Decisions Regarding Birth Control and Family Size in Mexican American Families

by

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A Thesis

Presented to
The Oregon Health Sciences University
School of Nursing
in partial fulfillment
of the requirements for the degree of
Master of Science in Nursing

May 1987

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This study was supported by a
United States Public Health Service Traineeship
from Grant Number 2 A11 NU00250-11

ACKNOWLEDGEMENTS

I would like to gratefully acknowledge my advisor Dr. Virginia P. Tilden for her wisdom, support, encouragement, and, above all, her kindness in helping me to complete this project. I also thank my readers Dr. Carol Howe and Laura Goldfarb for their time and excellent suggestions, and Laura Goldfarb for her help with the instrument translation.

This study would not have been possible without the generous cooperation of 30 members of the Oregon Mexican American community. Their contribution as subjects is greatly appreciated. Special thanks goes to the staff of the Salud Medical Center for their support and assistance during the data collection process.

I wish to express my gratitude to my classmates Teri Curry, Sandy Fisher, Paula Hammond, Creagh Hawes, and Debbie Warren for their invaluable support. I also wish to thank Jane Kirschling, Susan Cooksey, and Deborah Constans who each contributed in a special way to the development and completion of this study.

A special note of thanks goes to my family, especially my parents for their continual love and support, and my grandmother who always is a source of encouragement and inspiration.

Above all, I wish to thank Larry Knudsen. Not only was he my "first reader," but he also listened to my frustrations and provided abundant love, patience, and wisdom to help me through the most trying times.

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CHAPTER I

INTRODUCTION

The decision to practice family planning may be influenced by religious and cultural beliefs as well as socioeconomic status and political ideals. One important reason for practicing family planning is to adequately space pregnancies in order to protect the health and well-being of the mother and child (Garcia & Rosenfeld, 1977; Hunter, 1975; World Health Organization, 1980). In considering maternal health, pregnancy constitutes a stress that may deplete or significantly diminish a woman's physical, mental, and emotional resources (Hunter). Therefore, the time interval between the end of one pregnancy and the beginning of another is necessary for adjustment and the restoration of health. Garcia and Rosenfeld noted that short intervals between successive births of children correspond to an increase in fetal, neonatal, infant, and childhood morbidity and mortality. This rationale for adequately spacing pregnancies exists even if a large family is desired.

The spacing of births for optimal health of the mother and child is possible through family planning. Family planning is a means to reduce health hazards for families and enhance the quality of family health. Nurses and other health care providers can promote healthier outcomes in

their clients through education about the importance of spacing pregnancies and methods for practicing family planning.

Cultural beliefs may influence the manner in which a person makes decisions related to family planning (Fox, 1982). Although a variety of research has been carried out on family planning decision-making, few studies have looked at this phenomenon within the context of the Mexican American culture.

Although the exact number is uncertain, the 1985 U.S. Census Bureau estimated that 10.3 million persons of Mexican origin or descent inhabit the United States. This figure makes Mexican Americans the second largest minority group in the country. As a result of continuous immigration and a high fertility rate, the size of the Mexican American population relative to the total U.S. population has been increasing over the past 30 years (Alvirez, Bean, & Williams, 1981). Nurses have had and will continue to have increasing contact with this large and important ethnic group.

Many explanations have been given for the higher fertility rate of Mexican Americans including poverty (Bean, 1973; Bean & Wood, 1974), lack of education (Uhlenberg, 1973), unemployment (Johnson, 1976), Catholicism (Alvirez, 1973), and a desire for larger families (Sabagh,

1980). The desire for larger families by Mexican Americans has been explained by the cultural value placed on having children. Andrade (1982) noted that in much of the social science literature, Mexican American values are presented as differing significantly from most Anglos and Blacks with regard to the group's perception of large families. The two concepts that are often emphasized are machismo (the Mexican American man dominates decision-making within the family and his self-esteem is described as being determined by how many children he procreates) and familism (Mexican Americans desire a large family and the Mexican American woman especially values the maternal role).

Andrade further acknowledged that there is not sufficient research to evaluate whether or not these beliefs of machismo and familism actually exist. In particular, there appears to be a growing number of researchers who contend that the machismo concept of male dominance in decision-making is a myth (Cromwell & Ruiz, 1979; Hawkes & Taylor, 1975; Vasquez, 1984). Cromwell and Ruiz stated that the myth of male dominance is based "almost exclusively on simple descriptions or subjective impressions...and is seldom subjected to the scrutiny of empirical inquiry" (p. 370).

Thus, cultural beliefs may influence family planning decision-making but this has not been consistently verified

by research. It is likely, however, than an understanding of their client's culture is necessary if nurses are to provide appropriate and quality health care. With the continued growth of the Mexican American population, nurses will have increasing opportunities to provide health care including family planning services to this community. It is important for nurses to discuss family planning with those who are responsible for making the decisions regarding family planning be it the man, the woman, or the man and woman together.

Problem Statement

Nurses are in a position to provide family planning services to their Mexican American clients. These opportunities are likely to increase in the future as the Mexican American population continues to grow. Understanding who makes the decisions regarding use of family planning services will allow the nurse to provide more culturally sensitive and effective care.

There is, however, a controversy in the literature with respect to the accuracy of the traditional belief that the husband dominates decision-making. Few studies have looked at decision-making within the context of family planning in the Mexican American culture. In addition, no study about family planning has been conducted on Mexican

Americans who reside in the Northwest. Therefore, the purpose of this study was to explore family planning decision-making within a Mexican American community in Western Oregon.

CHAPTER II

REVIEW OF THE LITERATURE

The following review of the literature focuses on studies that have examined cultural factors relating to family planning decision-making among Mexican Americans. Throughout this study, the term Mexican American is used to denote persons of Mexican origin or descent living in the United States. Included under this term are many who identify themselves as Chicanos, Mexicans, and Mexican Americans. The term Hispanic is used to denote persons of Spanish origin, including persons of Mexican, Puerto Rican, Cuban, Central American, and South American descent.

The discussion begins with a brief demographic description of the Hispanic and Mexican American population in the United States and Oregon. In order to provide a background for family planning decision-making, several explanations for the higher fertility rate of Mexican Americans are presented. Among these explanations, the concept of culture is explored with an emphasis on the cultural interpretation of the higher fertility of Mexican Americans. A brief general discussion of decision-making, including the highlights of family planning decision-making, follows. Next, decision-making within the Mexican American culture is reviewed including traditional and recent thought on the subject. Finally, the available

literature specifically addressing family planning decision-making within the Mexican American culture is presented.

The Hispanic and Mexican American Population in the United States and Oregon

The Hispanic population in the United States is growing rapidly. In 1985, there were 16.9 million Hispanics in the United States representing an increase of about 2.3 million persons (16 percent) over the 1980 census figure of 14.6 million (U.S. Census, 1985). The 16 percent increase in the Hispanic population was significantly larger than the 3.3 percent total U.S. population growth during the same time period. Consequently, Hispanics constituted a larger proportion of the total population in 1985 (7.2 percent) than they did in 1980 (6.4 percent) (U.S. Census, 1985).

According to the U.S. Census Bureau (1985), this sizable increase in the Hispanic population was the result of both high fertility and substantial immigration to the United States. It is interesting to note that the median age of Hispanics was 25.0 years in 1985 as compared to 31.9 years for the non-Hispanic population (U.S. Census, 1985). As the influx of Hispanic immigrants to the United States continues, the pattern is expected to remain the same. One

reason may be that younger rather than older individuals are immigrating (Anthony-Zkach, 1981). As a result of this relative youth, Hispanics are more likely to be of childbearing age and in the midst of childrearing activities.

The 1985 Bureau of the Census delineated five separate categories when referring to the Spanish origin population: Mexican, Puerto Rican, Cuban, Central or South American, and other Spanish origin (U.S. Census, 1985). By far, those of Mexican descent comprise the largest number of Hispanic persons. Approximately 10.3 million persons (61 percent) out of the 16.9 million Hispanics were of Mexican origin in 1985 (U.S. Census). Although one can find literature on each of the Spanish origin populations, most of the Hispanic literature in the United States refers to persons of Mexican descent or origin.

Although two thirds of the nation's Hispanics reside in California, New York, and Texas, there are significant concentrations of Hispanic persons in communities throughout the United States (Rendon, 1985). In 1980, 65,847 Hispanic persons lived in Oregon (2.5 percent of the total population). Of those persons, 45,170 (69 percent) were of Mexican origin or descent (U.S. Census, 1980). In 1980, 16,763 persons of Spanish origin lived in Clackamas, Marion, Polk, and Yamhill counties. Of that population

12,780 (76 percent) were of Mexican origin (U.S. Census, 1980).

The Fertility Rate of the Mexican American Population

As noted in the preceding section, one of the reasons for increasing numbers of Mexican Americans in the United States is the higher fertility rate of Mexican American women as compared to Anglo or Black women. Exter (1985) reported that in 1981 the National Center for Health Statistics analyzed birth registrations in 22 states covering 95 percent of Hispanic births. According to the analysis, the Hispanic fertility rate, or the number of births per 1000 Hispanic women aged 15 to 44 was 50 percent higher than the rate for non-Hispanic women. Although Exter did not specify the Mexican American fertility rate, one can assume that the fertility rate for Mexican Americans was also higher than non-Hispanics as Mexican Americans comprised approximately 60 percent of the Hispanic population in 1980 (Rendon, 1985). In addition, according to the 1985 U.S. Census, the mean family size of Mexican Americans was 4.15 persons as compared to 3.88 persons of all Hispanics, and 3.23 persons in the non-Hispanic population.

