

# streamline

The Migrant Health News Source

## Public Health at Work:

# Healthcare Providers' Role in Strengthening Regulations and Preventing Pesticide-Related Illness in Farmworkers

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*Editor's Note: This is the first in a series of articles based on the research poster session sponsored by the Pacific Northwest Agricultural Safety and Health (PNASH) Center at the 2010 Western Stream Migrant Forum. For more information on PNASH, visit <http://depts.washington.edu/pnash/>.*

**A** 42-year old farmworker was spraying an apple orchard with a pesticide mixture, including the reversible cholinesterase inhibitor carbaryl. (Washington State Department of Health Division of Environmental Health, 2008). As the wind shifted, he could feel the spray of the chemicals. He reported suffering from respiratory, facial dermal and ocular symptoms. Three days later he sought medical care at a clinic, and his provider reported the case to the state. A department of health investigation discovered that the worker was wearing safety glasses instead of goggles, which may have allowed the pesticides to contact his eyes. Unless an employer hazard assessment requires goggles, however, safety glasses are a legally acceptable form of eye protection. This case is problematic because the pesticide handler wore all required protective equipment intended to prevent poisonings, but he still became ill.

Analysis of the factors contributing to this worker's illness and those of other poisoned workers help inform how poisonings can be prevented. A working group of staff from the Washington State departments of health, agriculture and labor and the Pacific Northwest Agricultural Safety and Health Center are reviewing surveillance data, research, and other relevant data to better understand the problem of pesticide poisoning in the region. The group wants to know how and why they are being exposed and what can be done to reduce over-exposures. Much of the data analyzed by this group come from clinical reports and clinic collaboration with university research.



### The Role of Healthcare Providers

A successful public health system that protects workers and the public from the negative effects of pesticides is truly in the hands of frontline primary care providers. The basic mechanism that triggers effective and nationwide changes in pesticide regulation and use is based on the action of healthcare providers who report to surveillance systems and participate in research. The information this generates can be used by the EPA to restrict or ban harmful or dangerous pesticides. For instance, 26 clinical reports of occupational illness related to the organophosphate mevinphos, scattered among workers from 19 apple orchards, initiated the process that resulted in banning the pesticide in 1995 (Skeers and Morrissey, 1995). Information generated by clinical reports can also be put to use by working groups like the one in Washington to design interventions to reduce pesticide over-exposures. These can include changes in work

practices, engineering controls, regulatory policies, and educational strategies.

Despite revision and expansion of the Worker Protection Standard in 1992 to reduce pesticide poisonings among agricultural workers, these workers continue to experience harmful levels of exposure (US EPA, 1992). In 1992, the US Environmental Protection Agency (EPA) estimated that 10,000 – 20,000 physician-diagnosed pesticide poisonings occur each year among hired farmworkers (US EPA, 1992). This was based on an extrapolation of rates in California, which at the time had the most robust surveillance system in the nation. A recent study in California from 1997 to 2000 found that no worker safety laws were violated in 38% of pesticide poisoning cases, calling into question whether standards are adequately protective (Reeves and Schafer, 2003).

### How Clinical Reports Influence Worker Safety Regulations

Under the Federal Insecticide, Fungicide and Rodenticide Act (FIFRA), the EPA is responsible for protecting agricultural workers from risks resulting from occupational exposure to pesticides and their residues. EPA gains information about risks and problems caused by pesticides in four ways: 1) direct reports from clinicians and the public, 2) poison control center data, 3) passive surveillance data, available in only twelve states and informed by clinical reports, workers compensation claims and other sources, and 4) reports from chemical manufacturers, which can be informed by clinical reports (NIOSH, 2010; Keifer and Liebman, 2010; GAO, 2000).

Currently, there are no comprehensive national data on pesticide poisonings in the United States and only about half of states require that physicians report occupational

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pesticide-related illness and injury. The National Institute of Occupational Safety and Health (NIOSH) and EPA conduct passive surveillance for occupational pesticide-related illness and injury through the SENSOR-Pesticides program, with twelve participating states. Six states (California, Iowa, Michigan, New York, Texas and Washington) also receive supplemental funds to enhance surveillance and investigations of pesticide-related illness and injury. This provides valuable, detailed information on occurrences in a few states, but an understanding of the national situation is lacking.

