



## CHAPTER ONE



# The State of the Art

## *Latinas in the Health Literature*

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*One of the editors of this book and two colleagues review the process of identifying and selecting literature on Latina health for inclusion in this book. Although the lack of adequate, commendable, or relevant literature on Latinas posed challenges, it also presented an opportunity to assess what exists (in terms of both strengths and limitations) and to identify needed areas of research and what there is of merit from which to build. The authors transform the inadequate attention to the health of Latinas and a weak existing literature into an opportunity to inform the research and practice communities of a course of action that might fill gaps and improve our understanding of the health of Latinas.*

This anthology represents another point on the continuum of efforts to bring the complex issues affecting the health of Latinos in the United States to the attention of the health and public health communities. In earlier books, *Latino Health in the U.S.: A Growing Challenge* (1994) and *Health Issues in the Latino Community* (2001), we faced the challenge of filling a gap in the literature while endeavoring to impart a comprehensive picture of the health needs of Latinos in the United States—the fastest-growing, youngest, and what is becoming the most heterogeneous ethnic/racial group in the country. In many instances, the challenge was finding ways to prepare a survey text that included topic areas and critical health issues in an environment of limited research and inadequate data on Latinos. Nevertheless, since the first volume, some gains have been made in the availability of Latino data, and more studies have been conducted on this population.

Like earlier efforts, the goal of *Latina Health in the United States: A Public Health Reader* is to provide an integrated understanding of Latina health at a time when their numbers are growing in our society and the subgroups are becoming more diverse (for example, by country of origin and levels of

#### 4 LATINA HEALTH IN THE UNITED STATES

acculturation). But the challenge is heightened by several factors. Specifically, Latinas are underrepresented in the research literature, which is a reflection of the paucity of studies that focus on these women. What does exist in general does not address the primary issues affecting their health and health status.

So why attempt to assemble an anthology constructed from the current literature when relevant research and literature are scarce? The reason is that the growing ethnic/racial diversity and demographic changes that are occurring in the United States have significant implications for public health, health care, and health policy. Latinas are prominent within these changes. They are part of the growing sector for which policy and programmatic interventions are needed to address disparities in health status and health care.

Latinas make up approximately half of the Latino community and 6 percent of the total U.S. population. By the year 2050, they will make up 25 percent of the U.S. total female population: one in four women will be a Latina. Furthermore, they represent the youngest population of women in the United States; 40 percent are under the age of 21 years. (See Exhibit 1.1 and Figures 1.1 and 1.2 for additional information.)

Beyond demographic changes, Latinas represent the social capital of the community as mothers, daughters, family caretakers, partners to their *compañeros* (partners or husbands), and contributors to the economic well-being of their family. Latinas also make major contributions to society as they enter the workforce and, more important, as they nurture future generations.

Despite data limitations, a publication is needed that works from what there is to identify promising studies on which to build and areas of need that are yet to be examined.

Many of the chapters in this book were selected because they highlight and review issues that are relevant but often neglected, and thus begin the process of identifying the multiplicity of issues affecting Latinas that the research and provider sectors do not take into consideration. Among these are the combined stressors affecting Latinas as migrant farmworkers, as adolescents attempting to mediate conflicting cultural worlds, as mothers seeking health insurance for themselves and their children, and as health care consumers in search of culturally and linguistically responsive services. Many of these stressors place them at high risk for health and related problems but are not adequately acknowledged in studies or the literature.

Notwithstanding prevailing health issues that have implications for the well-being of Latinas, this group has not captured the attention of those who contribute to the literature. Furthermore, Latinas have not been immune to the narrow focus on women's health that concentrates primarily on the biological processes of reproductive health. Therefore, there exists a need to look beyond