Several explanations have been put forth in the literature to account for the higher fertility rate of

Mexican Americans. These explanations have generally focused on religion, socioeconomic class, and culture. A brief review of the religious and socioeconomic interpretations will be presented followed by a more in depth presentation of the cultural explanation.

Religious Influences

The Roman Catholic Church officially prohibits artificial means of birth control and encourages large families (Alvirez, 1973). As most Mexican Americans (85 to 95 percent) claim to be Catholics (Grebler, Moore, & Guzman, 1970), one would expect a higher fertility among Mexican Americans as a result of their relationship to the Catholic Church.

However, Grebler et al. (1970) found in their survey of over 1500 Mexican Americans in Los Angeles and San Antonio that there was less agreement with the teachings of the church on birth control than was reported for a national sample of Catholic women. Among women in the Grebler et al. study, 73 percent felt the Church should change its position and over 80 percent had used non-approved methods of contraception. Although many couples were using birth control methods not approved by the Church (e.g. oral contraceptives), they were still having large families (Grebler et al.). It is not clear whether the

fact that this was an urban sample was related to the findings.

The findings by Grebler et al. (1970) have been supported by a survey of low income Mexican and Mexican American couples at a community health center in Detroit (Esparza, 1977), by ethnographic work in a Mexican American community in South Texas (Hotvedt, 1976), by a random survey of lower income Mexican American women in Tucson (O'Grady, 1973), and by the findings of Urdaneta (1977) with indigent family planning clinic clients in Austin, Texas. In each of these studies some Mexican American couples were practicing birth control while others were not. However, religion did not appear to be a major factor in their decision-making process.

Socioeconomic Influences

A second explanation for the higher fertility rate of Mexican Americans is based upon their generally lower socioeconomic status. Researchers have used census and survey data to study the structural variables of education, income, and occupation and their relationship to fertility of Mexican Americans. These researchers stated that lack of education and low income among Mexican Americans directly correlated with higher fertility (Uhlenberg, 1973; Bean & Wood, 1974) while labor force participation by women

has resulted in decreased fertility rates (Johnson, 1976).

In contrast to the preceding studies of education and income, however, Roberts and Lee (1974) concluded that the fertility pattern of Spanish-surnamed women in five southwestern states persisted even after controlling for socioeconomic status. They reanalyzed the 1970 census data using more precise definitions of ethnic minority membership and stated that there was an independent effect of ethnicity on fertility.

Cultural Influences

The third explanation for higher Mexican American fertility is related to the cultural value placed on having children. Before discussing this specific cultural value, it is important to have a general understanding of the concept of culture.

Use of the term "culture" was adopted by nineteenth century anthropologists and has spread to many other disciplines (Keesing, 1976). Aamodt (1978) noted that the concept of culture is controversial and that the definition of culture varies widely throughout the literature.

One of the oldest, and now classic definitions was developed by Tylor in 1871: "Culture is that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a

member of society" (Keesing, 1976, p.138).

Culture may also be defined as what one needs to know in order to behave appropriately in a given society (Goodenough, 1957). Kay (1978) believed that culture "encompasses the characteristic way in which experience is categorized, coded, and refined into the knowledge that is used to compose standards for behavior" (p. 96). In these definitions, culture is viewed as a cognitive system.

Culture may also be seen as an adaptive, dynamic system. According to Keesing (1974), cultures can be viewed as systems of socially transmitted behavior patterns that serve to relate human communities to their ecological settings; as systems of change and feedback mechanisms; and as systems of social organizations and ideation that may act as mediators for societal adaptation. All definitions imply that culture has a great impact on individual behavior. Furthermore, though the culture of any group is subject to change, certain ideological components tend to persist.

Bach-y-Rita (1982) stated that "contrary to the American 'melting pot' ideals, the Mexican American culture and mores have remained with the (Mexican American) family over many generations" (p.30). He further noted that most families maintain current contacts with Mexico and identify with its culture. The close proximity of Mexico and the

continuous influx of Mexican immigrants to the United States helps to reinforce and sustain the language, customs, and values of those living in the United States.

The Mexican American culture is heterogeneous, however, (Bach-y-Rita, 1982) making it difficult to generalize about certain aspects of the culture such as the family. As Murillo (1976) noted, Mexican American families differ significantly from one another in a variety of respects including regional, historical, political, socioeconomic, acculturation, and assimilation factors. Some families are of Spanish heritage while others trace their ancestry to Mayan, Zapotec, Toltec, or Aztec Indian. Most families, however, are a mixture of Spanish and Indian heritage (Murillo).

Within Mexican American culture, the family is likely to be the single most important social institution in life. Within the context of family, there is a high value placed on having children (Bean & Bradshaw, 1977; Clark, 1970; Grebler et al., 1970; Marín, Marín, & Padilla, 1981; Metress, 1982; Monrroy, 1983; Sabagh, 1980). Indeed, the bearing of children is seen as the most important function of a woman (Grebler et al.). Motherhood is considered to be the fulfillment of womanhood and is respected in a way that is unequaled by that accorded to any other role, male or female (Metress). Clark noted that childbearing is both

a privilege and an obligation of married women.

After interviewing more than 1000 Mexican American women in Tucson, Arizona as a part of five different research studies, Kay (1978) found that women felt it was unnecessary to have as many children as possible. Most women interviewed, however, felt it was necessary to have at least one child in order to really be fulfilled as a person.

The desire for children also has been explained by the cultural belief of "machismo" or maleness. Several social scientists have described one aspect of machismo as "the need for men to prove their virility through the domination and impregnation of women" (Canino, 1982, p. 117). Indeed, Díaz-Guerrero (1975) concluded from his ethnographic studies in Mexico that virility was measured primarily by sexual potency and only secondarily by physical strength, courage, or audacity. He further stated that other behavioral characteristics were also dependent upon the man's sexual capacity.

During the early 1960's, Madsen (1964) conducted ethnographic field work in a Mexican American community in Southeastern Texas. He concluded that the typical Mexican American male took his sex life seriously and believed that virility was better proven by direct action than by words alone.

Grebler et al. (1970) stated that attitudes towards birth control are intimately associated with machismo in traditional Mexican American culture. A pilot study conducted by Grebler et al. in the mid 1960's indicated that among traditional lower class Mexican Americans in a small California community, it was more often the husband than the wife who objected to the use of contraceptive measures. They noted that some men would even go to the extreme of hiding or taking away their wives' oral contraceptives.

Marín et al. (1981) interviewed a random sample of 100 Hispanic women waiting to receive birth control services at a clinic in East Los Angeles. They interviewed women to learn more about attitudes towards family size and contraceptive use among barrio Hispanics. The subjects were young, poorly educated, low socioeconomic status, mostly of Mexican origin, and the majority were recent immigrants. In response to the question of why they felt men had many children, the majority responded that it was the men's perceptions of machismo. In addition, the results showed that the best predictor of a woman's desired family size was her perception of her spouse's desired family size. This indicated to the researchers that men have a powerful influence. As a result, Marin et al. suggested that health care providers should more actively involve men in family

planning.

Other researchers, however, disagree that the higher fertility rate among Mexican American women is the result of machismo. Kay (1978), in her interviews with more than 1000 Mexican American women from Tucson, reported their evaluation of the machismo virility concept in one word, "absurd" (p.105). In addition, Kay noted that the women stated that "sometimes your husband even takes care of you" which meant that he practiced coitus interruptus.

Research in the areas of religion, socioeconomic status, and culture have not been able to completely account for the higher fertility rate of Mexican Americans. Mirande (1977), Montiel (1970), and Murillo (1976) stated that there is a paucity of data on the Mexican American family. Instead, generalizations have been most often based upon ethnographic studies that focused on relatively small, homogeneous samples and meager empirical evidence.

The focus of this study was on family planning decision-making within a cultural context. The next section focuses on decision-making and specifically family planning decision-making, decision-making within the Mexican American culture, and ends with a discussion of family planning decision-making in the Mexican American culture.

Decision-Making

Numerous decision theories have developed from a variety of fields including economics, mathematics, philosophy, sociology, and psychology (Fishburn, 1964). Most of the theories are based on the notion of the subjective value, or utility of the alternatives among which the decider must choose. All these theories assume to some degree that people behave rationally; their decisions are made to maximize expected utility (Edwards, 1967).

Brim, Glass, Lavin, and Goodman (1962) stated that the decision-making process consists of six phases usually linked in a sequence: (1) identification of the problem; (2) obtaining necessary information; (3) production of possible solutions; (4) evaluation of such solutions; (5) selection of a strategy for performance; and (6) actual performance of an action or actions, and subsequent learning and revision. They noted that most of the components of their formulation have appeared in decision analyses and descriptions of problem solving for many years. Brim et al. further stated that every decision need not involve all of the phases of the sequence.

The decision-making theories discussed above were predominantly developed in the context of North American and Western European societies. Their application to

Mexican Americans is uncertain.

Family Planning Decision-Making

Beckman (1982) agreed with Brim et al. (1962) that family planning decision-making, like all decision-making, must be understood as a process. However, Beckman stated that the exact nature of this sequential process remains a controversy. He noted that family planning decision-making may follow several types of patterns and may involve either a long or short term time frame.