In 2010, the Centers for Disease Control and Prevention added Acute Pesticide Poisoning to its list of nationally notifiable diseases. This has the potential to greatly improve national surveillance. As with all

**Case Study: WA State Working Group to Reduce Pesticide Exposure**

Pesticide-related eye injury is one of many facets that a multi-agency work group in Washington State is tackling. According to the WA Department of Health (DOH), the most common problem for handlers who mix and load pesticides is eye injury from a splash. In some cases, handlers were wearing permitted eye protection and still had an eye injury. EPA permits four ways to comply with their requirement for eye protection: safety glasses with side, brow and bottom protection; goggles; face shield; and full-face respirator. In particular, DOH found that safety glasses were "not effective in protecting against splashes or wind-blown spray mist" (Washington State Department of Health. Division of Environmental Health. Office of Pesticide Programs, *in press*). Safety glasses do not create a seal around the eyes, which may allow ocular contact with splashes or mist, particularly while applying pesticides with an airblast sprayer.

Another problem is that almost three-quarters of mixers and loaders with pesticide-related illness were not wearing required eye protection. In addition, dozens of worksites violated the Worker Protection Standard because they failed to provide an eyewash at mixing and loading stations and a pint of water in case of emergency. These factors may be one reason that a recent University of Washington study showed that handlers who mix and load pesticides are twice as likely to have a butyl-cholinesterase inhibition of at least 20% from baseline (Hofmann et al. 2009). This is a commonly accepted biomarker of over-exposure to organophosphate and carbamate pesticides. The multi-agency work group is now looking to address the training, enforcement and policy solutions to preventing eye injury, as well as a myriad of other issues identified.

nationally notifiable diseases, however, reporting of acute pesticide poisoning by states remains voluntary unless state legislation or regulation mandates it. In states where reporting is mandatory, Health Insurance Portability and Accountability Act (HIPAA) confidentiality requirements are exempted and personal health information may be reported to state entities.

**What Can Healthcare Providers Do?**

**Consider pesticide exposure in their differential diagnosis.** Focus groups conducted in Washington State found that many workers felt that their healthcare provider had not seriously considered the possibility that their symptoms were the result of pesticide exposure (Washington State Department of Health, National Institute for Occupational Safety and Health, 2004). Occupational health screening questions should be incorporated into patient encounters to insure this possibility is considered, as recommended by the Migrant Clinicians Network (Liebman and Rowland, 2009). (Also see the September-October 2009 *Streamline*.)

**Be familiar with the appropriate agency to report cases.** There is no standard national protocol for reporting suspected pesticide-related illness and injury; each state determines its own guidelines. Some states require that reports be sent to the local health department, whereas others mandate reporting directly to the state department of health. In a few cases, mandatory reporting can also be done through Poison Control

Centers or other agencies.

**Report "suspected" cases.** Many states with mandatory reporting require that the diagnosis of a pesticide-related illness be more likely than not. However, in some cases there may be insufficient toxicological information for providers to determine causality. In other cases, a patient may present with adverse health effects that are temporally related to a pesticide exposure, but have not been previously documented. In either case, documentation of such scenarios is critical because it can lead to improved safety laws and regulation of pesticide sale and use.

**Report suspected cases in a timely manner.** Many states require immediate reporting of hospitalized, clustered or fatal cases. Other suspected cases are often notifiable within three to seven days. If reporting is timely, investigators are more likely to confirm exposure through collection of foliage or clothing samples, and workers may have better precision in recalling the time of symptom onset and exposure, exact location, and products involved. If reports are not timely, investigators may be unable to contact migrant workers.

Healthcare providers have an important role in worker protection. Clinical reports of suspected and confirmed diagnoses are the principal source of information regarding the magnitude and nature of pesticide poisonings in the US. These reports trigger investigations of exposures and ultimately can help strengthen regulations and improve preventative measures to better protect workers. ■

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# Meeting the Needs of Patients with Limited English Proficiency: Guidelines for Federally Funded Healthcare Providers

Virginia Ruiz, JD, Farmworker Justice Inc.

## Who is a Limited English Proficient person?

Limited English Proficient (or “LEP”) persons are individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English. These individuals may be eligible to receive language assistance from health centers and other agencies that receive financial assistance from the US Department of Health and Human Services (HHS).