### Exhibit 1.1. Profile of Latinas in the United States

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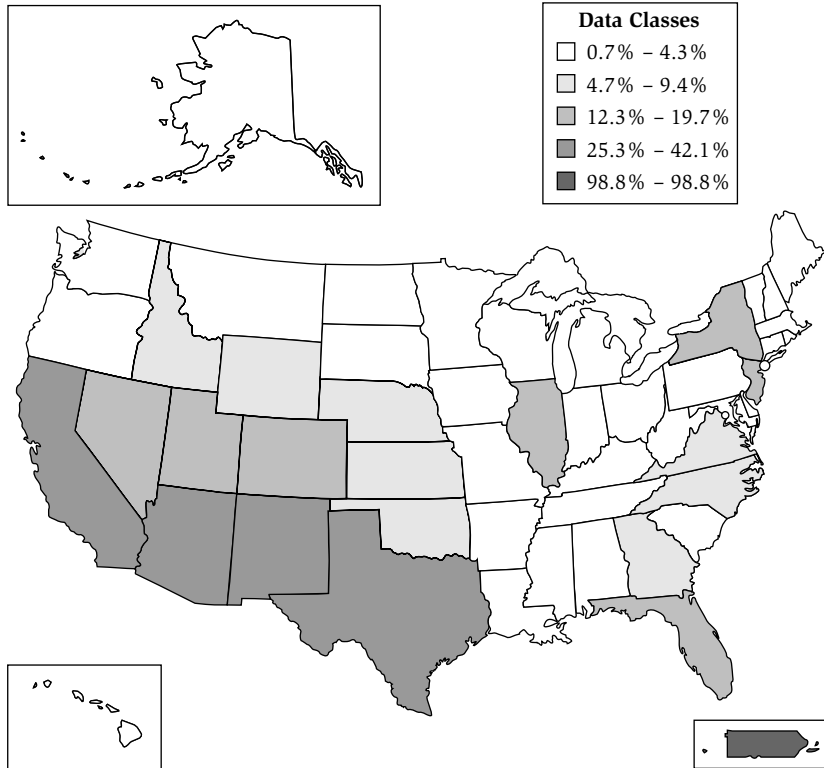
- Forty percent are under 21 years old.
  - Latina fertility rates per 1,000 women aged 15–44 years is (105.9 versus 66.5 for Whites, 71.7 for Blacks, and 70.7 for Asian Pacific Islanders) and birthrates (25.1 versus 14.1 for Whites, 17.6 for African Americans, and 17.8 for Asian Pacific Islanders) are the highest in the United States, which contributed to the growth of the Latino population, as did the high rates of immigration in the decade 1990–2000.<sup>a</sup>
  - Sixty percent of Latinas were born in the United States compared to 96 percent of White women.
  - Twenty-three percent of Latinas are heads of households compared to 14 percent of White women.
  - Twenty-five percent of Latinas live below the poverty level compared to 9 percent of White women.
  - Forty-three percent of Latinas have a twelfth-grade education or less compared to 12 percent of White women.
  - Eleven percent of Latinas have a bachelor's degree or more compared to 26 percent of White women.
  - Ninety-two percent of Latinas 16 years and older are employed compared to 97 percent of White women.
  - Although the majority of Latinas are in the workforce, they are concentrated in low-paying, part-time, or seasonal jobs and experience twice the rate of unemployment compared to White women (7.7 percent versus 3.3 percent).
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Sources: U.S. Bureau of the Census (2001); Anderson (2002).

<sup>a</sup>The birth, fertility, and total fertility rates for Central and South Americans include other and unknown Latino.

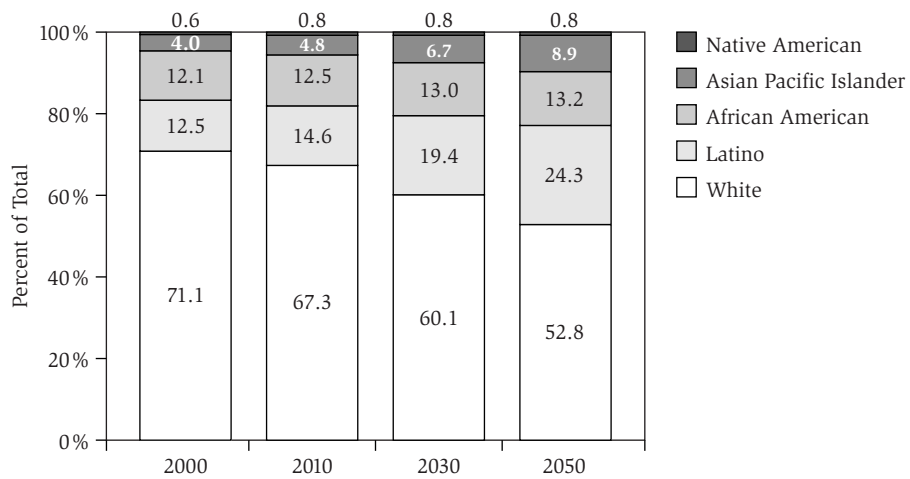
what there is in the literature to what is needed to inform policy and program development.

Often Latina sexual and reproductive health studies are guided by incomplete or inaccurate assumptions and cultural conjecture. Or they are studied outside a structural context and without adequate acknowledgment of the influence of subgroup variations, acculturation, gender relations, and other factors. When these variables are not taken into consideration, they often have adverse implications for Latinas, as negative stereotypes are reinforced and perpetuated.



**Figure 1.1.** Geographic Distribution of Latinos

Source: U.S. Bureau of the Census (2000).



**Figure 1.2.** Projection of U.S. Resident Population, 2000-2050

Source: Day (1996).

## MOVING BEYOND A SIMPLISTIC VIEW OF LATINAS' HEALTH

It is important to share how these observations and conclusions were reached, and the process used to identify, select, and assemble the chapters in this anthology. This was a learning process that is worth sharing because it makes known the state of the field and state of the literature on Latina health in the early years of the new millennium. The findings can help to identify a course of action that informs research, program development, health practices, and policies as they affect Latinas.

### Interview of Content Experts

An open-ended questionnaire was used to interview eleven experts on Latina health. The experts were identified through their prominence in the literature, the recommendations of others who are knowledgeable in the field, and the assistance of a colleague who contacted schools of public health across the country to assist in the process. The intent of this process was to identify essential topics for inclusion in this anthology and peer-reviewed articles that were both informative and of merit for a publication that would be of value to a professional audience.

The experts identified forty-eight topics, the majority of which focused on reproductive health, sexually transmitted diseases, mental health, and socioeconomic status and its impact on health. The literature recommended by this group primarily addressed substance abuse, HIV/AIDS, sexuality, and gender roles.