Family planning decision-making is subject to various influences at different times (Hass, 1974). The preconception period may encompass a day, a few months, or many years. Attitudes may change at various points within this period and decisions relating to fertility goals and contraceptive usage also may change (Hass). In the postnatal period, attitudes toward childbearing can change through time with influences such as the stage of the child's development and the parents' lifecycle stage (Hass). Similarly, decisions must also be made after conception as to whether or not to continue the pregnancy.

The attention people give to family planning decision-making also varies. As Beckman (1982) noted, some couples become parents without making any conscious decisions while others purposefully plan each birth. Decision-making may

involve only general discussion and agreement or a definite verbal committment and plan of action. In his review of the literature, though, Beckman (1982) noted that different family planning decision-making styles have not been adequately studied.

Decision-Making in the Mexican American Culture

As noted previously, machismo has been associated not only with virility, strength, courage, and audacity, but also dominance in decision-making within the family (Canino, 1982; Clark, 1970; Díaz-Guerrero, 1975; Jones, 1948; Madsen, 1964; Rubel, 1966). Alvirez, Bean, & Williams (1981) summarized the concept as male dominance and superiority. The father is seen as the absolute head of the family with full authority over his wife and children. All major decisions are his responsibility.

Staton (1972) surveyed available literature to ascertain some of the major features of the Mexican family that have been retained by the Mexican American family in the United States. He stated that three of the most obvious features retained by the Mexican American family are "masculine superiority, male dominance, and emphasis on submission and obedience to the father" (p. 326). In their review of the literature, Padilla and Ruiz (1973) concurred with Staton while emphasizing that these conclusions were

based on small ethnographic samples and not grounded in empirical research.

In the now classic Five Families, Oscar Lewis (1949) wrote of Mexican households that the husband is "an authoritarian, patriarchal figure who is head and master of the household...It is the husband who is expected to make all important decisions and plans for the entire family" (p.602). However, Lewis noted that there was considerable discrepancy between the ideal pattern and reality. He concluded that there were actually few homes in which the husband truly controlled his family and most marriages showed some conflict over the question of authority.

There is disagreement in the literature as to the accuracy of male dominance in decision-making within the Mexican American culture. As noted in the preceding paragraph, Lewis (1949) in some of the earliest descriptive literature of this nature, noted a discrepancy in male dominant decision-making. There are four separate, cross-national empirical studies on conjugal decision-making that call the machismo concept into question.

The Mexican Institute of Social Studies conducted a large scale study of family life from 1966 to 1968 (de Lenero, 1969). Questionnaires were administered to a representative sample of 2705 couples residing in 15 different rural and urban communities in Mexico. A portion

of the questionnaire involved responding to ten items on conjugal decision-making. The purpose was to determine how marital dyads made decisions in common life situations. Subjects provided one of five responses with respect to who made the decisions: wife, husband, joint, others, and no response. As a whole, neither wives nor husbands reported husbands as dominant across all decision-making situations.

Cromwell, Corrales, and Torsiello (1973) collected data during 1970-1971 from 119 couples in the Minneapolis-St. Paul area and 266 couples in five Mexican communities ranging from villages to an industrialized city. Conjugal decision-making was measured by asking wives and husbands in each of eight situations "Who should make the final decision?" The three responses were: wife more than husband, wife and husband about the same, and husband more than wife. Data on the Mexican couples resulted in "joint" choices more frequently than husband in six of eight decision situations. The remaining two decision-making areas were husband dominated.

Hawkes and Taylor (1975) studied familial power structure among residents of 12 state owned and operated camps for migrant workers in California. Respondents were selected randomly and included 76 women of Mexican or Mexican American origin between 19 and 65 years of age. There were six questions on decision-making and three

questions on action taking. Those that related to fertility are discussed in the next section. Response categories were husband, wife, and joint. Results indicated that egalitarianism was by far the most common mode in both decision-making and action taking.

Finally, Cromwell and Cromwell (1978) studied 44 Anglo, 44 Black, and 49 Mexican American couples in Kansas City, Missouri. The research design incorporated a stratified sample of parents with at least one child enrolled in a neighborhood elementary school. There were six decision-making items and six response categories: husband always, husband more than wife, husband half the time, husband and wife together, wife more than husband, and wife only. They concluded that "egalitarianism is the norm within these working-class marriages regardless of ethnic group membership" (p. 757).

In conclusion, these four studies on both Mexican and Mexican American subjects failed to support the concept of machismo in marital decision-making. The studies suggested that while the husband made the most unilateral decisions and wives made the fewest, joint decisions were the most common. As Hawkes and Taylor (1975) noted, the findings suggest that dominance-submission patterns are less universal than previously assumed. Either they never existed or they are undergoing radical change.

Family Planning Decision-Making in the Mexican American Culture

There have been few studies which have specifically looked at family planning decision-making within the Mexican American culture. The majority of the research that has been completed, however, supports egalitarian decision-making regarding family planning rather than male decision-making (Esparza, 1977; Grebler et al., 1970; Hawkes & Taylor, 1975; Kay, 1978; Marin et al., 1981; Otero, 1968).

As previously mentioned in this review of literature, Grebler et al. (1970) and Marín et al. (1981) found that men had a powerful influence on family planning decision-making. Grebler et al. stated that husbands, more than wives, objected to the use of contraceptive measures. The results of the Marín et al. study showed that the best predictor of a woman's desired family size was her perception of her spouse's desired family size. In both of these studies, interviews were conducted with persons of lower socioeconomic status from California. The Grebler et al. study was conducted in a small community while Marín et al. interviewed persons in East Los Angeles.

Other studies showed egalitarian decision-making (Esparza, 1977; Kay, 1978; Hawkes & Taylor, 1975). Esparza (1977) investigated fertility behavior among 120 low income

couples in Detroit with 30 couples from each of the following groups: Mexican Catholics, Mexican American Catholics, Anglo Catholics and Anglo Protestants. Among the survey interview data, Esparza found that Mexican Catholic women indicated that contraceptive use was the result of a shared decision-making process between themselves and their husbands. This was noted in spite of Esparza's findings that husbands were making many of the important family decisions. Esparza further noted that 68 percent of the Mexican American Catholic couples used a joint decision-making process. Also, 23 percent of these Mexican American Catholic women were making birth control decisions by themselves.

After interviewing more than 1000 women in five separate studies in the Tucson area, Kay (1978) concluded that the typically stereotyped sex roles were not supported by her data. She reported that men spoke of equality within marriage and more than half believed that their wives should share the responsibilities of family planning.

Two of the questions which Hawkes and Taylor (1975) asked their 76 subjects were "Who mainly decides on the desired number of children?" and "Who mainly acts to limit family size?" In answering the first question, 78 percent of these migrant farm labor women stated that the decision was made jointly, the husband made the decision 14 percent

of the time, and the wives made the decision in 8 percent of the families. In responding to the second question the results were very similar. The action was taken jointly in 75 percent of the families. Husbands acted unilaterally 12 percent of the time and wives acted to limit family size in 13 percent of the families.

The studies reviewed above were all conducted on persons of lower socioeconomic status. The following study by Otero (1968) was conducted on 2500 couples from varying socioeconomic classes including leaders in the social, political, and religious fields. In addition, both urban and rural subjects were asked to participate. Findings were gathered from an exploratory survey of family planning attitudes and opinions conducted by the Mexican Institute of Social Studies from 1966 to 1968. One of the questions asked subjects who made the decision whether to have or not to have children. Only 20 percent of the women said this decision was made by men, 58 percent stated the decision was made together, and 7 percent of the women said they made the decision alone (Otero).

Summary of the Review of Literature

The Mexican American population is growing rapidly. In part, the increasing numbers are due to the higher fertility rate of Mexican American women as compared to

Anglo or Black women. Most often, the higher fertility of Mexican American women has been explained by religious, socioeconomic, and cultural factors. However, disparate conclusions have been reached and research in these areas has not been able to completely account for this higher fertility rate. Several researchers have noted that generalizations were often based on ethnographic studies that focussed on relatively small, homogeneous samples and little empirical evidence.

Decision-making theories have described people as behaving rationally to maximize their expected utility. These theories were predominantly developed in North American and Western European societies. Decision-making within the Mexican American culture traditionally has been described by the cultural belief of machismo which implies that the male head of household dominates decision-making. Most often, this description has been based on small, ethnographic samples. Results from four empirical studies, though, have shown that an egalitarian power structure exists more often in Mexican American families than one dominated by machismo.

There also appears to be a discrepancy in the literature as to who makes the family planning decisions among couples in the Mexican American culture. Although most of the literature supports joint decision-making in the

majority of couples, a few studies have shown that men, alone, are highly influential. Unilateral decisions by women are evident as well, but they are fewer in number.

Conceptual Framework

In order to understand beliefs, one must have insight into the culture from which beliefs derive. This conceptual framework focuses on beliefs of Mexican Americans regarding their decision-making about family planning. The major concepts in the framework are culture and beliefs.

Culture is a system of learned behavior patterns characteristic of the members of any given society. It includes customs, language, artifacts, and shared systems of beliefs which are learned and transmitted from generation to generation (Kohls, 1979).

Beliefs are derived from culture. They are opinions or convictions that are developed historically and socially transmitted. A belief denotes confidence in the truth of something not immediately susceptible to rigorous proof (Stein & Urdang, 1983).