## What does federal law require?

Recipients of Federal financial assistance must insure that persons who face challenges communicating in English receive meaningful access to their services. Migrant and Community Health Centers (M/CHC) that serve a population with a substantial proportion of LEP persons must develop a plan and, to the extent practicable, make arrangements for providing services to such populations in their language and in an appropriate cultural context.<sup>1</sup>

Title VI of the Civil Rights Act of 1964 provides that no person shall “on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”<sup>2</sup> Following the passage of the Civil Rights Act, HHS issued regulations<sup>3</sup> that

- Forbid recipients of federal financial assistance from “utiliz[ing] criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular race, color, or national origin
- Require recipients to take reasonable steps to ensure meaningful access to the benefits, services, information, and other important portions of their programs and activities for individuals who are limited English proficient (“LEP persons”)

The Supreme Court interpreted the HHS regulations to hold that Title VI prohibits conduct that has a disproportionate effect on LEP persons because such conduct constitutes national-origin discrimination.<sup>4</sup> Executive Order 13166 required federal agencies develop and implement regulations to ensure LEP persons have meaningful access to the services provided by the agency.<sup>5</sup>

## Who is covered?

These regulations apply to both federal agencies and recipients of federal financial assistance, such

as state, county, and local health agencies, and M/CHCs. Federal financial assistance includes grants, use of equipment, donations of surplus property, and other assistance. The requirements apply to all parts of a recipient’s operations, even if only one part of the recipient receives the federal assistance. In addition, sub-grantees of federal assistance are also covered by these laws.

## HHS guidance on how to comply Title VI obligations

In addition to regulations, HHS has provided additional guidance on how federally-funded entities may best comply with their obligations under Title VI.<sup>6</sup> These guidelines are intended to ensure access by LEP persons to critical services while not imposing undue burdens. According to the guidance, recipients of federal funding should assess the language services they need to offer by balancing four factors: (1) Demography; (2) Frequency of contact; (3) Importance; (4) Resources

### Demography

Recipients should assess the number or proportion of LEP persons from a particular language group served or encountered in the eligible service population. The greater the number or proportion of LEP persons served or encountered, the more likely language services are needed. Data on the populations a Health Center serves may be found at [www.lep.gov](http://www.lep.gov).

It may be helpful to work with community-based organizations that are familiar with the language needs of populations in the service area.

### Frequency of Contact

Recipients should assess the frequency with which LEP persons are encountered, and their

respective language groups. The more frequent the contact with a particular language group, the more likely that enhanced language services are needed. A less intensified solution may be appropriate for serving individuals from language groups with minimal encounters. However, consider the fact that appropriate outreach to particular LEP language groups could increase the frequency of contact with those groups.

### Importance

Recipients should assess the nature and importance of programs, activities or services to people’s lives. The more important the program, activity, or service, the more likely language services are needed. Examples of important activities include

- programs or activities that have serious consequences, either positive or negative, for a person who participates (including health, safety, economic, environmental, educational)
- those where delays in the provision of services or participation in programs and activities will have a great impact (including economic, educational, health, and safety)

### Resources

Recipients should identify the resources (both monetary and personnel) available to ensure the provision of language assistance to LEP persons. The level of resources available may impact the language assistance provided, and healthcare providers may consider the benefits that result from the costs: “reasonable costs” may become “unreasonable” where the costs substantially exceed the benefits. Costs can often be reduced by technological advances or the sharing of language assistance materials and services among

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## LEP Resources

In determining what services your health center must provide and how best to provide them, the following resources may be useful:

### LEP Resources –

<http://www.lep.gov/resources/resources.html>

This site provides information about LEP compliance, including a page with links to resources that can help in developing, updating, or assessing your health center’s plan for LEP services. On the resources page, scroll down to the section titled “Health Care.”

### Language Assistance Self-Assessment

and Planning Tool – <http://www.lep.gov/selfassesstool.htm>

This self-assessment contains a series of questions that can be used to plan what services your health center should provide.

**Virginia Department of Health’s Website on Providing Culturally and Linguistically Appropriate Health Care** – <http://www.vdh.virginia.gov/ohpp/CLASact/default.aspx>

From the left navigation bar on the home page, go to Language Resources | Linguistically Appropriate Health Care for some useful tools to use in developing your LEP plan. Be sure to look at A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations, which provides profiles of LEP patients’ experiences with their health care providers and profiles of health care facilities who use a variety of methods to meet the language needs of their patients.

