cost, lack of insurance, service unavailability and language difficulties. These studies have generally found that access to services is reduced among Latinas. On one hand, Latinas may face barriers due to lack of information and education about services that might actually be available to them. For example, Latinas were much more likely than blacks or whites to report that a reason for contraceptive nonuse prior to an accidental pregnancy was due to not knowing about contraception or where to get it.[109] In a study of homeless women, Latinas were more likely than whites or blacks to report that contraceptive nonuse was due to not knowing how to use methods, not knowing which methods to use and their partner's dislike of method use.[110] On the other hand, Latinas are also often faced with barriers to finding any care that they can afford, due to their greater likelihood of being uninsured. Certain public policies and welfare reform have also reduced the ability of Latinas to obtain needed health care, potentially including sexual and reproductive health care services.[111] How exactly public policy intersects with women's ability to obtain care is an area where additional research is clearly needed. Towards this goal, some researchers have begun to explore ways of integrating the positive aspects of community within Latino culture into the wider systems for outreach and health care delivery.[112]

## Chapter 5

# Latinas' Experiences with STDs, Including HIV/AIDS

The research literature contains a growing number of studies on HIV prevention among Latinas. Basic data on the prevalence of STDs, including HIV/AIDS, among Latinas is available from the Centers for Disease Control and Prevention (CDC). Key data on the effects of HIV/AIDS on Latinos have been compiled by the National Minority AIDS Council and in a report compiled by the Henry J. Kaiser Family Foundation prior to a Capital Hill briefing.[113,114]

Nationally, Latinas have been disproportionately affected by HIV/AIDS, compared with non-Hispanic white women, and they are making up an increasingly greater share of all AIDS cases reported among Latinos. In 1990, women accounted for 15% of all AIDS cases among Latinos; by 2000, the percentage had risen to 23%.[115] Moreover, although Latinas make up only 13% of the U.S. female population, they comprise 18% of all new HIV infections among women.[116] Latinas have an AIDS case rate of 16.6 per 100,000; a rate that is nearly seven times higher than the rate for white women (2.4 per 100,000).[117] Among Latinas with AIDS, the majority of cases are due to heterosexual contact with an infected male (63%). This is slightly higher than the percentage of cases among white women due to heterosexual contact (56%). The bulk of the remaining AIDS cases are due to exposure through injection drug use (35% for Latinas and 41% for white women).[118]

Several overview articles and chapters provide summaries of the effect that HIV/AIDS is having on Latino communities and on the unique cultural issues that must be considered in designing prevention strategies.[119] Some of the issues outlined are similar to those we have already discussed in the sections covering sexual behavior and contraceptive use, and include discomfort talking about sexual issues, traditional gender role beliefs and homophobia. With regard to HIV prevention, the cultural norms identified here contribute to risky sexual behavior that may raise the likelihood for HIV transmission among both Latino women and men.

A national survey on public knowledge and attitudes toward HIV/AIDS has been analyzed separately for Latino respondents and indicates that Latinos are very concerned about AIDS, both as a national and global problem, and as a risk that they personally may face.[120] In 2000, four in 10 Latinos surveyed ranked AIDS as the most urgent health problem in the United States; a similar proportion ranked it as the number one health problem globally. Latinos responses are similar to those of non-Hispanic black Americans and are higher than those of non-Hispanic whites who are less likely to view AIDS as the most urgent health problem nationally or globally.

Although HIV/AIDS is recognized as a serious threat to Latino health and well-being, gaps remain in the research to identify appropriate prevention strategies. Most research examining knowledge, attitudes and behaviors related to HIV prevention among Latinas has been conducted using relatively small, localized populations. Several studies conducted in Northern California help to set the stage by measuring knowledge about HIV and its modes of transmission, and sources of information about HIV among Latinos.[121] These studies indicate that less educated and less acculturated Latinos are less knowledgeable about modes of HIV transmission. Although the findings were generated by local studies, they are probably applicable to Latinos elsewhere in the United States.

Gender relations and sexual power are key areas of investigation in many studies on HIV prevention among Latinas. Some studies focus solely or primarily on Latinas.[122] Other studies include more heterogeneous samples, typically examining behaviors among clinic or community samples of Latina and black women.[123] While most of these studies used small, often clinic-based samples, at least one study used a population-based sample of women in the nine states with the greatest Latino populations.[124] Additional studies have focused on STD and HIV prevention among adolescents.[125] Most of these studies measure

condom use and communication between partners around condom use. Combined, they provide further evidence of the importance of prevention strategies that address women's ability to negotiate condom use, given the realities of their lives and relationships, that encourage development of prevention methods that do not depend on negotiation (e.g., microbicides), and that directly address ways to encourage men to adopt safer sex practices.

Finally, a literature review is available that focuses on HIV prevention interventions for Latinos.[126] Based on a rigorous set of inclusion and exclusion criteria, it identified a total of 15 methodologically sound intervention trials, including randomized, controlled clinical trials, controlled clinical trials and studies utilizing a comparison group with pre- and post-test design. Based on this review, the components of programs that achieved positive behavioral changes included cultural sensitivity, gender sensitivity, peer educators, skills training and longer versus shorter intervention lengths. The authors expressed surprise at the lack of well-designed HIV-prevention intervention studies focusing on Latinos and suggest that this is an area where additional research is clearly necessary.

# Chapter 6

# Latina Fertility

The issue of high fertility rates among Latinas has received considerable attention from researchers and policymakers, but is still not fully understood. Birth rates among women of all ages are higher among Latinas than among non-Hispanic white or black women. And, although black teenagers have historically had higher birthrates than Latina teenagers, national trends show that, between 1990 and 2003, birthrates among Latina teenagers declined only gradually, falling 18%; at the same time, blacks and whites experienced much sharper declines in birthrates (declines of 44% and 35%, respectively).[127] Thus, in the mid-1990s, the birthrate for black teenagers fell below that of Latinas and the gap between the two groups continues to widen. A similar pattern is observed when looking at trends in teenage pregnancy rates; however, the rates for non-Hispanic black teenagers continue to surpass those of Latinas. Among Latinas, the teenage pregnancy rate fell from 162 pregnancies to 138 pregnancies per 1,000 teenage women (a 15% decline) between 1990 and 2000, while the pregnancy rate among black teenagers fell from 224 to 153 (a 32% drop), and the pregnancy rate among white teenagers fell from 87 to 55 (a 37% drop).[128]

In California, trends in teenage birthrates followed a somewhat different trajectory.[129] Between 1991 and 1999, Latinas experienced the sharpest decline in teenage birth rates, but because their rates were so high to begin with, Latinas continue to have higher teenage birth rates than other groups in the state. Other studies comparing birthrates among groups in California, according to race, ethnicity and immigrant status, have highlighted the high rates among Latinas.[130]

Studies investigating the determinants of high rates of fertility and unintended pregnancy and childbearing among Latinas typically focus on adolescents. Fewer studies have examined factors that contribute to unintended pregnancy among adult Latinas. Abortion among Latinas is also a neglected subject. On the other hand, more research has examined Latina maternal health and the fact that, despite being socioeconomically disadvantaged, immigrant Latinas have pregnancy outcomes that are equal to or better than those of non-Hispanic white women, which is part of the phenomenon referred to as the Hispanic Paradox (or epidemiological paradox).