### Review of Latinas' Health and Health Care Needs

Simultaneous with the interview of experts, morbidity and mortality data and patterns were reviewed to determine the leading causes of death and illness among Latinas, as well as issues related to access to care. (See Tables 1.1 through 1.4, Figures 1.3 and 1.4, Exhibits 1.2 and 1.3, and Chapter Five for more details.) This was conducted for the purpose of assessing the extent to which experts identified areas and topic of need that corresponded to the health and health care needs of Latinas, and determining the extent to which the peer-reviewed literature reflected the situation of Latinas.

Review of the experts' opinion of priority health issues did not correspond with the leading causes of illness and death among Latinas as reflected in national vital statistics (Anderson, 2002) or other reports regarding access to care (Salganicoff, Beckerman, Wyn, and Ojeda, 2002; Wyn, Solis, Ojeda, and Pourat, 2001).

### Assessing and Selecting Work for Inclusion

The next step was an assessment of the peer-reviewed literature and other reports to determine the extent to which they reflected the health and health care needs of Latinas, or, stated differently, the attention to which Latina health needs were reflected in studies reported in the research literature.

## 8 LATINA HEALTH IN THE UNITED STATES

**Table 1.1. Health Insurance Coverage of Latina Subgroups by Poverty Level,  
18–64 Years, 1997 and 1998**

	<i>Population (in thousands)</i>	<i>Uninsured</i>	<i>Medicaid</i>	<i>Job Based</i>
<i>Central and South American</i>				
All women	1,578	42%	8%	46%
200% or below of poverty	738	57	15	24
200% or more of poverty	840	28	NA	65
<i>Cuban</i>				
All women	441	20%	NA	58%
200 or less of poverty	150	34	NA	NA
200% or more of poverty	290	NA	NA	76
<i>Mexican origin</i>				
All women	5,638	41%	13%	43%
200% or less of poverty	3,160	53	20	24
200% or more of poverty	2,478	25	4	68
<i>Puerto Rican</i>				
All women	960	21%	28%	46%
200% or less of poverty	485	26	48	20
200% or more of poverty	475	17	NA	74

*Note:* Poverty designations are based on the 1998 U.S. Census Bureau poverty thresholds. The incomes corresponding to 100 percent of the total federal poverty threshold are \$10,972 for a family of two and \$16,660 for a family of four. Population totals are for 1998 only. NA (not available): The sample size was too small to produce a reliable estimate.

*Source:* Average of March 1998 and March 1999 Current Population Surveys.

A comprehensive literature review and database search were conducted to assess the quantity and quality of relevant information on Latinas. Peer-reviewed journals, book chapters, and other publications on women's health that were published between 1984 and 2002 were reviewed. Approximately two hundred articles were retrieved. The majority of this work was written between 1994 and 2002, with the year 2000 yielding the largest number of articles, thus reflecting a growing interest in this group of women (see Figure 1.5).

All of the peer-reviewed articles and other publications were assessed and ranked on a scale from 1 to 5, with 5 reflecting the highest score using the following criteria:

- Extent to which the focus of the study reflected Latinas' health needs and priorities (reflective of morbidity and mortality data, access to health care, other determinants of health)

*Text continued on page 17.*

Table 1.2. Access and Barriers to Care Issues for Women Ages 18–64 Years, by Race/Ethnicity

	<i>All Women</i> %	<i>Latinas</i> %	<i>Whites</i> %	<i>Blacks</i> %
<i>Experiences with provider in past two years</i>				
Doctor did not usually take time to answer all questions	10	14 <sup>a</sup>	9	8
Left doctor's office and did not understand or remember some of the information given	17	20	17	14
Out-of-pocket costs of doctor visit higher than expected	28	31	28	26
Concerns about quality of care (in past year)	22	34 <sup>a</sup>	20	24
<i>Barriers to care in past year</i>				
General access problem:				
Had a problem and needed to see a doctor but did not	27	32 <sup>a</sup>	25	32 <sup>a</sup>
Provider availability:				
Difficulty getting care due to lack of doctors and clinics	9	12 <sup>a</sup>	8	9
Referral issue:				
Was not able to see specialist when thought needed one	15	22	12	15
Cost of care:				
Did not fill prescription medication due to cost	21	20	21	21
<i>Reasons for delaying or not getting needed care in past year</i>				
Could not afford it	24	31 <sup>a</sup>	22	25
Hard to take time off	24	25	23	26
Could not get appointment with doctor wanted to see	22	23	21	21
Transportation	7	18 <sup>a</sup>	5	10
No child care <sup>b</sup>	10	15 <sup>a</sup>	9	11

<sup>a</sup>Significantly different from reference group (White women) at  $p < .05$ .

<sup>b</sup>Among women with children.

Source: Henry J. Kaiser Family Foundation (2001).