One aspect of Mexican American culture that may influence decision-making is the belief of machismo. Machismo refers to maleness or a traditional patriarchy (Murillo, 1976). Several authors have noted that masculinity is said to be demonstrated not only by the man's

sexuality but by domination over the affairs of his family and especially his wife.

In summary, people of the same culture tend to share certain similar beliefs. The value of family and bearing children is central to Mexican American culture. Machismo is one traditional belief that emphasizes male domination over the family including control over fertility. In a review of the literature regarding family planning decision-making, however, there was disagreement as to whether or not the belief of machismo ever even existed. Therefore, this study further explored the belief of machismo as it relates to family planning decision-making in the Mexican American culture.

Research Questions

The specific research questions addressed in this study were:

1. Who makes the decision regarding the ideal number of children in Mexican American families?

2. Who decides whether or not birth control will be used to achieve the desired number of children?

3. Who decides which method of birth control will be used to achieve the desired number of children?

CHAPTER III

METHODS

This chapter begins with a description of the study design, the setting, and the sample. The instrument used for data collection is described followed by procedures for data collection. Finally, a brief discussion of the data analysis is presented.

Design

A nonexperimental descriptive research design was used to study family planning decision-making in the Mexican American culture. Few studies have been conducted in this area. Therefore, a descriptive design was appropriate as descriptive information about the phenomenon is needed. Descriptive data regarding family planning decision-making was collected with a questionnaire developed by the researcher given to Mexican American women requesting gynecological health care services.

Setting

The setting for this study was a migrant health clinic. This clinic is located in a small, rural community (population 11,700 in 1985) 35 miles south of Portland, Oregon. The clinic is a private non-profit organization that provides outpatient primary health care services to migrant, seasonal, and low income families in Clackamas, Marion, Polk, and Yamhill counties. Funding is provided by

Public Health Service and Migrant Health Service grants. Services provided at the clinic include primary medical and dental care, nurse-midwifery services, nutrition counseling, mental health counseling, laboratory, pharmacy, radiology, transportation, and outreach services. There are approximately 45 full time health care providers working at this clinic, as well as several specialist consultants. During 1985, a total of 23,509 patient encounters were generated by clinic services.

Obstetrical and gynecological care in the clinic is provided primarily by the nurse-midwifery service. The nurse-midwifery service provides gynecological, antepartum, intrapartum, postpartum, and newborn care for low risk patients. Pregnant women are scheduled with the nurse-midwives once their pregnancy has been confirmed. Many will choose to see the nurse-midwives for gynecological services following their pregnancy and postpartum.

In addition to the nurse-midwives, a family nurse practitioner also provides gynecological services in the family practice portion of the clinic. Women who have not been scheduled with the nurse-midwifery service will see the family nurse practitioner. The nurse-midwives and family nurse practitioner both provide family planning services as part of their gynecological care. Patients with complications are followed by the clinic's physicians

or referred to a tertiary care facility in Portland.

Sample

More than one-half of the women who receive obstetrical and gynecological services from the clinic are Mexican Americans. Most of these women are migrant or seasonal farmworkers. A convenience sample of 30 Mexican American women presenting to the clinic for six week postpartum examinations and/or gynecological services, including family planning services, were inducted into the study. Criteria for selection included the following: (a) registered clinic patient; (b) clinic chart gave status as married (The chart does not differentiate between civil marriage and common-law marriage of which the latter is most prevalent in this population); (c) between the ages of 18 and 50; (d) subject's birth or birth of one or both parents in Mexico; (e) partner's birth or birth of one or both parents in Mexico; (f) subject and subject's partner are of Mexican American ethnic descent.

Instrument

Data regarding family planning decision-making was collected with an investigator-developed questionnaire. The questionnaire was written in English (Appendix A) and translated into colloquial Spanish (Appendix B) in order to accommodate the language preference of the subject. The questionnaire asked women who were either currently using

birth control, desiring birth control, or had used birth control in the past, who in their marital dyad makes the decision regarding ideal number of children and use and type of birth control. As this questionnaire was developed specifically for the present study, no data exist regarding reliability nor validity of the tool. Reliability and validity of the measure are not essential as the data are simply descriptive of the sample rather than inferential.

Both the Spanish and English versions of the instrument were reviewed by four bilingual nurses in the clinical setting prior to the full scale study in order to determine clarity, adequacy, completeness, sequence of questions, and unforseen problems. Their judgments were obtained on a rating form (Appendix C).

Procedure for Data Collection

Services in the clinic are scheduled Monday through Friday. The researcher was on site each day until the sample was recruited. Every consecutive patient who met the selection criteria and who was seeking gynecological or postpartum care from the clinic was asked to participate. Only one patient declined to participate and she did not state her reason. Subjects were approached while they waited for their clinic appointments (the usual waiting time was 15 to 45 minutes). Therefore, participation did not delay their appointment.

A consent form (Appendix D), approved by the Committee on Human Research, was read to each potential subject in either Spanish or English depending on the language preference of the subject. The consent form explained the purpose of the study and insured anonymity and confidentiality. Once the consent form was signed, the researcher brought the subject into a small private office to conduct the interview.

The interview was conducted orally so that reading ability did not affect the responses. The questions were read by the interviewer in either Spanish or English depending on the language preference of the subject. First, demographic information (Appendix E) was elicited from the subject regarding age; years of education; birthplace of subject, subject's parents, husband, and husband's parents; length of time in the United States; language preference; employment outside of the home; and number of pregnancies. Income was determined indirectly by the clinic payment classification schedule and was obtained from the subject's chart. Next, the family planning decision-making questionnaire was administered. Any comments or questions by the subjects were also noted by the researcher. The responses were reviewed for completeness and numbered for identification purposes.

Analysis of Data

Analysis of the data was aimed at describing the sample and identifying who made the decisions regarding family planning in the sample. Data were entered into the computer using the Personal Filing System (PFS) and analyzed using the Statistical Package for the Social Sciences (SPSS). Descriptive statistics were applied to the demographic data and the family planning decision-making questionnaire.

CHAPTER IV

RESULTS

Results from this study are presented in two parts. First, the demographic characteristics of the sample are described. Second, findings from the family planning decision-making questionnaire are presented.

Characteristics of the Sample

This study surveyed 30 Mexican American women. Seven of the women were patients presenting to the nurse-midwifery service for postpartum care and 23 women were requesting gynecological services from the Family Nurse Practitioner. Although one woman was born in the USA, the remaining 29 women were born in Mexico. One Mexican born woman stated that her mother was born in the USA while a second Mexican born woman stated that her father was born in the USA. All of the women stated that their husbands and husbands' parents were born in Mexico.

The ages of the women were fairly diverse, ranging from 19 to 46 years of age with a mean age of 28.1. The educational level of the women also varied greatly ranging from no formal education to three years of college. The mean educational level was 6.1 years, which is similar to the mean educational level (5.6 years) of the Mexican American clinic population in general. In the sample, 22 of the women (73.3%) had 6 years or less of formal educa-

tion and only four women (13.3%) completed high school.

One woman had lived in the USA for less than one year. Half of the women (n=15) had lived in the USA between one and five years, approximately one fourth (n=8) between six and ten years, and 20% (n=6) had lived in the USA for more than ten years. Interestingly, the majority (n=25, 83%) of the women spoke only Spanish. Four of the women (13%) spoke Spanish and English, and only one woman preferred to speak English. Not surprisingly, this woman was born in the USA.

In response to the question of whether or not the women worked outside of their homes, the sample was fairly evenly divided. Fourteen of the women (47%) were employed while 16 (53%) were not employed.

The income level of the sample can be determined indirectly by the clinic payment classification scale seen in Table 1. In the clinic, payment is determined by total annual household income and number of persons in the family. Those persons that fall into the 0% pay category are expected to pay a flat fee of $10.00 per clinic visit. Nine of the women (30%) had a household income and family size which placed them in the 0% pay category. The majority of women (n=19, 63%) paid 25% of the clinic fee. Only two women (7%) had family incomes which required full payment.

Table 1

Percent of Clinic Payment Based on Family Size and Annual Income

Family Size	Percent of Full Payment				
	0%	25%	50%	75%	100%
1	0-5,360	5,361-7,182	7,183-8,898	8,899-10,719	over 10,720
2	0-7,240	7,241-9,702	9,703-12,018	12,019-14,479	over 14,480
3	0-9,120	9,121-12,221	12,222-15,139	15,140-18,239	over 18,240
4	0-11,000	11,001-14,740	14,741-18,260	18,261-21,999	over 22,000
5	0-12,880	12,881-17,259	17,260-21,381	21,382-25,759	over 25,760
6	0-14,760	14,761-19,778	19,779-24,502	24,503-29,519	over 29,520
7	0-16,640	16,641-22,298	22,299-27,622	27,623-33,279	over 33,280
8	0-18,520	18,521-24,817	24,818-30,743	30,744-37,039	over 37,040
9	0-20,400	20,401-27,336	27,337-33,864	33,865-40,799	over 40,800
10	0-22,280	22,281-29,855	29,856-36,985	39,986-44,559	over 44,560
11	0-24,160	24,161-32,374	32,375-40,106	40,107-48,319	over 48,320

The number of pregnancies experienced by these women ranged from 1 to 10. Twenty-one women (63%) had been pregnant three or more times. The number of living children per subject ranged from one to eight with a mean of 3.0.