### LEP Information from HHS –

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html>

The HHS site provides more information about LEP requirements and links to additional resources.

Other helpful resources include a module on effective use of translators in one of MCN’s online courses. <http://courses.migrantclinician.org/mod/resource/view.php?id=450>

1. 42 C.F.R. §§ 51c.303(l), 56.303(l).

2. 42 USC 2000(d)

3. 45 CFR 80.3(b)(2)

4. Lau v. Nichols, 414 U.S. 563, 568 (1974).

5. Exec. Order No. 13166, 65 FR 50121 (2000).

6. 68 Fed. Reg. 47311



# The Vocation of Migrant Health

Jennie McLaurin, MD, MPH

[Editor's Note: The following is excerpted from testimony given by Jennie McLaurin, MD, MPH at the February, 2010 National Advisory Council on Migrant and Farmworker Health in Seattle, WA]

**M**y career in migrant health started in 1982 when I spent a summer volunteering as an outreach worker in North Carolina migrant camps while I was a first year medical student. That experience ignited a passion in me for the well-being of the people who work in the fields. I was amazed that we never learned about this population in medical school, even though they were all around us. I returned to the same place in 1988, after finishing my pediatric residency and starting my master's degree in public health. I then worked at Tri-County Community Health Center as staff physician and eventually medical director.

I had a great orientation to migrant health and was encouraged by my CEO to be active in the Migrant Clinicians Network (MCN) and the North Carolina Primary Care Association (NCPA). Participation in these groups made a huge difference in my career commitment to migrant health. In my career I have served as medical director of the North Carolina Office of Rural Health Migrant Program, an MCN employee and contractor, worked nationally on the Health Disparity Collaboratives and on a number of other initiatives to improve farmworker health. I have also worked with medical schools, AHECs, health departments, and the American Academy of Pediatrics to write, publish, and speak on migrant health topics so that students and practicing professionals understand this special population.

Those of us working in migrant health know that the model requires community-ori-

ented primary care, access for all, sliding fees, outreach, and cultural competency. But, in my experience, what has the biggest effect is an attitude and orientation among leadership that allows the flourishing of those who have the greatest expertise, the greatest commitment, and the greatest vision for impacting the world of farmworker health and justice. You might call this a leadership practice, but it is a force for health when unleashed. Every health center I've seen that flourishes and makes a significant difference in reshaping the shameful disparities in health faced by the underserved has leadership that values clinicians and staff and sets them free to do their best work.

More specifically, programs and practices that are initiated by clinicians who are given resources and time to test and implement changes have the most powerful effect. This is performance improvement at the ground level. It allows risk taking, failure in the short run, imagination, and collaboration. A good example is the Health Disparity Collaboratives that had clinicians tracking health disparities and encouraging patient self-management. We saw migrant women doing "best diabetes cooking" competitions, migrant women getting healthier through a dancing group at a clinic, and diabetic patients meeting for breakfast groups. Clinicians wrote grants, partnered with each other, and worked hard to document whether their practices made a difference. We have also seen positive effects in immunization programs that have partnered with medical students and public health students to do special campaigns.

Real change happens when clinic administration encourages clinician leadership at the board and PCA level, and when there is support for clinician sabbaticals which re-energize

and provide opportunities for learning and growth. Such opportunities include Spanish immersion study, international work, or education in an adjunct field like massage or acupuncture. These clinic settings retain clinicians, encourage leadership and innovation, increase quality, and focus on the mission of health care justice to the mobile poor.

The greatest impact comes when we don't reinvent things every two years. Every time we lose a clinician, we have to reinvent a new one. The lack of change in farmworker health after forty years of a federal program is appalling. We don't know what works because it hasn't been recorded. We don't know what works because we keep building models based on a primary care system that doesn't fit with the reality of clinicians coming into the field. We don't know what works because our clinicians aren't given the opportunity to show us, they are often just "providers" not health care champions. A provider is an economic term; it discounts the human person who is in relationship with the population being served. We are clinicians with an array of skills and abilities and passions. We have to recover the idea that clinicians can help change the face of migrant health, but to do that we have to honor them as specialists in their field.