Table 1.3. Top Ten Leading Causes of Mortality for Latinas and Non-Hispanic White Women, All Ages

Rank <sup>a</sup>	Cause of Death <sup>b</sup>	Latinas			Non-Hispanic White Women				
		Number <sup>c</sup>	Percentage of Total Deaths	Rate <sup>c</sup>	Rank <sup>a</sup>	Cause of Death <sup>b</sup>	Number <sup>c</sup>	Percentage of Total Deaths	Rate <sup>c</sup>
...	All causes	47,082	100.0	291.5	...	All causes	1,015,138	100.0	1,011.7
1	Diseases of the heart	12,253	26.0	75.9	1	Diseases of the heart	307,255	30.3	306.2
2	Malignant neoplasms	10,022	21.3	62.0	2	Malignant neoplasms	222,268	21.9	221.5
3	Cerebrovascular diseases	3,322	7.1	20.6	3	Cerebrovascular diseases	86,210	8.5	85.9
4	Diabetes mellitus	2,821	6.0	17.5	4	Chronic lower respiratory diseases	56,670	5.6	56.5
5	Accidents (unintentional injuries)	2,134	4.5	13.2	5	Alzheimer's disease	32,123	3.2	32.0
6	Influenza and pneumonia	1,322	2.8	8.2	6	Influenza and pneumonia	31,526	3.1	31.4
7	Chronic lower respiratory diseases	1,238	2.6	7.7	7	Accidents (unintentional injuries)	27,066	2.7	27.0
8	Certain conditions pertaining to perinatal period	951	2.0	5.9	8	Diabetes mellitus	26,698	2.6	26.6
9	Chronic liver disease and cirrhosis	875	1.9	5.4	9	Nephritis, nephritic syndrome, and nephrosis	14,357	1.4	14.3
10	Nephritis, nephritic syndrome, and nephrosis	841	1.8	5.2	10	Septicemia	13,461	1.3	13.4
...	All other causes	11,303	24.0	70.0	...	All other causes	197,504	19.5	196.8

<sup>a</sup>Rank based on number of deaths.

<sup>b</sup>Causes of death based on the *Tenth Revision, International Classification of Diseases, 1992*.

<sup>c</sup>Figures for age not stated are included in "all ages" but not distributed among age groups.

Source: Anderson (2002).

**Table 1.4. Top Ten Leading Causes of Mortality for Latinas, by Age Group**

		Latinas, 15–19 Years				Latinas, 20–24 Years			
Rank <sup>a</sup>	Cause of Death <sup>b</sup>	Percentage of		Rank <sup>a</sup>	Cause of Death <sup>b</sup>	Percentage of		Rank <sup>a</sup>	Rate <sup>c</sup>
		Number <sup>c</sup>	Total Deaths			Number <sup>c</sup>	Total Deaths		
...	All causes	425	100.0	...	All causes	531	100.0	...	39.6
1	Accidents (unintentional injuries)	195	45.9	1	Accidents (unintentional injuries)	183	34.5	1	13.6
2	Malignant neoplasms	50	11.8	2	Assault (homicide)	70	13.2	2	5.2
3	Assault (homicide)	42	9.9	3	Malignant neoplasms	63	11.9	3	4.7
4	Intentional self-harm (suicide)	35	8.2	4	Diseases of the heart	25	4.7	4	1.9
5	Diseases of the heart	13	3.1	5	Intentional self-harm (suicide)	25	4.7	5	1.9
6	Congenital malformations, deformations, and chromosomal abnormalities	5	1.2	6	Pregnancy, childbirth and the puerperium	22	4.1	6	1.6
7	Nephritis, nephritic syndrome, and nephrosis	4	0.9	7	Cerebrovascular diseases	11	2.1	7	*
8	HIV	3	0.7	8	Congenital malformations, deformations, and chromosomal abnormalities	10	1.9	8	*
8	Cerebrovascular disease	3	0.7	9	Influenza and pneumonia	8	1.5	9	*
8	Influenza and pneumonia	3	0.7	10	Septicemia	5	0.9	10	*
...	All other causes	72	16.9	10	Diabetes mellitus	5	0.9	10	*
				...	All other causes	104	19.6	...	7.8

(Continued)

**Table 1.4. Top Ten Leading Causes of Mortality for Latinas, by Age Group (Continued)**

		<i>Latinas, 25–34 Years</i>				<i>Latinas, 35–44 Years</i>			
<i>Rank<sup>a</sup></i>	<i>Cause of Death<sup>b</sup></i>	<i>Number<sup>c</sup></i>	<i>Percentage of Total Deaths</i>	<i>Rate<sup>e</sup></i>	<i>Rank<sup>a</sup></i>	<i>Cause of Death<sup>b</sup></i>	<i>Number<sup>c</sup></i>	<i>Percentage of Total Deaths</i>	<i>Rate<sup>e</sup></i>
...	All causes	1,309	100.0	50.8	...	All causes	2,488	100.0	103.0
1	Accidents (unintentional injuries)	277	21.2	10.8	1	Malignant neoplasms	761	30.6	31.5
2	Malignant neoplasms	235	18.0	9.1	2	Accidents (unintentional injuries)	301	12.1	12.5
3	Assault (homicide)	113	8.6	4.4	3	Diseases of the heart	210	8.4	8.7
4	HIV	91	7.0	3.5	4	HIV	159	6.4	6.6
5	Diseases of the heart	81	6.2	3.1	5	Cerebrovascular diseases	122	4.9	5.0
6	Intentional self-harm (suicide)	50	3.8	1.9	6	Chronic liver disease and cirrhosis	102	4.1	4.2
7	Cerebrovascular diseases	43	3.3	1.7	7	Assault (homicide)	88	3.5	3.6
8	Pregnancy, childbirth, and puerperium	36	2.8	1.4	8	Intentional self-harm (suicide)	65	2.6	2.7
9	Influenza and pneumonia	21	1.6	0.8	9	Diabetes mellitus	59	2.4	2.4
10	Congenital malformations, deformations, and chromosomal abnormalities	20	1.5	0.8	10	Septicemia	33	1.3	1.4
...	All other causes	342	26.1	13.3	...	All other causes	588	23.6	24.3