## Teenage Pregnancy and Childbearing

Teenage pregnancy and childbearing among Latinas in the United States must be examined both in the larger context of American society and in the context of cultural norms and influences specific to Latinos. In terms of the larger context, a large body of research suggests that many of the antecedents of teenage childbearing are related to some form of social disadvantage (poverty, poor education, family and residential instability, unemployment and limited career opportunities, etc.).[131] Exactly how disadvantage affects teenage reproductive behavior is not fully understood and is complicated even further by the intersection of disadvantage and membership in a racial or ethnic minority group. Explanations of high fertility rates among adolescent Latinas often begin with a review of the ethnographic literature suggesting that Latino culture supports early childbearing and high fertility rates, and values motherhood over other female roles.[132] However, although a number of researchers have examined the effects of families, parents, partners and socioeconomic or cultural status on adolescent pregnancy and childbearing among young Latinas, key gaps remain. None of the studies reviewed here adequately address the combined impact of disadvantage and cultural support for childbearing on young Latinas.

***Families.*** Like youth from other racial or ethnic groups, Latinas benefit from living in stable families where communication is open. Latina adolescents in two-parent families are less likely to get pregnant,[133] and those who do are more likely to have an abortion.[134] There is some support for the hypothesis that adolescent Latinas who talk to their parents about sex

are less likely to become pregnant.[135]

Parent-child communication also appears to influence the decisions of pregnant teenagers. Interestingly, pregnant Latina teenagers who received pregnancy education from a parent are more likely to terminate a pregnancy than other teenagers.[136]

***Partners.*** The characteristics of one's partner can influence the likelihood that young Latinas will become pregnant and bear children. In particular, having an older partner has been found to be associated with greater likelihood of pregnancy. In general, relationships involving Latinos have an average age gap between partners that is wider than that found among relationships that do not include a Latino partner. In a study of very young teenage mothers in California (younger than 15 at time of conception), babies born to Latinas were more commonly found to have fathers who were at least 20 years old than those born to non-Hispanic whites.[137]

There is also some evidence that a larger proportion of young Latinas who become pregnant intend to do so, compared with non-Hispanic black or white teenagers. A small study in Central California found that, among 187 pregnant teenagers aged 15–18, 34% of U.S.-born Latinas reported having intended to become pregnant, compared with 46% of foreign-born Latinas, and only 14% of non-Hispanic black teenagers.[138] Having a partner who wanted the pregnancy was the most important predictor of whether or not the young women reported pregnancies as intended.

Having been sexually abused or raped is another risk factor for teenage pregnancy. In the study described above, young women who had been in a controlling or abusive relationship were significantly more likely than those who had not to have intended to become pregnant.[139] In another study of young women in the Southwest, researchers found that young Latinas, as well as teenagers from other racial and ethnic groups who had experienced a teenage pregnancy were much more likely to have also experienced sexual coercion or rape than were those young women who had never been pregnant.[140]

***Socioeconomic status (SES).*** The relationship between socioeconomic status and teenage pregnancy and childbearing is complex. As discussed earlier, disadvantage, which is measured in a number of ways, is commonly associated with adolescent pregnancy. However, few studies are able to tease out the effects of disadvantage, race/ethnicity and social class. A recent qualitative study of young, mostly unwed mothers, illustrates the complexities of their lives and the factors that lead them to bear children early.[141]

An analysis of zip codes in California assessed the association between teenage birth rates and poverty, education, employment and ethnicity, and found that the proportion of the population living in poverty was by far the most important predictor and accounts for 64% of the variance in teenage birth rates.[142] This finding held true for all three racial/ethnic groups studied, including Latinos. In a study of more than 300 Latinas in Los Angeles County, SES, measured using welfare status, was found to be a risk factor for teenage pregnancy.[143] However, it is unclear whether Latinos from families with a higher SES were less likely to get pregnant because they postponed sex longer than their more disadvantaged peers or because they were more consistent and effective contraceptive users (or some combination of both). SES also appears to play a role in the decision of Latina adolescents about whether to carry a pregnancy to term or terminate it. Using Medicaid as a proxy for SES, Sullivan found that low SES Latina teenagers (primarily Puerto Ricans) were much less likely to terminate a pregnancy than those who were somewhat better off.[144] Over 80% of poor teenagers carried their pregnancies to term, while only one-third of those not on Medicaid gave birth.

Among teenagers that give birth, there is evidence that maternal education moderates the effect of a teenage birth on young Latinas' futures. Adolescent Latinas who become mothers are more likely to complete high school and have more years of schooling if their mothers have more education.[145]

***Acculturation.*** The search for an explanation for birth outcome differences across generations has focused on the attitudes and behaviors of less acculturated immigrant women, compared with their U.S.-born, more highly acculturated counterparts.