Figures 1 and 2 portray subjects' responses to the question regarding desired number of children. Eleven women (36.7%) desired three children while ten women (33.3%) wanted four children. Therefore, 70% of the women desired three or four children. Four women (13%) wanted five to eight children, while three women (10%) desired two children. Two women were not sure how many children they would like to have. Eight women (26.7%) felt that their husbands would like to have three children while nine women (30.3%) stated that their husbands desired four children. Therefore, 57% of the women felt that their husbands desired three or four children Eight women (27%) stated that their husbands wanted five to eight children. Three women (10%) felt that their husbands wanted one or two children. Two women were not sure how many children their husbands desired. Complete demographic characteristics of the sample are portrayed in Table 2.

Family Planning Decision-Making Questionnaire

The first research question posed was: "Who makes the decision regarding the ideal number of children in Mexican

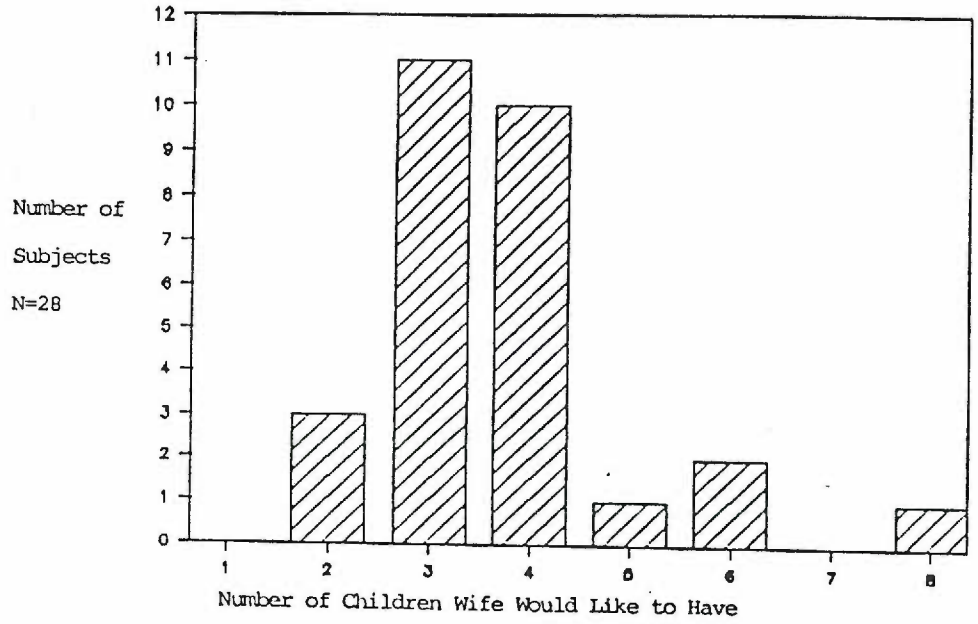

Figure 1. Wives' Ideal Number of Children

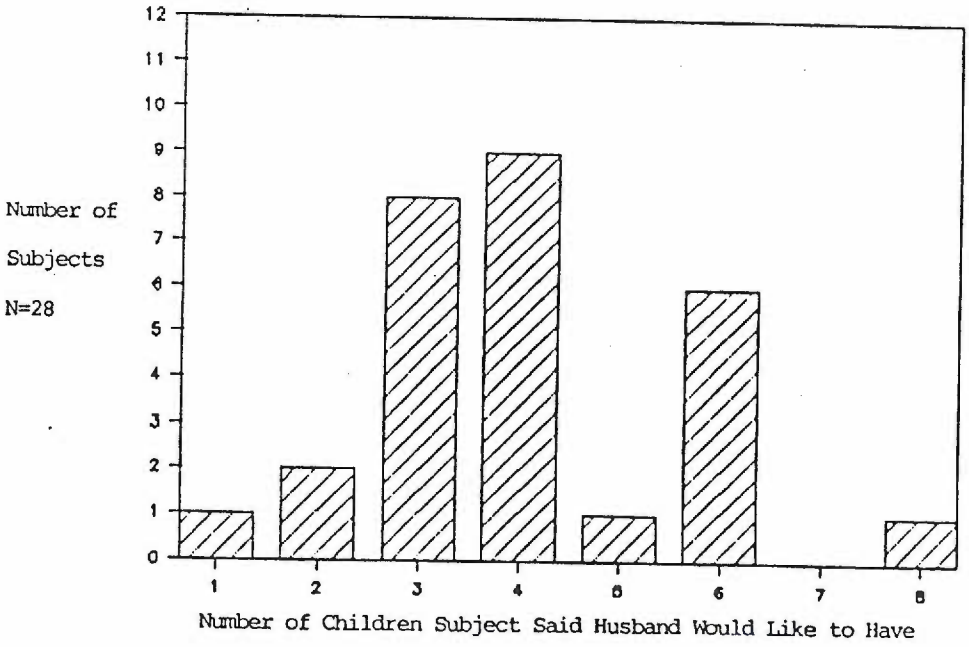

Figure 2. Husbands' Ideal Number of Children

Table 2

Demographic Data of Sample Women (N=30)

Characteristic	Frequency	Percent
Age (years)		
Mean 28.1		
Range 19-46		
Education (years)		
Mean 6.1		
Mode 6.0		
Range 0-15		
Gravida		
Mean 3.6		
Mode 3.0		
Range 1-10		
Living Children		
Mean 3.0		
Mode 3.0		
Range 1-8		
Time in USA		
Less than 1 year	1	3.3
1 - 5 years	15	50.0
6 - 10 years	8	26.7
Greater than 10 years	6	20.0
Language Preference		
English	1	3.3
Spanish	25	83.3
English & Spanish	4	13.3
Employed		
Yes	14	46.7
No	16	53.3
Clinic Payment		
0%	9	30.0
25%	19	63.3
100%	2	6.7

American families?" Data relative to this question are portrayed in Table 3. Twenty-three women (76.7%) stated that this decision was made jointly with their husbands. Three women (10%) reported that they made the decision unilaterally while two women (6.7%) stated that their husbands made the decision. One woman stated that the opinions of her family and of her husband's family would be considered along with her and her husband's decision. Finally, one woman stated that her doctor made the decision regarding ideal number of children for her family. In this particular case, the doctor had stated that the woman's health would be severely compromised if she had any more children.

Table 3

Who Decides Ideal Number of Children (N=30)

Person(s)	Frequency	Percent
Husband	2	6.7
Wife	3	10.0
Both	23	76.7
Others	2	6.6

Twenty-one women (70%) were currently using birth control. Of the nine women (30%) who were not, seven were postpartum and desiring birth control. The remaining two women were requesting gynecological services and were attempting to conceive.

Those who were currently using birth control (n=21) were asked the second research question: "Who decides whether or not birth control will be used to achieve the desired number of children?" (see Table 4). Virtually all

Table 4

Who Decides Use and Method of Birth Control (n=21)

Item	Wife		Husband		Joint		Others	
	n	%	n	%	n	%	n	%
Who Decided:								
Birth Control Should Be Used	3	14.3	0	0.0	18	85.7	0	0.0
Method of Birth Control	9	42.9	1	4.8	6	28.6	5	23.7

of the respondents (n=18, 85.7%) replied that this decision was made by both husband and wife. The other three women (14.3%) stated that they made the decision alone. However when asked the third research question, "who decides which method of birth control should be used", a joint decision

was made by only 28.6% of the sample (n=6). Forty-three percent of the women (n=9) chose their method of birth control while only one woman stated that her husband made the decision. Twenty-four percent of the women (n=5) stated that "others" decided which method of birth control should be used. This category included doctors, midwives, nurse practitioners, relatives, and friends.

Figure 3 illustrates the various methods of birth control women and their husbands were using. Eleven women (52.4%) were taking oral contraceptives. Six women (28.6%) indicated that they and their husbands were either using condoms alone or in conjunction with contraceptive foam or oral contraceptives. Four women (13.3%) had a tubal ligation. Finally, one woman reported using an IUD.