		<i>Latinas, 45–54 Years</i>				<i>Latinas, 55–64 Years</i>			
<i>Rank<sup>a</sup></i>	<i>Cause of Death<sup>b</sup></i>	<i>Percentage of</i>		<i>Rank<sup>a</sup></i>	<i>Cause of Death<sup>b</sup></i>	<i>Percentage of</i>			
		<i>Number<sup>c</sup></i>	<i>Total Deaths</i>			<i>Rate<sup>c</sup></i>	<i>Number<sup>c</sup></i>	<i>Total Deaths</i>	<i>Rate<sup>c</sup></i>
...	All causes	3,548	100.0	223.5	...	All causes	4,973	100.0	525.0
1	Malignant neoplasms	1,343	37.9	84.6	1	Malignant neoplasms	1,746	35.1	184.3
2	Diseases of the heart	447	12.6	28.2	2	Diseases of the heart	1,008	20.3	106.4
3	Accidents (unintentional injuries)	203	5.7	12.8	3	Diabetes mellitus	430	8.6	45.4
4	Diabetes mellitus	199	5.6	12.5	4	Cerebrovascular diseases	289	5.8	30.5
5	Cerebrovascular diseases	197	5.6	12.4	5	Chronic liver disease and cirrhosis	177	3.6	18.7
6	Chronic liver disease and cirrhosis	147	4.1	9.3	6	Accidents (unintentional injuries)	145	2.9	15.3
7	HIV	105	3.0	6.6	7	Nephritis, nephritic syndrome and nephrosis	117	2.4	12.4
8	Viral hepatitis	53	1.5	3.3	8	Chronic lower respiratory diseases	98	2.0	10.3
8	Assault (homicide)	53	1.5	3.3	9	Influenza and pneumonia	72	1.4	7.6
10	Chronic lower respiratory diseases	52	1.5	3.3	10	Septicemia	65	1.3	6.9
...	All other causes	749	21.1	47.2	...	All other causes	826	16.6	87.2

(Continued)

**Table 1.4. Top Ten Leading Causes of Mortality for Latinas, by Age Group (Continued)**

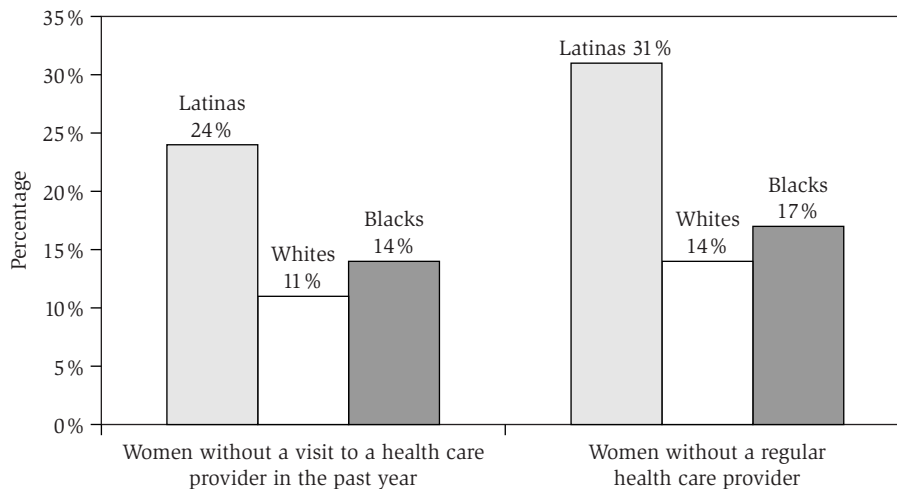
<i>Latinas, 65 Years and Over</i>				
Rank <sup>a</sup>	Cause of Death <sup>b</sup>	Number <sup>c</sup>	Percentage of Total Deaths	Rate <sup>c</sup>
...	All causes	30,881	100.0	2,741.5
1	Diseases of the heart	10,406	33.7	923.8
2	Malignant neoplasms	5,709	18.6	506.8
3	Cerebrovascular diseases	2,638	8.5	234.2
4	Diabetes mellitus	2,109	6.8	187.2
5	Influenza and pneumonia	1,101	3.6	97.7
6	Chronic lower respiratory diseases	1,033	3.3	91.7
7	Alzheimer's disease	732	2.4	65.0
8	Nephritis, nephritic syndrome and nephrosis	634	2.1	56.3
8	Accidents (unintentional injuries)	474	1.5	42.1
10	Chronic liver disease and cirrhosis	436	1.4	38.7
...	All other causes	5,609	18.2	497.9

<sup>a</sup>Rank based on number of deaths.

<sup>b</sup>Causes of death based on the *Tenth Revision, International Classification of Diseases, 1992*.

<sup>c</sup>Figures for age not stated are included in "all ages" but not distributed among age groups.