In my own career, I call myself a specialist in migrant health, and it has motivated me to learn all I can, to focus on a distinct population, and to craft practices that are central to this core population, rather than just marginally about them. Real change will happen when we decide migrant health is a valuable, mainstream specialty that is integrated into how we care for everyone in our country. And we'll listen to, encourage, and champion those clinicians who decide that a career in migrant health is their dream too. ■

## ■ Multiple Risk Factors for Lead Poisoning in Hispanic Sub-Populations *continued from page 3*

other organizations.

Each health center must make an individual determination of what services to provide to LEP patients based on those four factors.

### Providing Language Services

Healthcare providers have two main ways to provide language services

- (1) oral interpretation either in person or via telephone interpretation service
- (2) written translation

Competency to provide spoken interpretation or written translation does not necessarily require formal certification, but not all bilingual individuals have the skills needed to interpret or translate information into and out of English. The skill of written translation is different from that of oral interpretation: someone qualified as an interpreter may not be qualified as a translator, and vice versa.

### Oral Interpreters

Options for providing oral interpretation include: hiring bilingual staff, hiring staff interpreters, contracting for interpreters, using telephone interpreter lines, and using community volunteers. Oral Interpreters should

- Be proficient in and able to communicate information accurately in both English and in the other language
- Have knowledge in both languages of any specialized terms or concepts peculiar to the program or activity and of any particularized vocabulary and phraseology used by the LEP person
- Understand and follow confidentiality and impartiality rules
- Understand and adhere to their role as interpreters without deviating into other roles, such as counselor or legal advisor

Oral interpretation must be timely. That is, it

should be provided at a time and place that does not cause a denial, delay or the imposition of an undue burden in the receipt of important services to the LEP person.

### Written Translators

Some languages may not have a direct translation of some medical terms — a translator should be able to provide an appropriate translation. Work with translators to create a glossary of such terms to ensure consistency.

When quality and accuracy of written translation is vital, such as with legal and other information with important consequences, ensure that the highest-quality work is performed. Translators should

- Be competent, skills should be certified or verified by independent parties
- Should understand the expected reading level of the audience ■

# A Cultural Meaning of Sexual Risk Among Latino Adolescents in North Carolina

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[Editor's Note: This article was excerpted with permission from *Hispanic Health Care International*, Vol. 7, No. 3, 2009, p. 160-169. For the full text of the article go to <http://www.springerpub.com>]

The purpose of this ethnographic study was to explore the cultural meaning of sexual risk from the perspectives of Latino adolescents and their parents in the context of migration.

Adolescents in the United States have higher rates of premature childbearing and sexually transmitted infection than adolescents in other developed countries (Centers for Disease Control and Prevention [CDC], 2008). The limited research available suggests that health disparities in these areas are greatest for Latino youth (Driscoll, Biggs, Brindis, & Yankah, 2001). For example, the teenage pregnancy rate for Latinas in North Carolina is four times greater than White teenagers (North Carolina State Center for Health Statistics, 2006). This fact is particularly salient, as North Carolina experiences the greatest Latino population growth in the nation (Kochhar, Suro, & Tafoya, 2006) and a Latino school-age population that has increased over the past 10 years by 558% (North Carolina Department of Public Instruction, 2008).

## Methods

An ethnographic approach was used that included in-depth interviews with Latino adolescents and their parents as well as participant observation in the school and the community. The study was based in a rural county in eastern North Carolina. Students in seventh, eighth, and ninth grades were recruited using specific criteria to ensure sampling variation. These criteria included variations in age, gender, country of origin, length of residence in the United States, family structure, and English-/Spanish-language ability. The sample was restricted to Latino adolescents of Mexican and Central American heritage since other scholars have indicated similarities in these groups with respect to immigration experience and employment status in the United States (Portes & Rumbaut, 2001). Adolescents who were unable to speak either English or Spanish or had difficulty sitting for an hour-long interview were excluded from the study.

## Participants

One or both parents ( $n = 18$ ) and one or two siblings ( $n = 15$ ) in 12 families were interviewed. In addition to these family members,

10 other adolescents, including two sets of siblings, were interviewed whose parents were unable to participate because of work constraints or other obligations. A total of 25 adolescents (17 girls and 8 boys) participated in the study.