Foreign-born pregnant adolescent Latinas are more likely than their U.S.-born counterparts to report that their pregnancy was intended. Moreover, they are less likely to be in abusive relationships and more likely to have strong support from the father of their child.[146] On the other hand, Latino men with more traditional gender role beliefs, who are presumably less acculturated than those with less traditional beliefs on this topic, are more sexually coercive towards their partners.[147]

Although more acculturated pregnant teenagers seek prenatal care earlier, on average, than less acculturated adolescents, this does not appear to translate to

a difference in birth outcomes.[148] Young Mexican women in Los Angeles who scored high on an acculturation scale reported more prenatal stress than less acculturated women, which is associated with earlier delivery, and therefore with lower birth weight.[149]

Finally, pregnant immigrant Latinas are less likely to choose to have an abortion than native teenagers. Thus, although the rate of sexual activity is lower among immigrant adolescents, their birth rate is higher due to their decisions about contraception and abortion.[150]

***Pregnancy prevention interventions.*** Interventions designed to reduce adolescent pregnancy and childbearing have not always addressed the needs of Latinos. An early review of programs implemented in the late 1980s and early 1990s, found that, while some programs demonstrated success in the general population, little was known about the effect of different interventions on population subgroups.[151] Since then, a number of prevention programs have been developed with Latino youth in mind. One set of recommendations for effective teenage pregnancy prevention programs among Latinos was developed by the National Council of La Raza.[152] Their recommendations included having culturally sensitive, nonjudgmental staff; being responsive to Latino subgroup differences; emphasizing education and supporting high aspirations; recognizing cultural values regarding gender roles; involving the parents and families of teenagers; conducting outreach to involve young men (or teenage fathers) in programs; and incorporating age-appropriate sexuality education. Two recent studies interviewed practitioners serving Latino youth[153] and Latina teenage mothers[154] about the continued relevance of these strategies for reducing teenage pregnancy. Both studies found wide agreement with these strategies among practitioners.

## Unintended Pregnancy Among Adult Latinas

We have not identified any studies that focus only on Latina adults and their experiences with unintended pregnancy. National studies on unintended pregnancy provide estimates of the proportion of pregnancies to Latinas that are unintended. Among the 900,000 pregnancies to Latinas in 1994, 51% resulted in intended births, 22% resulted in unintended births and 26% ended in abortion.[155] In comparison, 57% of pregnancies to whites were intended, while only 28% of pregnancies to blacks were intended. However, because fertility among Latinas is higher than that of whites, the rate of unintended pregnancies (the number of unintended pregnancies per 1,000 women of reproductive age) is higher—69.4 for Latinas, 35.5 for whites and 98.4 for blacks. An analysis of births in the late 1980s found that half of all births to Latinas (52%) were intended, compared with 63% of births to white women and 34% of births to black women. Of the 48% of births to Latinas that were unintended, 41% were mistimed and 7% were unwanted.[156]

An analysis of the 1995 National Survey of Family Growth examined some of the factors associated with planned and unplanned childbearing among unmarried women according to race and ethnicity.[157] Among unmarried Latinas, higher levels of education were associated with fewer planned births, but not with fewer unplanned births; while being in a cohabiting relationship was highly predictive of having both planned and unplanned births. For planned births, the effects of cohabitation were much stronger among Latinas than either whites or blacks, suggesting that among Latinas, cohabitation is viewed as similar to marriage, at least in terms of childbearing.

Another study focused on premarital childbearing among Puerto Rican women and found that first- and second-generation Puerto Ricans living in New York had much higher rates sexual activity and premarital births than did similar women who remained in Puerto Rico.[158] Although they did not address whether or not these premarital births were unintended, they suggest the high premarital pregnancy and birth rates among migrants (similar at the time to the rates for blacks), create conditions which increase migrants' likelihood of becoming more disadvantaged than they were prior to migration.

## Abortion

Data on abortion are available from the Centers for Disease Control and Prevention[159] and from the Guttmacher Institute.[160] Similar to the findings for unintended pregnancy, Latinas have higher abortion rates than whites, but lower rates than blacks—in 2000, the abortion rate for Latinas was 33 per 1,000 women aged 15–44, a drop from 1994 when the rate was 37. A small study of Latinas in San Francisco found that foreign-born Latinas were less likely than either U.S.-born Latinas or U.S.-born non-Hispanics to have a history of abortion.[161] Another study looks at the characteristics of women receiving abortions at a large abortion clinic in San Diego, comparing Latinas who have crossed the border from Mexico to receive an abortion with and non-Hispanics and Latinas residing in the United States.[162] They conclude that, since the typical woman crossing the border into the United States to ob-

tain an abortion faces multiple barriers, this group consists primarily of women who have the economic resources to make the trip and pay for the procedure; they also tend to be older and have healthier habits.

Latinas' attitudes toward abortion have been examined in a number of studies. A survey conducted by the National Latina Institute for Reproductive Health in 1998 found that 53% of Latinas actively identify as pro-choice and a large proportion oppose any restrictions on abortion rights.[163] Similar trends are found in unpublished survey and focus group results from studies conducted by Planned Parenthood Affiliates of California. A series of focus groups conducted by the Latino Issues Forum found that Latinas held conflicting views about abortion.[164] While a majority of Latinas responded that it should be the woman's choice, some suggested that they would not consider abortion as an option or that they would/did feel guilty about having an abortion. A few women indicated that they would rather try to "take something" or have their friend "take something" to induce a miscarriage, rather than go through with a medical appointment.

### Maternal Health

Many studies have examined the maternal and perinatal health of Latinas, particularly recent immigrants.[165] In particular, a fair amount of attention has been focused on the seeming paradox of favorable birth outcomes to otherwise disadvantaged Latina immigrants (often called the Hispanic or epidemiological parodox).[166] A number of explanations have been suggested, including possibilities that immigrants are healthier than those who remain at home, immigrants bring with them culturally protective behaviors or that immigrants have other personal or socioeconomic characteristics that, if properly measured, would explain the outcomes. For the most part, studies have concluded that it is the culturally determined protective behaviors— avoidance of alcohol, tobacco and drugs—common among immigrants that explains their positive outcomes. The idea that immigrants are healthier than those left behind was tested by comparing birth outcomes in Tijuana and San Diego.[167] The study concluded that the immigrants were not any healthier than those who did not emigrate, and therefore the selectivity hypothesis was not supported. Other possible explanations include personal orientations to motherhood and male partner support that may change as women immigrate and become acculturated and may also be related to pregnancy outcomes.[168] Acculturation and time in the United States often serve to diminish the positive affects observed among recent immigrants and the perinatal outcomes of second generation immigrants typically worsen.

# Chapter 7

# Research Gaps and Conclusions

Improving our understanding of Latina sexual and reproductive health is critical for the development of strategies that will improve the health and well-being of Latinas and their families. Such strategies could address a range of needs in areas that include information, education and counseling; service delivery (in terms of basic availability and accessibility, as well as improvements in aspects specific to the needs of Latinas); policies and programs regarding health care coverage for the uninsured and the undocumented; and governmental funding and policies. The preceding chapters have reviewed a large number of studies that, in one way or another, shed light on the sexual and reproductive behavior and health care use and needs of Latinas. However, much more work needs to be done. The goal of this report was relatively limited: to briefly review the information and research that exists in order to identify areas where more research is needed.