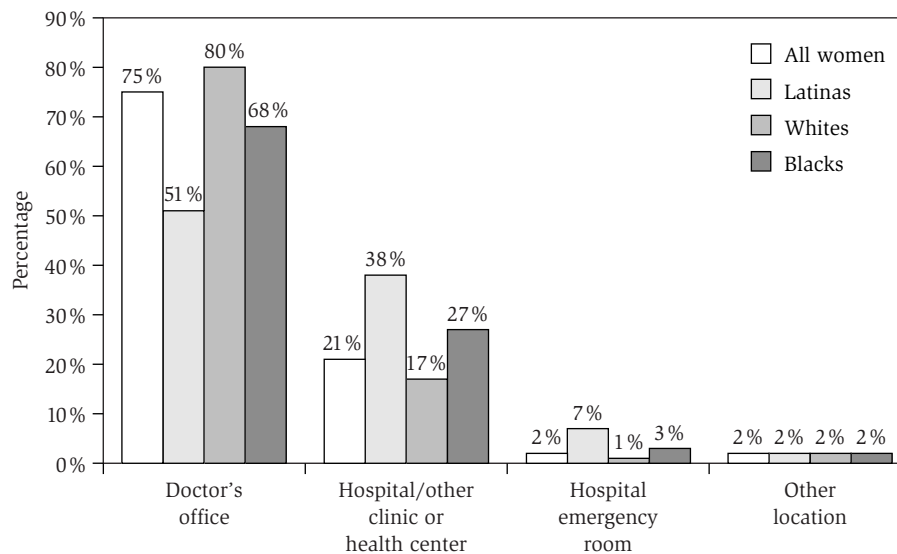
Source: Anderson (2002).



**Figure 1.3.** Provider Visits for Women by Race/Ethnicity, Ages 18 to 64

\*Significantly different from the reference group (White women) at  $p < 0.05$ .

Source: Henry J. Kaiser Family Foundation (2001).



**Figure 1.4.** Site of Care by Race/Ethnicity, Women Ages 18 to 64 Years

\*Significantly different from reference group (White women) at  $p < .05$ .

Source: Henry J. Kaiser Family Foundation (2001).

## 16 LATINA HEALTH IN THE UNITED STATES

### Exhibit 1.2. Access Barriers to Care for Latinas

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- Latinas are at the highest risk for being uninsured; nearly four in ten (37 percent) are without health coverage compared to 16 percent of White women and 20 percent of Black women. Among poor Latinas (below 200 percent of poverty level), just over half (51 percent) were insured in 1999, and they experienced a 5 percent increase in uninsurance rates between 1994 and 1999.
- Central and South American (42 percent) as well as Mexican women (41 percent) are more likely to be uninsured compared to Cuban (20 percent) and Puerto Rican women (21 percent) (see Table 1.1).
- Among Latinas, a little over a third do not have a regular provider and are more likely than White women and African American women not to have visited a doctor in the past year (24 percent versus 11 percent and 14 percent, respectively) (see Figure 1.3).
- Latinas are more likely to rely on hospital clinics and health centers (38 percent) and hospital emergency rooms (7 percent) for medical care than other women see Figure 1.4).
- Compared to other women, Latinas reported higher levels of difficulty when communicating with their providers and faced considerable access problems and barriers to care (see Table 1.2).

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Sources: Salganicoff, Beckerman, Wyn, and Ojeda (2002); Wyn, Solis, Ojeda, and Pourat (2001).

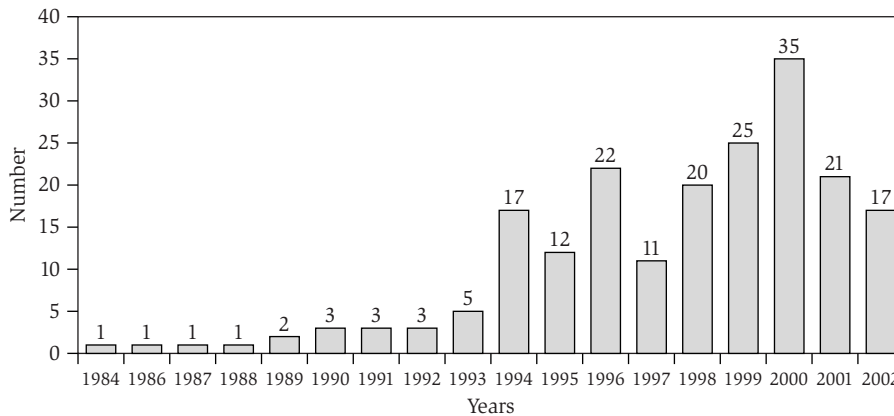
### Exhibit 1.3. Critical Health Issues Affecting Latinas

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- Despite being a younger population, Latinas (29 percent) were the most likely to report being in fair or poor health compared to White women (13 percent) and African American women (20 percent).
- Among Latinas 15 to 34 years, the top three leading causes of death are unintentional injuries, assault, and cancer.
- In the 25–34 age range, HIV is the fourth leading cause of death for Latinas, whereas it is the seventh leading cause of death among White women.
- Cancer, diseases of the heart, and unintentional injuries are the top three leading causes of death among Latinas 35 to 54 years.
- Diabetes continues to be a major cause of morbidity for Latinas 45 years and older. More specifically, it is either the third (55–64 years old) or fourth (45–54 years old) leading cause of death for these women.

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Sources: Salganicoff, Beckerman, Wyn, and Ojeda (2002); Anderson (2002).