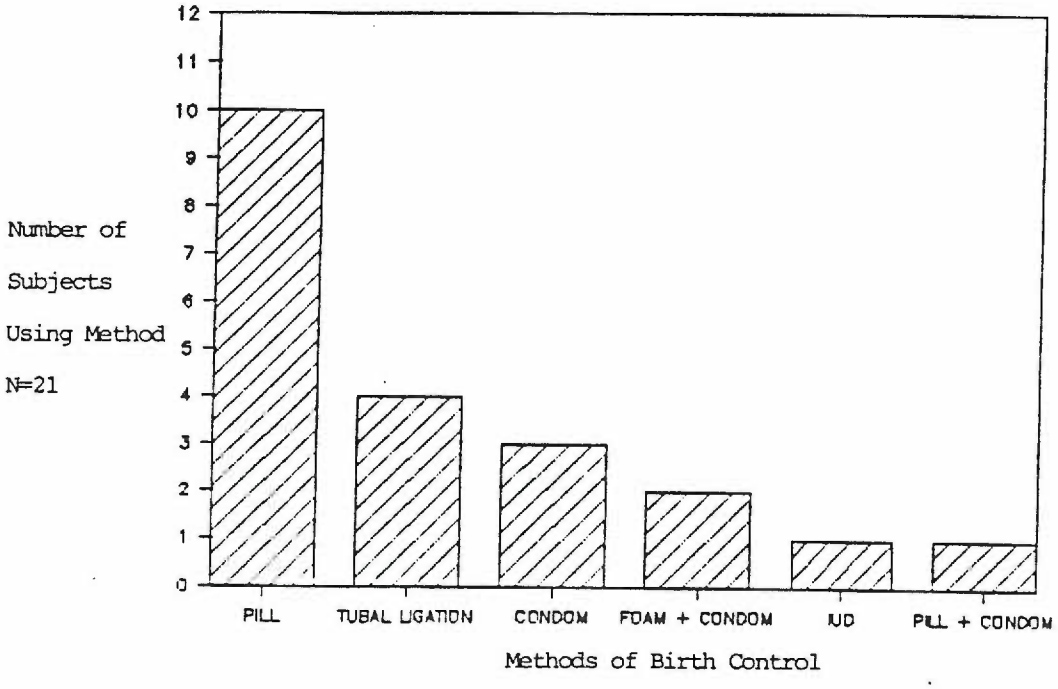

Figure 3. Types of Birth Control Currently Being Used

Of those women desiring birth control (n=7), again the research question was asked: "Who decides whether or not birth control will be used to achieve the desired number of children?" These data are portrayed in Table 5. Almost unanimously (n=6, 85.7%), the women stated that this decision was made jointly. One woman stated that she made the decision alone. Decision making regarding method of birth control was divided. Four women (57.1%) stated they made the decision unilaterally while three women (42.9%) stated the decision was made jointly.

Table 5

Who Decides Use and Method If Birth Control is Desired (n=7)

Item	Wife		Husband		Joint		Others	
	n	%	n	%	n	%	n	%
Who Decides:								
Birth Control Will Be Used	1	14.3	0	0.0	6	85.7	0	0.0
Method of Birth Control	4	57.1	0	0.0	3	42.9	0	0.0

Figure 4 illustrates the methods of birth control these seven women and their husbands desired. Methods were split evenly between oral contraceptives, the IUD, and not

knowing which method they desired. One woman stated that she and her husband planned to use contraceptive foam and condoms.

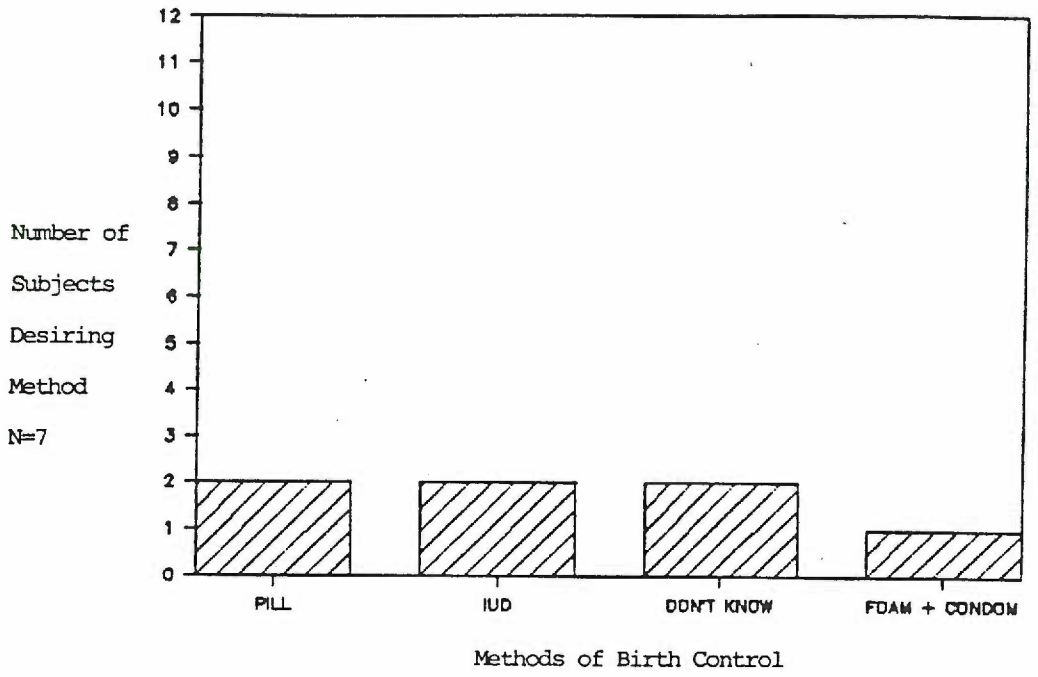

Figure 4. Types of Birth Control Desired by Women Currently Not Using Birth Control

Finally, the two women in the sample not using nor desiring birth control in order to conceive stated that this decision was made jointly with their husbands. Prior to this time, both women stated that they had been taking oral contraceptives. This prior decision about birth control method had been made by the woman alone in one case and jointly with her husband in the other.

Summary of Results

In general, the subjects were in their late twenties, had little formal education, and had limited financial resources. They were of Mexican heritage, spoke Spanish, and had lived in the USA for several years. The women and their husbands desired three or four children and most often made that decision jointly. The decision to use birth control to achieve the desired number of children was, again, most often a joint decision. Of those women currently using birth control, decision-making regarding selection of method was made 43% of the time by wives, by husbands and wives together in 29% of the cases, 24% by others, and 3% by husbands. Of those women desiring birth control, but not currently using a method, 57% of the women decided alone which method they wanted to use and 42% decided jointly with their husbands. Two women in the sample were actively attempting to conceive.

CHAPTER V

DISCUSSION

The interpretation of the findings of the study, limitations of the study, implications for nursing practice, and suggestions for further research are presented in this chapter. The chapter concludes with a summary of the study.

Interpretation of the Findings

The mean educational level of the sample was 6.1 years. There are several factors which may account for this relatively low level of educational attainment. First, it may be difficult to obtain a formal education when one is continually migrating to a new location in search of work. Further, 80% or more of the women spent their school-age years in Mexico. Although Mexican law during the 1950's and 1960's required children to complete primary school, there was a great shortage of classrooms and teachers (Johnson, 1964). In the rural areas, there were even fewer schools and many did not offer an education beyond the fourth grade (Ewing, 1961). Johnson noted that it was also common practice to take children out of school and put them to work in times of economic hardship. Finally, the Mexican Minister of Education reported that 983 out of each 1000 children who entered primary school withdrew before reaching the sixth grade in 1963 (Ewing).

The economic characteristics of this sample are similar to what one may have expected from a fairly rural, poor migrant Mexican American population. Wages are generally low for field and nursery work (the primary occupation of these women and/or their husbands), ranging from $4000 to $6000 per year. Therefore, women and their families qualified for clinic services at a reduced rate.

As noted in the review of the literature, the mean Mexican American family size in 1985 was 4.15 persons as compared to 3.23 persons in the non-Hispanic population (Bureau of the Census, 1985). The sample in this study exemplified this higher fertility rate among Mexican Americans. Two thirds of the subjects had three or more living children and 83% of the women desired three or more children. Similarly, 84% of the women felt that their husbands wanted three or more children. In this sample and as reported in the literature, there seems to be a high value placed on having children.

Interestingly, 27% of the women stated that their husbands desired five to eight children as compared to only 13% of the women who desired that many children. One can only speculate as to the reasons why husbands desired more children than their wives. However, such a desire is consistent with the virility aspect of machismo described in the literature by Canino (1982), Diaz-Guerrero (1975),

and Madsen (1964).

Three research questions were explored in this study. The first question asked: "Who makes the decision regarding ideal number of children in your family?" Seventy-seven percent of the women stated that this decision was made jointly. A similar question was asked by Hawkes and Taylor (1975). In their study, 78% of the 76 migrant Mexican American women also stated that this decision was made jointly.

Unilateral decisions were slightly different between the two studies. In the present study, 10% of the wives and 7% of the husbands made the decision alone as compared to 8% of the wives and 14% of the husbands in the study by Hawkes and Taylor. The "others" category accounted for approximately seven percent of the responses in the present study. Although twice as many husbands made unilateral decisions in the study by Hawkes and Taylor than in this study, decision making regarding ideal number of children was predominantly made jointly in both studies.

The Hawkes and Taylor study was conducted 12 years ago. Comparisons with the present study should consider whether attitudes regarding decision-making may have been influenced during the intervening period due to societal changes (e.g. the womens' movement, the pervasiveness of electronic media, increasing ease of mobility, etc.).

These societal changes may have accounted for the fewer number of unilateral decisions regarding family size in the present study.

The results of a 1981 study by Marín et al. appear to be contrary to the Hawkes and Taylor (1975) study and the present study. Marín et al. reported that the best predictor of a woman's desired family size was her perception of her spouse's desired family size. Marín et al. further stated that men appeared to have a powerful influence on the number of children a couple chose to have. Unfortunately, the Marín et al. study did not state which questions were asked, so it is difficult to determine the extent to which the man dominated the decision-making process regarding ideal number of children.