## Research Gaps

Some of the key gaps in research identified include, but are not limited to, the following:

***Improving data collection efforts.*** More nationally representative data are needed that include large enough sample sizes to study the behavior of Latinas according to both immigration status and country of origin, in addition to basic characteristics such as age, marital status, sexual activity and socioeconomic status. Currently, many national surveys have sample sizes of Latinas that are too small for analysis according to even the basic characteristics. Various options can be considered; for example, increasing the sample sizes of existing surveys to over-sample important groups, including Latinas; or implementing special surveys focused specifically on Latinas.

***Evaluating the impact of national health care and welfare policies on access to services.*** Changes in health care financing, public funding for the range of sexual and reproductive health services (including family planning services, STD testing and treatment, maternal health services and gynecological care) and welfare benefits and restrictions have the potential to adversely affect Latinas' ability to obtain necessary care for themselves and their families. New research is needed to document these trends and to assess what their impact may be on Latinas' health.

***Understanding how protective aspects of immigrant culture can be leveraged to help others.*** Several studies have found that new immigrants fare better than others on certain health outcomes; others have found that some Latino communities provide protection against early childbearing or are able to help mitigate some of the negative outcomes often associated with early childbearing. Studies are needed to better understand these processes and to find ways to leverage the protective aspects of community more broadly.

***Identifying the most important barriers to contraceptive use.*** Additional studies are needed to identify the most salient barriers that limit Latinas from accessing and using contraceptives consistently and effectively for both pregnancy and HIV prevention, and, based on this information, to design and evaluate new interventions for improving use. Barriers to effective use may include difficulties that women encounter when attempting to access services, as well as personal, cultural, or structural factors that restrict their ability to even begin the process of seeking care.

***Addressing the needs of adolescents and young women.*** Young Latinas have a host of unique needs. Although a fair amount of research has examined the sexual and reproductive behavior of adolescent Latinas, more is needed. An especially promising area of future research may be to examine the protective effects that Latino culture, family structure and community have played in the lives of some young women and to find

ways to maintain those beneficial effects as acculturation proceeds. In addition, the issue of pregnancy wantedness is especially complex for adolescent Latinas and is in need of more in-depth examination from the perspective of the young women themselves.

***Documenting adult Latinas' experiences with unintended pregnancy and abortion.*** Because most studies of Latino culture emphasize its strong positive view of motherhood and childbearing, little work has been done to examine Latinas' attitudes toward and experiences with unintended pregnancy and abortion. New studies are needed to investigate the factors that contribute to unintended pregnancy among adult Latinas, including not using contraceptives or using them incorrectly or inconsistently, as well as the decision-making process that leads some women to choose abortion.

## Limitations of This Report

This review took a particular and relatively narrow focus on sexual and reproductive health of Latinas. However, we recognize that there is room for and great value in also carrying out research from a broader perspective; for example, drawing out the linkages between Latina health, in general, and sexual and reproductive health. In addition, while this review focuses on Latinas, it should be acknowledged that many of the issues discussed are not unique to Latinas, but may be relevant both for other women of color and for women in general. Additional research that compares different racial and ethnic groups is important, because such studies are useful for assessing the degree to which inequities are being reduced or continue to exist. Moreover, although we recognize that many of the trends in sexual and reproductive health indicators reported here, as well as changes in service utilization, have occurred simultaneously with broader changes in health care policy and financing, welfare reform and immigration policy, to name only a few, it has not been our intention to draw conclusions or inferences beyond those that have been scientifically examined by other researchers. It is our hope that other researchers will recognize these limitations and gaps and be encouraged to design and implement new studies that will provide the evidence necessary for improved understanding about these important relationships.

## Conclusions

In addition to the identification of research gaps and priorities, this review is part of a broader effort to stimulate collaboration and funding for innovative approaches to the advancement of Latina sexual and reproductive health. As part of that wider effort, a two-day meeting was convened in Los Angeles in February 2004, bringing together community members, policy advocates and researchers to discuss improving policymaking, research and resources for Latina sexual and reproductive health nationwide. Based on those discussions, an action plan was developed which enumerated key areas for action and recommendations for research approaches considered critical for research among Latino populations. (See Appendix C for the full text of this action plan. Appendix A provides contact information for organizations that can be used as resources for information on Latina sexual and reproductive health; and, Appendix B provides a full bibliography of the literature reviewed for this report.)

One of the recommendations of this meeting was for a Latino organization to adopt this review and to maintain it on an ongoing basis as a resource for the community, ideally as a Web-based document. The goal would be to have a centralized and up-to-date annotated bibliography of research on Latinas' sexual and reproductive health. Another key recommendation of this meeting was to highlight the importance of community participation in research, particularly if the research findings are to be applied. Clearly, it is valuable to incorporate the community perspective into Latina research, and this is possible in a variety of ways. Making available listings and annotated bibliographies of existing research studies for public use can assist in stimulating research ideas not only among researchers but also within the Latino community as a whole. A continuing compilation is also a useful mechanism for encouraging collaborations within the Latina research community and between it and other researchers. We hope that an organization is able to marshal the resources to improve and maintain this first compilation.

Follow-on consultative meetings of the kind that took place in February 2004 would also be an appropriate mechanism for ensuring that the activities undertaken so far are productive. Such meetings may be more specifically targeted; for example, addressing one or more of the specific gaps identified by this review, in any of the number of ways: developing calls for new research, developing specific research proposals, sharing ideas for analysis of existing data that may be used to fill the knowledge gaps identified here, or building public education efforts based on the existing research that has been summarized in this review.