**Figure 1.5.** Articles Retrieved by Year ( $n = 200$ ).

- Soundness and rigor of methodology employed in the study (valid and reliable study methods, identification of subgroup variations and acculturation where relevant)
- Sample size and selection process (for example, a sufficient number of Latinas in studies)
- Conclusions that are supported by study findings and studies that provided informative insights or have the potential of informing future studies and stimulating research questions and issues to build on

Studies that did not meet at least three of the five criteria were eliminated from further consideration. This resulted in 105 studies that received a second review and ranking by four readers. The outcome is the inclusion of 26 articles in the reader, plus an additional two commissioned papers and this introductory chapter, resulting in a total of 29 chapters for the book.

## WHAT WAS LEARNED FROM THE PROCESS

### Limited Focus of Studies on Latinas

In spite of the growing numbers of Latinas and what is known about their health status, there continues to be limited research and literature reflective of their health and health care needs. In spite of the data from national registries and surveillance reports documenting the leading causes of morbidity and mortality among Latinas, as well as reports on health indicators, there continues to be a disconnect between researchers' focus and interests, and the health needs of Latinas. There is limited attention in the literature to chronic conditions, even

## 18 LATINA HEALTH IN THE UNITED STATES

though chronic diseases such as cancer and heart disease are the leading causes of death (age specific) for Latinas. Neither is there adequate attention to issues such as barriers to care and the impact of welfare reform.

For example, although Mexican American women represent the largest subgroup of Latinas in the United States and are the subgroup most represented in the research literature, their specific needs are still underdocumented. Although they suffer from one of the highest rates of diabetes in the country (10.9 percent versus 4.5 percent for White women and 9.1 percent for African American women) (Harris and others, 1998), it was extremely difficult to identify a study for inclusion in this book that adequately addressed this issue. Therefore, we included a small focus group study of Latinas with pregnant or postpartum diabetes that raises a number of preliminary insights for future research.

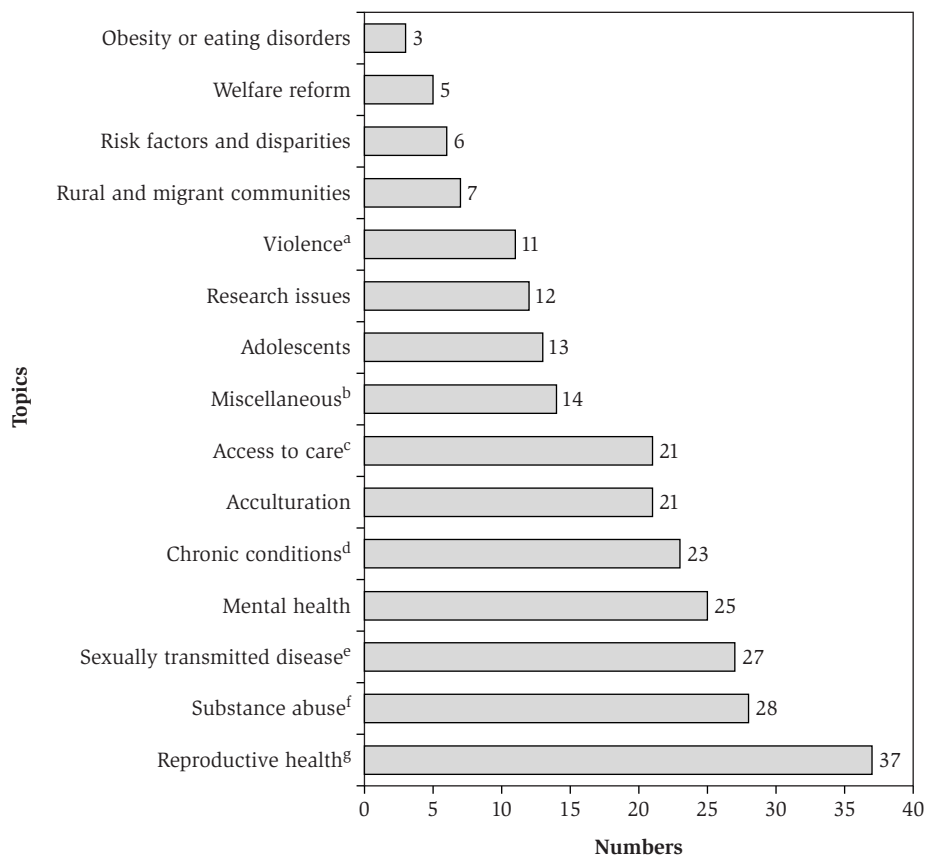
Research attention is heavily weighted toward reproductive health and some to substance abuse. More specifically, following are the topics most frequently addressed in the literature on Latinas (see Figure 1.6):

- Reproductive health (for example, contraception, pregnancy, abortion, prenatal and perinatal care, and sexuality issues)
- Alcohol, tobacco, and other drug use
- Sexually transmitted diseases (including HIV/AIDS)

### Limitations of the Studies

One of the two most obvious limitations across the many studies reviewed is the failure to adequately account for the effects of acculturation. When taken into consideration, the definition and variables used to measure acculturation vary tremendously. This is a significant limitation in the light of what is known about the influence of increased acculturation and the negative effect on health behaviors and health status. Among the studies reviewed, one sought to identify the reasons that Latinas do not seek prenatal care. Only English-speaking Latinas were recruited for the study. The authors posit that the ability to understand and speak English was an indicator of acculturation, implying that speaking English would enable the women to learn about available health services in the health care facilities they frequent. The methodology employed is problematic for many reasons. Acculturation cannot be measured by English comprehension alone. Other variables that go beyond language need to be considered (for example, length of residence and media language preference). Furthermore, limiting the study to Latinas who speak only English can lead to misguided assumptions that should not be generalized.