The second research question asked those women currently using birth control and those desiring birth control, "Who decides whether or not birth control will be used to achieve the desired number of children?" In both of these groups, joint decision-making again prevailed. Only four women stated that this decision was made by the women themselves. None of the women stated that this decision was made by their husbands or others. These findings do not concur with those of Grebler et al. (1970) and Marín et al. (1981) who found that husbands most often made the decision whether or not to use birth control. The

present findings are similar, though, to those of Esparza (1977), Hawkes and Taylor (1975), Kay (1978), and Otero (1968). These researchers found that 58% to 75% of the decisions to use birth control were made jointly. A greater number of unilateral decisions by both men and women, though, ocurred in these four studies than in the present study. Once again, cohort changes may be occurring as these studies were conducted between 10 and 19 years ago.

The third and final research question asked women, "Who decides which method of birth control will be used to achieve the desired number of children?" In this area, joint decision making no longer predominated. Unilateral decisions by the women accounted for 47% of the responses, joint decisions were made 33% of the time, and husbands made the decision alone in only 3% of the cases. Thus, although decisions to use birth control were made jointly, women assumed more responsibility and decision making power for actual fertility control. No other studies were found which asked a similar question.

Birth control methods were predominantly female oriented (i.e. oral contraceptives, tubal ligation, the IUD, and contraceptive foam). Approximately one fourth of the husbands were using condoms. This is consistent with current female and male participation in contraceptive

methods for the United States in general (Gallen, 1986). Gallen noted that male participation in family planning included not only condoms, but also vasectomy, withdrawal, and periodic abstinence as well. Of course, one should keep in mind that most birth control methods have been designed to be used by women. In addition, women are more often the focus of birth control education than men. Further, the effects of the womens' movement and the weakened influence of the Catholic church may have given rise to increased responsibility for fertility control by women (Waterman & Johnson, 1979).

Interestingly, health care providers, relatives, and friends of the women selected the method of birth control for the couple 17% of the time. Several factors may explain this fairly high percentage. Perhaps the women and their husbands had not had the opportunity to learn about the various methods of birth control and therefore depended on someone else to make the selection. Also, one may ask the question whether or not health care providers have given their clients the opportunity to choose their method of birth control. In this particular clinic, birth control methods are somewhat limited. For example, only one health care provider currently inserts IUD's. If this person is not available, the woman must go elsewhere or reschedule her appointment. In addition, breastfeeding women are

generally offered contraceptive foam and condoms or a diaphragm because the one type of oral contraceptive available to breastfeeding women is very expensive. Further, tubal ligations are strongly recommended to women who have had several children.

In summary, joint decision-making regarding ideal number of children and use of birth control predominated in this study. Although joint decision making was apparent in decisions regarding method of birth control, unilateral decisions by women were indicated in nearly half of the responses. These results concur with the literature finding joint decision-making on use of birth control and family size in the majority of Mexican American couples (Esparza, 1977; Hawkes & Taylor, 1975; Kay, 1978; Otero, 1968). These results do not support the belief of machismo with respect to male dominance in family planning decision-making as reported by Grebler et al. (1970) and Marín et al. (1981). Thus, the results are contrary to the discussion in the conceptual framework presented in chapter II and tend to indicate that machismo exerts little influence in family planning decisions.

Limitations

Several limitations of this study should be considered. First, the small sample size limits the generalizability of the findings. The subjects in this

study were a convenience sample of women who chose a particular clinic for any of a variety of reasons (e.g. location, multilingual services, income eligibility, and family planning services). Any of these factors may have limited the degree of heterogeneity and resulted in a biased sample. Oregon has a relatively small Mexican American population. Those living in the four county area that the clinic serves may not experience the same type of cultural environment as Mexican Americans living in the Mexican barrios of large U.S. cities. Furthermore, the sample may have been biased by those women who were coming to the clinic for family planning services only. Perhaps those women were more likely to make decisions about family planning by themselves or jointly with their husbands. Women influenced by husbands' "machismo" may not be coming to the clinic at all as their husbands may have decided against using birth control.

External validity may have been threatened by the "experimenter effect." It is possible that subjects did not answer honestly because they were trying to provide a socially acceptable response or because they did not trust the researcher.

The cross-cultural nature of this study raises a number of significant concerns. Foremost among these is translation of the interview questions and responses.

Although the investigator consulted with several Spanish-speaking nurses during the development of the interview schedule, Spanish is not the investigator's primary language. The nuances of colloquial Spanish may not allow for complete understanding of subjects' questions and responses, making access to the more intimate subtleties of Mexican American family life difficult (Peñalosa, 1968).

A further limitation of the study is that husbands were not questioned. Certainly husbands' responses would have been desirable. Unfortunately, such data would have been difficult to collect because husbands often do not accompany their wives to clinic appointments.

In sum, just as there is no uniform Anglo American family, there is no uniform Mexican American family. Many family types exist that vary according to region, length of time in the USA, education, social class, age, and urban-rural locale. Therefore, generalizability of findings must be done with caution.

Implications for Nursing Practice

Family planning favorably influences the health, development, and well-being of the family. Nurses providing family planning services to Mexican American clients are likely to have increasing opportunities to provide family planning services in the future as this population

continues to grow. Findings from this study and those of others (Esparza, 1977; Hawkes & Taylor, 1975; Kay, 1978; Otero, 1968) have shown that both the husband and the wife are involved in decision-making regarding family size and the use of birth control. In some health care centers, the male role is downplayed and discussions involving family planning are directed primarily towards women. Nurses may be able to provide more culturally sensitive and effective care if they asked their clients who makes the decisions regarding use of birth control in their family. If men were involved in the decision-making process, then they, too, should be consulted and educated.

It is indeed important for the nurse to educate clients about the benefits of family planning. Seventeen percent of the women in this study stated that the birth control method they were using had been selected by someone other than themselves or their husbands. Nurses have a responsibility to provide clients with accurate and thorough information so that the client can make informed choices about health care. This applies to selecting methods of birth control as well. Clients should be given information regarding all available methods of birth control including instructions for use and the risks, benefits, and effectiveness of each method. Then, clients will be better able to make an informed decision regarding

their chosen contraceptive method and reduce the probability of discontinuation or misuse (Reeder, Mastrianni, & Martin, 1980).

Suggestions for Further Research

Relatively few studies have investigated the attitudes and decision-making practices of Mexican Americans regarding family planning. Those studies which have been conducted have reached disparate conclusions. Further, decision-making regarding method of birth control has not been previously studied. Therefore, it would be prudent to continue conducting research in family planning decision-making among Mexican Americans.

Future studies should collect data on both members of the marital dyad even though access to men may be more difficult to obtain. Studies of non-migrant, urban, and better educated populations might be useful also. In addition, the machismo aspect of virility should be investigated further to explore if men are desiring more children due to cultural beliefs promoting fecundity for males. Finally, studies examining Mexican American adolescents' perceptions of fertility and their decision-making process regarding contraception might provide useful insights.

Summary

The purpose of this study was to explore who makes

decisions regarding family planning and ideal number of children in Mexican American families. The study was based on a conceptual framework that incorporated the relationship between Mexican American culture and the belief of machismo. Much of the scientific and popular literature has stressed the dominant role of the male in the Mexican American culture as a portrayal of machismo. However, a growing number of researchers dispute the accuracy of male dominance in decision-making and support a more egalitarian power structure within Mexican American families. Few studies have described decision-making within the context of family planning in the Mexican American culture and no studies of this nature have been conducted in the Pacific Northwest.

The study was conducted in a migrant health clinic serving a four county area in the Willamette Valley of Oregon. Thirty female subjects of Mexican heritage constituted a convenience sample of patients waiting for gynecological and postpartum health care services. Subjects were interviewed regarding demographic information, the type of birth control they currently were using or desired to use, and who in the marital dyad makes family planning decisions. The data were analyzed descriptively using the Statistical Package for the Social Sciences (SPSS).

In general, the subjects were in their late twenties, were poorly educated, had lived in the United States for several years, desired three or four children, and had limited financial resources. Joint decision-making was most evident in reference to decisions about the couple's ideal number of children and the decision to use birth control. Decision-making regarding selection of birth control method was most often made by women alone. Oral contraceptives were the preferred method of birth control.

This study supports the research indicating that family planning decisions are most often made by both members of the marital dyad in Mexican American families rather than by the male alone. In addition, unilateral decisions by women regarding the type of birth control they use suggests that women frequently make their own decision regarding fertility. As health care providers, nurses should discuss family planning with those who are responsible for making the decisions be it the couple together, the woman, or the man.

References

Aamodt, A. M. (1978). Culture. In A. L. Clark (Ed.), Culture, childbearing, health professionals (pp. 3-19). Philadelphia: F. A. Davis Company.

Alvirez, D. (1973). The effects of formal church affiliation and religiosity on the fertility patterns of Mexican American Catholics. Demography, 10(1), 19-36.

Alvirez, D., Bean, F. D. & Williams, D. (1981). The Mexican American family. In C. H. Mindel & R. W. Habenstein (Eds.), Ethnic families in America (pp. 269-292). New York: Elsevier North-Holland, Inc.

Andrade, S. J. (1982). Social science stereotypes of the Mexican American woman: Policy implications for research. Hispanic Journal of Behavioral Sciences, 4, 223-244.

Anthony-Zkach, C. (1981). Care of the Mexican American patient. Nursing and Health Care, 2, 424-427, 432.

Bach-y-Rita, G. (1982). The Mexican American: Religious and cultural influences. In R. M. Becerra, M. Karno, & J. I. Escobar (Eds.), Mental health and Hispanic Americans clinical perspectives (pp. 29-40). New York: Grune & Stratton, Inc.