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## Appendix A

# Resources for Information on Latina Sexual and Reproductive Health

**Center for Reproductive Health Research and Policy**
3333 California Street
Suite 335, Box 0744
San Francisco, CA 94143-0744
(for UPS or FedEx, use 94118)
P: (415) 502-4086
F: (415) 502-8479
www.crhrp.ucsf.edu

**Center for Reproductive Rights**
120 Wall Street
New York, NY 10005
P: (917) 637-3600
F: (917) 637-3666
www.reprorights.org

**Guttmacher Institute**
120 Wall Street
21st Floor
New York, NY 10005
P: (212) 248-1111
Toll free: (800) 355-0244
F: (212) 248-1951
www.guttmacher.org

**Hispanas Organized for Political Equality (HOPE)**
634 South Spring Street, Suite 920
Los Angeles, CA 90014
P: (213) 622-0606
F: (213) 622-0007
www.latinas.org

**Latino Commission on AIDS**
24 West 25th Street, 9th Floor
New York, NY 10010
P: (212) 675-3288
F: (212) 675-3466
www.latinoaids.org

**Latino Issues Forum**
160 Pine Street, 7th Floor
San Francisco, CA 94111
P: (415) 284-7220
www.lif.org

**MANA, A National Latina Organization**
1725 K Street, N.W.
Suite 201
Washington, DC 20006
P: (202) 833-0060
F: (202) 496-0588
www.hermana.org

**MySistahs**
Advocates for Youth
Suite 750
2000 M Street, N.W.
Washington, DC 20036
P: (202) 419-3420
F: (202) 419-1448
www.mysistahs.org

**National Alliance for Hispanic Health**
1501 16th Street, N.W.
Washington, DC 20036
P: (202) 387-5000
www.hispanichealth.org

**National Council of La Raza**
Raul Yzaguirre Building
1126 16th Street, N.W.
Washington, DC 20036
P: (202) 785-1670
www.nclr.org

**National Latina Health Network**
1680 Wisconsin Avenue, N.W.
2nd Floor
Washington, DC 20007
P: (202) 965-9633
F: (202) 965-9637
www.nlhn.net

**National Latina Institute for Reproductive Health**
50 Broad Street
Suite 1825
New York, NY 10004
P: (212) 422-2553
F: (212) 422-2556
www.latinainstitute.org

**National Latino Alliance for the Elimination of Domestic Violence**
P.O. Box 672, Triborough Station
New York, NY 10035
P: (646) 672-1404 or 1-800-342-9908
F: (646) 672-0360 or 1-800-216-2404
www.dvalianza.org

**National Minority AIDS Council (NMAC)**
1931 13th Street, N.W.
Washington, DC 20009-4432
P: (202) 483-6622
F: (202) 483-1135; (202) 483-1127
www.nmac.org

**Office of Minority Health Resource Center**
P.O. Box 37337
Washington, DC 20013-7337
P: (800) 444-6472
F: (301) 251-2160
www.omhrc.gov

**SisterSong**
Women of Color Reproductive Health Collective
P.O. Box 311020
Atlanta, GA 31131
P: (404) 344-9629
F: (404) 346-7517
www.sistersong.net

## Appendix B

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Appendix C

# Opportunities for Action: Addressing Latina Sexual and Reproductive Health

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Latinas account for approximately one in every seven U.S. women of reproductive age.[1] Although several national organizations and numerous local groups are dedicated to improving Latino health, significant gaps exist in the breadth and depth of information available on Latina sexual and reproductive health. Analyses from national and small-scale investigations usually compare Latinas with other groups on only one or two sexual and reproductive health indicators. National surveys often include too few Latina respondents to permit rigorous analyses, and sample size constraints prevent researchers from comparing subgroups of Latinas. Moreover, existing information on Latina sexual and reproductive health has not been adequately analyzed or assembled in a way that is accessible to health professionals, policymakers and advocates. Too often, research projects solicit assistance from community-based organizations in translating materials or fielding interviews, only to later alienate them by shaping outreach messages and disseminating findings without community input.

In February 2004, The Alan Guttmacher Institute (AGI) and the Latino Issues Forum (LIF) convened a meeting of health professionals, advocates and researchers to begin a discussion on improving policymaking, research and resources for Latina sexual and reproductive health nationwide. Participants represented a range of experiences with different health care systems and populations. For many, the meeting marked their first opportunity to voice concerns and ideas with colleagues from different disciplines. The priorities they identified to strengthen sexual and reproductive health information and services for Latinas are presented here as an action plan for marshaling the evidence and funding needed to improve Latina sexual and reproductive health across the United States. While the action plan highlights Latinas' experiences with sexual and reproductive health care, it aims to call attention to the issues involved in providing quality health care to all minority groups. Other minority groups, including black, Asian American and American Indian women, face similar difficulties in accessing sexual and reproductive health care. The action plan uses a positive framework for exploring issues related to Latina health specifically and minority health in general. As one participant noted, it is important to incorporate the idea of community and its assets instead of using a perspective that designs research, policy and programs solely around deficits.

As the recommendations make clear, Latina sexual and reproductive health cannot be neatly compartmentalized under the rubric of minority health, women's empowerment, human rights, poverty alleviation or the movement for universal access to general health care. Latina sexual and reproductive health is crucial to the advancement of all these causes and requires targeted and sufficient resources; innovative strategies for collaboration; and direct, immediate attention. AGI and LIF intend the action plan to be a catalyst for an ongoing effort to mobilize new knowledge and resources.

## THE CONTEXT: LATINAS AND HEALTH CARE

As the Department of Health and Human Services recognizes in its Healthy People 2010 objectives, the elimination of health disparities among different segments of the U.S. population is one of the country's most important goals. While the high rate of pregnancy and births among Latina teenagers has received a good deal of attention, a relatively scant amount of research has investigated unintended pregnancy and contraceptive use among Latinas in their adult lives. In general, research on sexually transmitted diseases (STDs) in the Latina population has been limited; however, some attention has been paid to HIV transmission, in particular.

Attempts to improve sexual and reproductive health care for Latinas must proceed from a basic understanding of the context surrounding women's lives and health care needs. Latinas are more likely than the general population to be low-income[2] and are therefore more likely to be eligible for publicly funded prenatal, family planning, abortion and STD services. Although they may be eligible for public services, low-income Latinas (and Latinos) are less likely than low-income whites or blacks to have health insurance; 43% of low-income Latinos were uninsured in 2002, in contrast with 25% of low-income whites and 26% of low-income blacks.[3] Many Latinas without insurance depend on publicly funded clinics for their sexual and reproductive health care needs. However, public funding has not kept pace with increases in the cost of contraceptive services, and these clinics have an increasingly difficult time offering uninsured women the most effective—and expensive—contraceptive methods.[4] In addition, 40% of Latinos are immigrants,[5] who may not understand their entitlement to free or low-cost services or may fear that their immigration status could be jeopardized if they seek health care.

The community leaders, service providers and research experts at the two-day meeting convened by AGI and LIF delved into these complicated issues and identified five priorities: access to information and services, adolescents, abortion, advocacy and communication, and approaches to research.

Our action plan, based on the discussion at the meeting, outlines the necessary steps to address these areas.