## Data Collection and Analysis

Data were collected over a 12-month period beginning in January 2004. Adolescents and parents completed a short demographic form and participated in one or two in-depth interviews. A second interview was conducted with five adolescents to follow up on greater detail after an event, such as *la fiesta de los quince años*. A semi structured interview guide developed through a pilot study (Larson & McQuiston, 2008) was used initially to elicit the concepts of interest and to allow other topics to become part of the interview as participants directed. Interviews with adolescents and parents were conducted separately, in private, and in the preferred language of the participants.

## Findings

One of the major findings was that gender-specific Latino cultural norms clashed with mainstream U.S. norms, confusing adolescents and parents about what were appropriate and inappropriate sexual behaviors. Three themes made up this finding: *La fiesta*, Boyfriend as Husband, and *libertinaje* (sexual freedom).

### La Fiesta

*La fiesta de los quince años*, the 15th birthday celebration, marks the transition from girl to woman. Safe passage through this transition depends on the presence of family and friends who assist the teenager in navigating the adult world (Cantu, 1999). According to this tradition, dating is prohibited before the 15th birthday. So while *la fiesta* acknowledges the female sexual self, it also aims to control early sexual activity. By controlling when dating begins, the cultural practice protects girls from early marriage and childbearing.

Most of the parents and adolescents agreed that *la fiesta de los quince años* was an important life transition. Twelve girls in the study had either celebrated or were preparing for *la fiesta*. However, five girls were either denied or refused the celebration, thereby deviating from this norm. A major safeguard that served to assist girls in this transition was a supportive family and community network.

A supportive family network was observed among some of the families as they attempted to reconstruct a *rancho* (Mexican village),

moving into the same neighborhood where other relatives were living. The teenage daughters in one such family walked about the neighborhood freely visiting relatives. In this family, the oldest daughter had just celebrated *la fiesta de los quince años*. Her mother explained, "We did not think we could have it [la fiesta] because we did not have enough money, but her uncles, cousins, and nephews said, 'We are going to have it, if the parents want it.' We had a simple one with just the family."

However, a lack of family and community support was evident among several families in the study. A single mother and her 13-year-old daughter had moved every year in the past 5 years because of sporadic employment. This mother had recently been discharged from a drug and alcohol treatment program, and her daughter was dating a 19-year-old man living in the same trailer park. The 13-year-old responded, "My mom said to me, 'You can't dance, and you can't have a boyfriend before [age] 15.'" In a separate interview, her mother explained, "No, she will not have it [la fiesta] because she already has a boyfriend." Two 14-year-old girls in the study both reported that they would not celebrate their *fiesta de los quince años* and associated the reason to the recent separation of their parents. One of these girls was dating a 19-year-old man living in the same neighborhood, a relationship that she kept secret from her mother.

Most parents worked 10 to 12 hours, 6 days per week, commuting long distances. Mothers described the potential danger in leaving their daughters home alone and accepted the blame for problems that arose. One mother of a 14-year-old girl explained, "I think all our problems [with her daughter and boyfriend] started when I went to work." Another mother also expressed concern: "It worries me that she stays here all day alone, and she has other girlfriends that are alone also."

In-depth interviews with adolescents and parents also revealed a history of physical and/or sexual abuse in 5 of the 12 families participating in this study. Four mothers reported having lived with an abusive spouse for most of their married life. A 13-year-old Latina participant who had been a victim of sexual abuse explained what she considered a risk to her health:

For girls who live alone with their mother and a man arrives in their house and enters the house, this is a risk for the girls because he could take her and something

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like that could happen. According to participants, women and girls were particularly vulnerable to sexual abuse, as they frequently depended on extended family or friends for temporary housing. Official institutions, such as the local domestic violence shelter, the department of social services, and the school, served to support the immigrant community; however, problems were slow to be identified and interventions often too late to help.

### Boyfriend as Husband

Most parents agreed that girls could begin dating after age 15, but according to parents, even at this age chaperones were expected to supervise dates. When girls deviated from this norm, parents described deviations in the context of migration. One mother was convinced that “here, to have a boyfriend is like having a husband.” Another mother commented, “Here, when you have a boyfriend, you have sexual relations, and in Mexico, no.” A third mother knew four girls who “went to live with their boyfriend like husband and wife.” The notion of “boyfriend as husband” implied a sexual relationship with an older man who had the financial capability, such as a car and money, to provide for a wife.