The second most obvious limitation of most studies is the failure to disaggregate data by Latina subgroups. Most studies report data in aggregate form, with no indication of the ethnic origin of women in the study. Preliminary studies



**Figure 1.6.** List of Topics and Frequency, 1984–2002

*Note:* Each topic covered in the article was included in the final count and does not equal the total of articles retrieved ( $n = 200$ ).

<sup>a</sup>Violence includes assault, domestic or intimate partner violence, abuse, and rape.

<sup>b</sup>Miscellaneous includes topics on midlife women (45–64 years old), workforce issues, self-perception of health status, general minority health, lesbian women of color, transnational motherhood, health issues among Southwest Latinos, and policies affecting health status.

<sup>c</sup>Access to care includes access issues in general, barriers to care, insurance, quality of care, and patient-provider interaction.

<sup>d</sup>Chronic conditions include cancer, cardiovascular disease, and diabetes.

<sup>e</sup>Sexually transmitted disease also includes HIV/AIDS.

<sup>f</sup>Substance abuse includes substance abuse in general, alcohol, tobacco, other drug use, and recovery and treatment.

<sup>g</sup>Reproductive health includes family planning, perinatal care, prenatal care, sexuality issues, teen pregnancy, forced sterilization, abortion, and other topics.

## 20 LATINA HEALTH IN THE UNITED STATES

indicate that there are significant differences across Latina groups that may result from acculturation levels, educational level, socioeconomic status, and other factors. In some cases, the failure to disaggregate data homogenizes the finding to the extent that the meaning and significance are lost.

There are very few studies that focus on Puerto Rican, Cuban, Dominican, or Central or South American women primarily. The last two represent growing numbers for which data and studies are almost nonexistent, but whose growth over the past decade and presence in our society require the attention of the public health and medical care communities. In many cases, these groups are almost invisible when it comes to the research literature.

### Sample Size and Selection Process

A number of the studies reviewed contained an insufficient sample of Latinas. For example, a study on health practices of adult Latinas used a sample of seven respondents who were each interviewed four to seven times about their health practices. In spite of the small sample size, the authors reported the findings in such a manner as to imply the generalizability of the results.

In another instance, a study of what was reported to be of Mexican American women in Chicago, the sample was selected from a list of Spanish-surnamed women who visited a variety of local health centers and hospitals. The majority of the women were then contacted by telephone or recruited during their hospital stays. This process of participant selection by surname is problematic. It assumes that all women interviewed were Mexican American; the survey instrument did ask respondents to self-identify their ethnic group. A portion of the women may have not been of Mexican origin or Latino for that matter; Filipinos and Guamanians also have Spanish surnames.

### Conclusion Reached by Research

The use of small sample sizes, lack of comparison groups, or use of Spanish surnames as the primary method of sample selection can lead to a number of limitations regarding the generalizability of the findings, adequacy of the sampling process, and validity of the conclusions reached. In general, these limitations can mask certain inter- and intraethnic differences, misdirect research efforts, and result in erroneous assumptions about the health behaviors and needs of Latinas. We observed several cases where conclusions did not correspond to findings.

### Inclusion of Latina Health Topics in Leading Journals

During the review process, another interesting finding was the limited number of journals that include Latina health issues among the articles published. The articles retrieved by the research team were most commonly found in the *American Journal of Public Health* and the *Hispanic Journal of Behavioral*

*Sciences*. Other journals where articles on Latinas were published were the *American Journal of Obstetrics and Gynecology*, *Harvard Review of Psychiatry*, *Journal of Adolescent Health*, *Journal of Pediatrics*, and *Public Health Reports*. Although these journals should be commended for covering materials relevant to Latina health, the focus has been narrow and often concentrated on reproductive issues or substance use.

## NEEDED COURSE OF ACTION

Ideally, more studies of Latinas are needed in a broader range of peer-reviewed journals and publications. They are needed for professionals, providers, and policymakers to inform the process of addressing and reducing health disparities. However, the research team realizes that the paucity of literature on Latina health is ultimately a reflection of public and private sector funders' lack of attention to or awareness of Latinas' health needs. Although it is easy to look to the journals and publications that publish these works, a more critical assessment needs to be conducted with respect to the support provided to researchers who choose to do work in this community. The paucity of available funding for minority women's health issues in turn shapes the interests and studies conducted by investigators, and thus may be contributing to the continued underrepresentation of Latinas in the research literature. It is vital that the philanthropic and public funding sectors become more cognizant of the need and act accordingly.

Funders, researchers, and advocates for women's health alike can play an integral role in bringing to the forefront the health needs of Latinas to policymakers and decision makers. Collaboration across these groups can help facilitate the needed advocacy to convey the importance of the health needs of Latinas so that they may understand the benefit it will serve these women, society, and future generations of Latino children and families as well.

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