## ACTION PLAN

### Improving Access to Information and Services

Latinas are more likely than black and white women to delay health care appointments because of transportation or child care difficulties or an inability to pay for health care services.[6] Research has an important role to play in highlighting structural improvements in health care provision that can address these difficulties, such as extending clinic hours beyond the nine-to-five workday or helping women meet the cost of transportation to clinics. Investigations on this topic should draw attention to the disturbing alternatives that confront women who cannot access family planning services, such as forgoing contraceptive use, even when pregnancy is unwanted; obtaining pharmaceuticals through underground suppliers who cannot guarantee product quality; or finding that basic sexual and reproductive health services, information and referrals are unavailable at the growing number of hospital clinics operated by Catholic institutions.

Placing access issues into a cost-benefit framework is another way to strengthen the case for government support of various interventions—including contraceptive services. As the federal government considers changes to Medicaid policy, and as private insurance companies review their coverage options, researchers need to evaluate existing sexual and reproductive health services to provide a baseline for measuring the costs and benefits of different funding options. Such studies might demonstrate, for example, that by covering a wide range of contraceptive methods, insurance programs can improve contraceptive use and decrease costs by reducing unintended pregnancy.

Even if Latinas can access sexual and reproductive health services, they must contend with a lack of culturally and linguistically competent services. Only 5% of U.S. physicians[7] and 2% of nurses[8] are Latino; yet Latinos comprise almost 14% of the U.S. population.[9] Many health care providers do not speak Spanish and do not have trained, on-site interpreters; as a result, mothers must often use their children as translators. This awkward situation may compromise the quality of information women receive, the services they use and the extent to which they feel their concerns are adequately and sensitively addressed. These reasons may explain why Latinas often report being dissatisfied with their visits to sexual and reproductive health care providers.[10]

Information is needed on the role of providers in Latinas' decision-making and on perceived or real biases in how providers may talk (or perhaps not talk) to Latinas about sexual and reproductive health care and prevention issues. The dynamics between providers and Latina patients may also be shaped by the cursory nature of health care visits that take place in managed care systems or, for uninsured women, in emergency room settings. Nonetheless, investigations should explore strategies for making health care more culturally and linguistically competent by seeking input directly from Latina women and providers themselves—traditional medical providers and nontraditional providers of outreach education, such as community health *promotoras,*[11] who use peer education to reach underserved communities.

Although nearly half of adult Latinas (46%) have not completed high school and may therefore lack basic health education,[12] there is a shortage of community health education programs designed to improve Latinas' understanding of the health care system and help them play a more active role in their own care. Such programs are especially critical because some Latinas may not use available services as a result of concerns about the medical examination, the gender of their potential clinician or distrust of medical providers. Mass media may have an important role to play in communicating sexual and reproductive health information to women and adolescents who do not regularly visit physicians; research should explore the effectiveness of different media approaches among both English- and Spanish-speaking Latinas.

### Adolescents and Young Women

Like their adult counterparts, Latina teenagers experience higher birthrates than their counterparts from other racial and ethnic groups.[13] Latinas are considerably less likely than black or white women to use a method of contraception at first intercourse.[14] Since 1990, birthrates among Latina, black and white adolescents have decreased. However, the decline in birthrates among Latina teenagers was less than half that of blacks,[15] suggesting that socioeconomic disadvantage cannot entirely account for the high rates of teenage births among Latinas. The concept of unintended pregnancy among Latina teenagers and adults requires further exploration: Latinas are more likely than white women to experience contraceptive failure,[16] yet the proportion of pregnancies they report as unintended (one-half) is similar to that reported for all U.S. women.[17]

The dominant research paradigm in mainstream investigations views adolescent childbearing as a negative outcome. However, as the experts at the AGI-LIF meeting confirmed, teenage parenting may be viewed more positively in some Latino communities—especially immigrant populations in which early marriage and childbearing are the norm. Researchers have not explored teenage pregnancy within the wider context of Latinas' lives, in terms of the cultural and familial expectations that shape the futures of Latina teenagers who become pregnant and questions related to subsequent pregnancy prevention or birthspacing. While research has documented high pregnancy rates among Latina adolescents, less attention has been paid to potential factors that explain these rates, including partnership or marital status at the time of conception, contraceptive use and failure, abortion and the extent to which young women report births as mistimed or unwanted. Without this background information, research cannot adequately address the difficult question of how to approach unplanned pregnancy in communities in which adolescent

childbearing may be viewed positively and how to support teenagers who choose to give birth.

To design effective programs, the roles of partners, family and peers in shaping Latina adolescents' attitudes toward pregnancy must first be understood. Some studies have explored the role of gender and relationship dynamics in HIV transmission among Latinas.[18] However, a dearth of information exists on the roles that authoritarian family dynamics, family and relationship violence, or coercion may play in the lives of Latina teenagers who become pregnant. This may require researchers to be more fully informed about the attitudes and values elucidated by research in Mexico and other Latin American countries. It also requires exploration of decision-making related to other aspects of sexual and reproductive health—such as why some groups of Latinas use condoms to prevent pregnancy but not STDs.[19] Furthermore, research to learn whom Latinas teenagers talk with about sexual and reproductive health issues would allow clinics to better market outreach campaigns concerning STDs, help young Latinas to make informed decisions about their health care and ensure they are supported in their decisions.

Cultural strength is another factor that should be explored. Mention of the role of culture in health care is often weighted with a negative focus on barriers and difficulties. However, Latino communities with strong social networks—often, those that have close ties to their country of origin—may protect adolescents from the negative effects of poverty and have teenage birthrates lower than those of the general Latino population.[20] Latinos' strong sense of family identification and commitment to family support systems is an important factor to consider in designing health care programs for Latina youth. Adolescents whose parents talk openly with them about issues such as contraceptive use are less likely than other adolescents to engage in risky sexual behavior.[21] Although the prevailing belief is that Latino parents are unwilling to talk about this, research may reveal that this is a misperception and that educators should design programs encouraging family discussions about sexual behavior. Additional knowledge about the degree to which Latino parents and communities support in-school sex education would be critical information for policymakers, educators and advocates.

Last, and perhaps most important, research must extend its scope beyond studies of risk behaviors to explore factors that encourage positive health outcomes. Anecdotal stories in the media and from providers have described instances in which resiliency, or the ability to rise above the expectations that social circumstances normally impose, is evident in Latino communities. For example, young mothers may begin using birth control after their first pregnancy and successfully delay further pregnancies, enabling them to complete their education. Research on the determinants of such resiliency could have tremendous policy implications and may suggest ways to improve services, even in the face of poverty and limited resources. Moreover, a focus on resiliency helps to create a framework for success in underserved communities and a hopeful message for policymakers who may feel paralyzed by the scope of other problems in the community.