Adolescents in the study made a connection between teenage pregnancy and the theme of “boyfriend as husband.” A 15-year-old male participant remarked, “The girls that have a kid when they are so young, they go with a man that is older. They are not going to have a kid with a boy their same age.” Likewise, a 14-year-old female participant described the connection in this way:

It’s a problem [teenage pregnancy] and mostly for Hispanic girls. Like right after their 15th [birthday], they run away with a guy, get married, something always happens. My cousin [15 years old] was having a real rough life because her mom remarried. She didn’t get along with her stepfather, so her mom kicked her out of the house, and she just got married. And he was really old, he’s 27. Then my other cousin, at her 15th she was already pregnant 3 months. Nobody knew. Stuff like that.

According to cultural norms, Latina girls less than 15 years old were not allowed to date but were highly sought after by older men. The theme of “boyfriend as husband” also emerged in relation to *machismo* in the comments of a father in the study:

I don’t know if this could be called *machismo*, but a man only wants a woman that is a virgin. This is the Hispanic culture. In our case, she [his wife] was very young. I was 26 years old, and it was a good time for me to have a family. But for her, no. I committed an error; she was too young [14 years old].



As indicated by this comment, teenage girls were sought as potential partners in Latin America just as they were in rural North Carolina. The fact that the majority of the mothers in the study had married as teenagers to older men may have given their daughters and sons a reason to perpetuate this practice.

### Libertinaje (Sexual Freedom)

Parents described adolescent behaviors that deviated from traditional practices as *libertinaje*, or sexual freedom. The English translation of *libertinaje* is licentiousness, defined as promiscuity or a disregard for commonly accepted rules or conventions (Trumble & Stevenson, 2002). One mother blamed parents for these deviations:

The parents are guilty because they don’t give them *libertad* [freedom], but instead they get *libertinaje* [sexual freedom]. I have seen many girls going to dances alone; they aren’t with a brother, a cousin, or their mother. They are at the dance alone with other girlfriends, and they aren’t given respect.

By attending social events without a chaperone, girls deviated from traditional rules that provided protection from early sexual activity. When girls were alone or with other girls, they were not “respected” by men; in other words, their virginity was not honored. Without chaperones or parental supervision, cultural controls were weakened, allowing Latinas more sexual freedom and placing them at increased sexual risk.

Latina girls were the apparent targets of *libertinaje*. The boys in this study described Latina girls as girls who were “doing whatever they wanted.” One boy insisted, “The girls let the boys go as far as they let them.” Another boy who knew a Latina who dropped out of high school because of pregnancy stated,

“They want to have sex so they have to suffer the consequences. Girls think they are grown up and can do whatever they want.”

Several boys were convinced the sexual behavior of Latina girls changed on arrival to the U.S. One boy summarized this sentiment this way:

In Mexico the girls think different from the girls who live here. In Mexico, they think better than the ones here. They don’t have sex with their boyfriend. But once they move from Mexico over here, they start to think different.

Parents also believed that the American culture had a negative influence on the sexual behavior of Latina girls. One father remarked, “The American culture is different. We don’t see it as good when a girl has relations with this one and that one.” A mother echoed this remark by saying, “Here in this country the women are liberated. They have a boyfriend, and they want to go to bed with him.” This same mother believed that one reason for this sexual freedom or *libertinaje* was because parents “don’t talk to their children.”

### Discussion

All the parents in this study were first-generation immigrants, and the vast majority of the adolescents had lived in the United States fewer than 7 years. Thus, recent migration and traditional gender and cultural norms shaped sexual risk behaviors in important ways. Sexual development for Latina girls was embedded in the age linked transition known as *la fiesta de los quince años*. At the time of this research, no studies were found that linked sexual risk or teenage pregnancy with the cultural tradition of *la fiesta de los quince años*. However, following the completion of this study, an award-winning documentary (Clements, Glatzer, & Westmoreland, 2006) and a major work of nonfiction (Alvarez, 2007) juxtaposed sexual risk behaviors and teenage pregnancy with this cultural rite of passage. For most of the families in this study, the custom was important in maintaining a girl’s virginity and therefore had a role in the management of sexual risk. However, the social context of the school and community facilitated deviations from traditional norms.