### Abortion: Attitudes and Experiences

It is a commonly held misperception that Latinas do not exercise their right to abortion, because of the influence of Catholicism in their communities. In fact, abortion rates among Latinas are higher than those among non-Latina white women (but lower than those for black women).[22] Still, not enough is known about how these rates vary among Latinas of different generations or different countries of origin—especially given that abortion is illegal in many Latin American countries—or about the factors that influence success in preventing unplanned pregnancy, such as patterns of contraceptive use.

Research can play a vital role in destigmatizing issues such as abortion and contraceptive use by recognizing that they are normative parts of women's lives. Quantitative studies that document Latinas' support for and use of abortion services validate the efforts of advocates who are working to improve access to these services. Qualitative research that explores Latinas' attitudes and experiences with unwanted pregnancy and abortion is important in empowering Latina advocates to confront cultural taboos and address sexual and reproductive health issues. However, because these issues are complex and sensitive, the involvement of community-based organizations in information gathering, message development and outreach is critical. Community members—especially those who are interviewed or surveyed for studies—are an important audience for outreach, since they are not likely to see research as worthwhile if they are not informed of project findings.

Participatory research that involves community-based organizations will incorporate the perspectives and priorities of Latina communities and therefore make a compelling case to legislators that they must address this issue and improve reproductive health services in the communities they represent. Information on abortion rates among Latinas is also important as part of national efforts to draw attention to the disproportionate harm that federal legislation withholding funding for abortion services inflicts on Latina communities, given that Latinas are more likely than the general population to be low-income. In addition, documentation of Latinas' use of these services is important information to convey to directors of clinics that do not offer abortion services but would consider adding them in response to a demonstrated need in the community.

### Advocacy and Communication

Perhaps the most urgent priority in the realm of Latina sexual and reproductive health is the need to communicate information more effectively to policymakers and program leaders. This goal shapes advocates' and researchers' calls for further investigation into the specific areas outlined in the preceding sections.

Advocates have begun to deconstruct the belief that Lati-

***. . . research must extend its scope beyond studies of risk behaviors to explore factors that encourage positive health outcomes.***

no communities do not want to talk about issues of sexual and reproductive health, do not use these services, and would not vote for candidates who support sexual and reproductive health and rights.[23] Research must assess Latinas' need for and use of these services to raise the priority of Latina sexual and reproductive health on the agendas of state and federal legislators. Documenting Latina support for sexual and reproductive health services is also an important step in encouraging mainstream Latino organizations to address this issue directly. Improving the communication of information on Latina sexual and reproductive health will require a wide range of strategies on the part of researchers, advocates and funders.

***Information on Latina sexual and reproductive health should emphasize that this area of health care encompasses issues…that should concern the entire community.***

First, advocacy messages should frame issues of sexual and reproductive health in ways that are appealing to other interest groups, the media and policymakers. This may require outreach strategies that balance information on abortion services with information on wanted pregnancies and prenatal care. Information on Latina sexual and reproductive health should emphasize that this area of health care encompasses issues such as fertility, childbearing and healthy pregnancies—issues that should concern the entire community, given that Latinas have a maternal mortality rate that is 1.7 times that of white women.[24] Outreach on these issues can also be strengthened by research that links sexual and reproductive health to interrelated issues—such as education, poverty, insurance, domestic violence and mental health—that affect Latinas' ability to access services.

Second, effective advocacy messages must be based on an understanding of the most urgent program and policy issues in Latina communities. Research is useful to advocates when it answers relevant questions such as whether large numbers of undocumented immigrants forgo HIV testing and treatment because of U.S. policy on deportation of HIV-positive noncitizens, or whether the incidence of HIV infection among Latina mothers could be decreased through family-centered prevention programs. Advocates also need information on emerging issues, such as the proliferation of antichoice "crisis pregnancy centers" in Latina neighborhoods. This information will help advocates develop effective outreach messages by anticipating issues that are likely to surface and develop preemptive plans to respond immediately. More information on the role of Spanish-language media in influencing public opinion on these issues could be of great use in this effort.

In creating and marketing these messages, Latina advocates and researchers can draw on the success of advocates, professionals and communication experts in other fields. This knowledge-sharing can be supported by studies and workshops on how to use credible research to develop clear, successful advocacy messages. Previous health care research, for example, has demonstrated that programs using community health workers were cost-effective in reducing asthma rates,[25] and this information helped to convince several insurance companies to invest in programs that use these workers. Latina advocates also need a mechanism or forum for distributing information to each other on their own success and "best practices" in message development. As one meeting participant noted, "We need more information on what works."

Finally, researchers can enhance the quality and impact of their work by collaborating with community-based organizations to shape the development of research studies, frame outreach messages and disseminate findings. This collaboration benefits the organizations by helping to build their expertise in advocacy and research design; researchers gain an invaluable understanding of contemporary issues affecting ever-changing communities. Forums for networking between researchers and advocates are critical to initiating and sustaining these efforts. Funders can lead the way in encouraging collaboration between researchers and advocates by building in to their requests for proposals a requirement that researchers work with community-based organizations in the design of research projects and dissemination of findings.

### Research Approaches

Several key approaches must be used to address the areas for urgently needed research. These approaches are no different from what is needed to develop a solid evidence base for any other group, but they are particularly urgent for addressing gaps in research on Latinas.

- *Interdisciplinary.* First and foremost, a systematic review of research on different aspects of Latina sexual and reproductive health in different fields is critical to identifying areas in which the knowledge base is most lacking. A series of working papers to summarize what is currently known could provide a solid basis from which to begin this initiative. Ultimately, this effort could culminate in an online database to showcase the review and facilitate access to studies according to topic and methodology. Ideally, this would be designed in a format that could be continually updated.
- *Longitudinal.* The scope of research must be expanded to encompass longitudinal data that take into account Latinas' sexual and reproductive health experiences over their entire lifetime. The many uses of such research might include demonstration that investment in the sexual and reproductive health of Latina youth is cost-effective and will improve adult and maternal health outcomes.
- *Diverse and multigenerational.* Some research has explored variation in sexual and reproductive behaviors according to Latinas' country of origin and generation.[26] However, the reasons why subgroups differ in their sexual and reproductive health decisions have not been as well studied. Research should examine these differences according to the following measures, assessing the relative importance of each: generational status, citizenship status, acculturation, country of origin, socioeconomic status, sexual orientation and rural-urban residence. Critical to this effort will be the development of more forums in which to publish and promote high-quality research on Latina sexual and reproductive health.
- *Qualitative.* Quantitative research must be balanced by

qualitative documentation of Latinas' sexual and reproductive health experiences. A qualitative perspective lends a more nuanced understanding to the interpretation of quantitative data and actively engages Latinas in research and discussion on sexual and reproductive health in their communities. Qualitative research also provides valuable opportunities for involving—and empowering—community-based organizations.