The school environment offered a wealth of opportunities for interactions between girls and boys. School became an environment where Latino adolescents could explore their sexuality with little intervention from teachers or parents because behaviors between couples such as kissing, hugging, and touching were ignored. Latina girls gained sexual freedom in the school, which they had not previously experienced. In their study on risky behaviors of Latino youth, Talashek, Peragallo, Norr, and Dancy (2004) also found minimal involvement



from parents and schools in preparing teens with information to protect against early pregnancy and parenting.

Although all the parents in the study came to North Carolina to join other family members, maintaining close ties with relatives was difficult. Families moved to where work opportunities were available, often in cities distant from the initial destination of relatives. In many cases, immigrant families found themselves more on their own than they had anticipated. Thus, Latina girls were left to reconfigure traditional practices in a sexually permissive environment. In this way, some Latina girls entered the adult world of sexual relationships at an early age with the expectation of marriage and childbearing. Other studies identified the importance of social capital (strong community networks) among Latino populations in the prevention of teenage pregnancy (Denner, Kirby, Coyle, & Brindis, 2001).

One interesting characteristic of the families in the study was in the variation in family structure. Adolescents were living in families with both biological parents ( $n = 10$ ) and in families with single parents ( $n = 6$ ), stepparents ( $n = 3$ ), or a guardian ( $n = 1$ ). This suggests that the Latino family is changing in the face of migration. The protective Latino family and concept of familismo was absent for many adolescents. Although the high number of nontraditional families may be an artifact of the small sample, other researchers have also reported increasing single parent households among Hispanic families (Rucibwa, Modeste, Montgomery, & Fox, 2003).

This study had several limitations. First, the sample included only 8 boys compared to 17 girls. This lack of male participation suggests a need for using different strategies to include males in sexuality research. A research design using focus groups and male interviewers might be more feasible in eliciting responses on sexual risk with boys. Second, all the parents could not be interviewed because of their varied work schedules and other obligations. Interviews with these parents might have yielded other insights into immigrant family life and sexual risk behaviors. Third, the study was conducted in a rural area of eastern North Carolina, with primarily immigrant Mexican families, and cannot be generalized to other Latino populations in the United States.

## Conclusions and Implications For Practice

*La fiesta de los quince años* may be one of the cultural mechanisms that controls sexual risk behavior, but other turning points in the lives of adolescents must also be understood. In this study, parental and marital discord, untenable housing, and loss of community safeguards were turning points that shifted the life

course trajectory for these adolescents. No variation in the norms and customs of *la fiesta de los quince años* was noted in this sample. As in other studies, cumulative and simultaneous turning points at a time of heightened sensitivity, such as *la fiesta de los quince años*, may have contributed to early sexual activity (Clausen, 1991; Guo, 1998). The line between following tradition and sexual freedom became blurred in the liberal school environment. In this context, some parents further restricted adolescent freedom, thereby increasing defiant and deceptive behavior among some girls. The findings from this study contributed to the placement of a school-based child-family support team in the fall of 2006. A nurse and social worker are now located at the school to screen and identify at-risk children and connect them and their families with appropriate health and social services.

Continued research with vulnerable populations, especially non-English-speaking persons, is imperative for understanding the nuances of immigrant life (Davila et al., 2007). National leaders believe that health disparities will be eliminated only if this nation adopts a public health approach rather than a biomedical approach (Satcher & Higginbotham, 2008). This approach calls for taking into account the influence of the physical and social environments on health disparities. Community-based participatory research is a methodology that engages community members in addressing health problems at the community level and has gained increasing acceptance among academics (Israel et al., 2003; Viswanathan et al., 2004). Gaining entrée to the Latino community through Latino-led advocacy groups, clinicians could form partnerships to discover a community solution to the negative sexual health outcomes facing Latino youth. Leaders in the Latino community in eastern North Carolina and nursing faculty with the East Carolina University College of Nursing are exploring this strategy through the design of culturally sensitive sexual health messages from a community perspective (Larson & Cartagena, 2007). Sexual health messages that incorporate concepts of communication, negotiation, and decision making in relation to cultural risks identified in this study can be a starting point toward developing capacity in Latino communities. ■

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