• *Representative.* In addition to developing new methods and survey tools, researchers must work to improve existing instruments for measuring Latina health care and gathering demographic information. The U.S. census, the National Survey of Family Growth, the Current Population Survey and the Youth Risk Behavior Survey may need to update the phrasing of their questions or to ask new questions that better reflect issues, behaviors and service needs specific to Latinas and other minority groups. To improve analysis of different subgroups of Latinas, it is also important to increase the number of Latina respondents.

• *Participatory.* Research is unlikely to be relevant to community needs or to be successfully communicated if it is developed without input from culturally competent researchers—especially when dealing with difficult research concepts such as acculturation and unintended pregnancy. This insight is invaluable in conducting affirmative research that draws on community strengths—research that is likely to be of use to program and policy leaders in the community. Participatory research guided by the input of Latina researchers and community-based organizations is also likely to carry considerable political weight, especially among local leaders. Mentoring programs that facilitate professional networking opportunities would help to increase the number of Latina researchers and the participation of community-based organizations in research. Funders and policymakers can also encourage participatory research by supporting Latina-led investigations and ensuring that Latina researchers and community-based organizations have equal roles in the development of collaborative efforts with other researchers.

The way in which knowledge on Latina sexual and reproductive health is disseminated is as important as the content of the information. The research approaches for individual studies and surveys are only one part of the answer. It is equally necessary to strengthen the communications infrastructure and the collaboration that we have described throughout this action plan to ensure that research is effectively disseminated to policymakers, advocates, program leaders and community members. Support from concerned funders is central to all of these efforts.

## CONCLUSION

From 1990 to 2000, the rate of Latino population growth was more than four times that of the total U.S. population.[27] As participants in the expert meeting confirmed, there is an urgent need to address the knowledge gaps that stand in the way of the design and implementation of effective programs and policies for Latina sexual and reproductive health. Meeting the health care needs of this population will be a major step toward achieving the Healthy People 2010 goal to eliminate health disparities among different groups of Americans. Although this is a challenging goal, it represents a tremendous opportunity to improve the health of a major U.S. minority group through best practices that can be adapted in addressing the needs of other racial and ethnic groups. The expert meeting made it clear that the springboard for these efforts must be improved collaboration between researchers and advocates. With their combined insights and expertise, the community of professionals concerned about Latinas' sexual and reproductive health needs can move forward with the goal of filling the knowledge gaps outlined in this plan for action. This collaboration will generate the evidence needed to support successful policies and programs that are informed by Latinas themselves and that are relevant to the everyday lives of Latina women and their families.

## APPENDIX: MEETING PARTICIPANTS

**Community leaders:** Angela Acosta, Hispanas Organized for Political Equity; Karla Alvarado, Planned Parenthood of Pasadena; Adriana Andaluz, Planned Parenthood Los Angeles; Adam Arzate, Planned Parenthood of Pasadena; Yolanda Arzate, Planned Parenthood of Pasadena; Luz Chacon, Maternal and Child Health Care Access; Melinda Cordero, Planned Parenthood Los Angeles; Rocio Cordoba, California Coalition for Reproductive Freedom; Janette Robinson Flint, Black Women for Wellness; Thelma Garcia, East Los Angeles Women's Center; Gloria Giraldo, Orange County Latina Breast Cancer Task Force; Cristina Gomez-Vidal, Darin M. Camarena Health Centers; Sandra Ibarra, East Los Angeles Women's Center; Bethany Leal, California Women's Law Center; Rocio A. Leon, National Council of La Raza; Esther Arias McDowell, Los Angeles County Office of Women's Health; Jesús María Núñez, Organización en California de Líderes Campesinas; Virginia Ortega, Organización en California de Líderes Campesinas; Rosalinda Palacios, National Latina Health Organization; Araceli Perez, American Civil Liberties Union of Northern California; Patricia Perez, Valencia, Perez and Echeveste; Lourdes Rivera, National Health Law Program; Ana Rodriguez, Pacific Institute of Women's Health; Claudia Rodriguez, Bienestar—Hollywood; Margie Fites Seigle, California Family Health Council; Esperanza Sotelo, Organización en California de Líderes Campesinas; Olga Talamante, Chicana/Latina Foundation; Esperanza Torres, Breast Cancer Fund; Mily Treviño-Sauceda, Organización en California de Líderes Campesinas; Francine Trujillo, National Council of La Raza; Loretta Franke Valero, ACCESS; Nora Vargas, Planned Parenthood of Orange and San Bernardino Counties; Nicole Zendedel, Women and Youth Supporting Each Other.

**Research experts:** Marilyn Aguirre-Molina, Mailman School of Public Health, Columbia University; Claire Brindis, University of California, San Francisco (UCSF); Vignetta Charles, The William and Flora Hewlett Foundation; Anne Driscoll, UCSF Institute for Health Policy Studies; Elena Flores, School of Education, University of San Francisco; Melissa Gilliam, University of Illinois at Chicago; Cynthia Gómez, UCSF Center for AIDS Prevention Studies; Sylvia Guendelman, School of Public Health, University of California, Berkeley; Elena Gutierrez, University of Illinois at Chicago; Silvia Henriquez, National Latina Institute for Reproductive Health; Fatima Juarez, The Alan Guttmacher Institute (AGI); Kathy Kneer, Planned Parenthood Affiliates of California; Carmen Rita Nevarez,

Public Health Institute; Norma Ojeda, San Diego State University; Victoria Ojeda, Harvard Medical School; Britt Rios-Ellis, California State University, Long Beach; Diana Romero, Mailman School of Public Health, Columbia University; Laura Romo, Graduate School of Education, University of California, Santa Barbara; Beatriz Solis, Cultural and Linguistic Services, L.A. Care Health Plan; Kathy Toner, The David and Lucile Packard Foundation.

**Moderator:** Inca Mohamed, Management Assistance Group.

**Organizers:** Latino Issues Forum—Luis Arteaga, Raquel Donoso, Marisol Franco; AGI—Risha Foulkes, Beth Fredrick, Jennifer J. Frost, Susheela Singh.

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