Bean, F. D. (1973). Components of income and expected family size among Mexican Americans. Social Science

Quarterly, 54, 103-116.

Bean, F. D. & Bradshaw, B. S. (1977). Mexican American fertility. In C. H. Teller, L. F. Estrada, J. Hernandez, & D. Alvirez (Eds.), Cuantos Somos: A demographic study of the Mexican American population (pp. 101-130). Austin: University of Texas Press.

Bean, F. D. & Wood, C. H. (1974). Ethnic variations in the relationship between income and fertility. Demography, 11, 629-640.

Beckman, L. J. (1982). Measuring the process of fertility decision-making. In G. L. Fox (Ed.), The childbearing decision, fertility attitudes and behavior (pp. 73-95). Beverly Hills: SAGE Publications, Inc.

Brim, O. G., Glass, D. C., Lavin, D. E. & Goodman, N. (1962). Personality and decision processes. Stanford: Stanford University Press.

Canino, G. (1982). The Hispanic woman: Sociocultural influences on diagnoses and treatment. In R. M. Becerra, M. Karno, & J. I. Escobar (Eds.), Mental health and Hispanic Americans clinical perspectives. (pp. 117-138). New York: Grune & Stratton, Inc.

Clark, M. (1970). Health in the Mexican American culture. Berkeley and Los Angeles: University of California Press.

Cromwell, R. E., Corrales, R. G., & Torsiello, P. M.

(1973). Normative patterns of marital decision making power and influence in Mexico and the United States: A partial test of resource and ideology theory. Journal of Comparative Family Studies, 4, 177-196.

Cromwell, V. L. & Cromwell, R. E. (1978). Perceived dominance in decision-making and conflict resolution among Anglo, Black and Chicano couples. Journal of Marriage and the Family, 40, 749-759.

Cromwell, R. E. & Ruiz, R. A. (1979). The myth of macho dominance in decision making within Mexican and Chicano families. Hispanic Journal of Behavioral Sciences, 1, 355-373.

Díaz-Guerrero, R. (1975). Psychology of the Mexican. Austin: University of Texas Press.

Edwards, W. (1967). The theory of decision making. In W. Edwards & A. Tversky (Eds.). Decision making (pp. 11-64). Harmondsworth, Middlesex, England: Penguin Books Ltd.

Esparza, R. (1977). The value of children among lower class Mexican, Mexican American and Anglo couples. Dissertation Abstracts International, 38, 1397-B. (University Microfilms No. 77-17, 991)

Ewing, R. C. (1966). Six faces of Mexico. Tucson: University of Arizona Press.

Exter, T. G. (1985). Focus on Hispanics. American

Demographics, 7(8), 29-33.

Fishburn, P. C. (1964). Decision and value theory. New York: John Wiley & Sons, Inc.

Fox, G. L. (Ed.). (1982). The childbearing decision, fertility, attitudes, and behavior. Beverly Hills: SAGE Publications, Inc.

Gallen, M. E. (Ed.). (1986). Men-new focus for family planning programs (Series J, No. 33). Baltimore, MD: The Johns Hopkins University, Population Information Program.

Garcia, C. R. & Rosenfeld, D. L. (1977). Human fertility: The regulation of reproduction. Philadelphia: F. A. Davis Company.

Goodenough, W. H. (1957). Cultural anthropology and linguistics. In P. Garvin (Ed.), Georgetown university round table on language and linguistics. Washington DC: Georgetown University Press.

Grebler, L., Moore, J. W., & Guzman, R. C. (1970). The Mexican American people. New York: The Free Press.

Hass, P. H. (1974). Wanted and unwanted pregnancies: A fertility decision-making model. Journal of Social Issues, 30(4), 125-165.

Hawkes, G. R. & Taylor, M. (1975). Power structure in Mexican and Mexican American farm labor families. Journal of Marriage and the Family, 37, 807-811.

Hotvedt, M. E. (1976). Family planning among Mexican Americans of South Texas. Dissertation Abstracts International, 37, 2277-A. (University Microfilms No. 76-21, 509)

Hunter, H. J. (1975). Health benefits of family planning: Information for social workers about reproduction and health. Ann Arbor: The University of Michigan.

Johnson, C. A. (1976). Mexican American women in the labor force and lowered fertility. American Journal of Public Health, 66, 1186-1188.

Johnson, W. W. (1964). Mexico. New York: Time, Inc.

Jones, R. C. (1948). Ethnic family patterns: The Mexican family in the United States. American Journal of Sociology, 53, 450-452.

Kay, M. A. (1978). The Mexican American. In A. L. Clark (Ed.), Culture, childbearing, health professionals. (pp. 89-108) Philadelphia: F. A. Davis Company.

Keesing, R. M. (1974). Theories of culture. In B. J. Siegel, A. R. Beals, & S. A. Tyler (Eds.), Annual review of anthropology (pp. 73-97). Palo Alto: Annual Reviews Inc.

Keesing, R. M. (1976). Cultural anthropology: A contemporary perspective. New York: Holt, Rinehart and Winston, Inc.

Kohls, R. (1979). Survival kit for overseas living.

Chicago: Intercultural Network/SYSTRAN Publications.

de Lenero, D. C. (1969). Hacia donde va la mujer Mexicana? Mexico City: Instituto Mexicano de Estudios Sociales.

Lewis, O. (1949). Husbands and wives in a Mexican village: A study of role conflict. American Anthropologist, 51, 602-610.

Madsen, W. (1964). Mexican Americans of South Texas. New York: Holt, Rinehart and Winston, Inc.

Marín, G. Marín, B. V., & Padilla, A. (1981). The meaning of children for Hispanic women. (Report No. RC 01 3092). Los Angeles, CA: University of California, Los Angeles. (ERIC Document Reproduction Service No. ED 211 287)

Metress, J. F. (1976). Mexican American health: A guide to the literature. Chicago: Council of Planning Librarians.

Mirandé, A. (1977). The Chicano family: A reanalysis of conflicting views. Journal of Marriage and the Family, 39, 747-756.

Monrroy, L. S. (1983). Nursing care of Raza/Latina patients. In M. S. Orque, R. Bloch, & L. S. Monrroy (Eds.), Ethnic nursing care: A multicultural approach (pp. 115-148). St. Louis: The C. V. Mosby Company.

Montiel, M. (1970). The social science myth of the Mexican American family. El Grito, 3(4), 56-63.

Murillo, N. (1976). The Mexican American family. In C. A. Hernandez, M. J. Haug, & N. N. Wagner (Eds.), Chicanos (pp. 15-25). St. Louis: The C. V. Mosby Company.

Otero, L. L. (1968). The Mexican urbanization process and its implications. Demography, 5, 866-873.

Padilla, A. M. & Ruiz, R. A. (1973). Latino mental health: A review of the literature. Washington DC: National Institute of Mental Health.

Peñalosa, F. (1968). Mexican family roles. Journal of Marriage and the family, 30, 680-689.

Reeder, S. J., Mastroianni, L., & Martin, L. L. (1980). Maternity nursing. Philadelphia: J. B. Lippincott Company.

Rendón, A. B. (1985). We...the Mexican Americans, the Puerto Ricans, the Cubans, and the Hispanics from other countries in the Caribbean, Central and South America, and from Spain...Washington, DC: U.S. Government Printing Office.

Roberts, R. E. & Lee, E. S. (1974). Minority group status and fertility revisited. American Journal of Sociology, 80, 503-523.

Rubel, A. J. (1966). Across the tracks: Mexican Americans in a Texas city. Austin: University of Texas Press.

Sabagh, G. (1980). Fertility planning status of Chicano

couples in Los Angeles. American Journal of Public Health, 70, 56-61.

Staton, R. E. (1972). A comparison of Mexican and Mexican American families. Family Coordinator, 21, 325-330.

Stein, J. & Urdang, L. (1983). The Random House dictionary of the English language, unabridged ed. New York: Random House, Inc.

Uhlenberg, P. (1973). Fertility patterns within the Mexican American. Social Biology, 20, 30-39.

Urdaneta, M. L. (1977). Fertility regulation among Mexican American women in an urban setting: A comparison of indigent vs nonindigent Chicanas in a Southwest city in the United States. Dissertation Abstracts International, 38, 1507-A. (University Microfilms No. 77-18,607)

U.S. Bureau of the Census. (1980). Census of the population, Volume I: Characteristics of the population (PC80-1-B39, Oregon). (Table 16). Washington DC: U.S. Government Printing Office.

U.S. Bureau of the Census. (1985). Persons of Spanish origin in the United States: March 1985 (Series P-20, No. 403). Washington DC: U.S. Government Printing Office.

Vasquez, M. J. (1984). Power and status of the Chicana: A social-psychological perspective. In J. L. Martinez

& R. H. Mendoza (Eds.), Chicano psychology (pp. 269-287). Orlando: Academic Press, Inc.

Waterman, C. & Johnson, D. (1979). The Chicana: Traditional values in transition. (Report No. RC 011 952). Paper presented at the Speech Communication Association, San Antonio, TX. (ERIC Document Reproduction Service No. ED 184 771)

World Health Organization. (1980). Towards a better future: Maternal and child health. Geneva: Author.

Appendix A

Family Planning Decision-Making Survey in English

Subject #_____
Clinic_____
Date _____

Family Planning Decision-Making Survey

1. How many children do you have? _____

2. How many children would you like to have?_____

3. How many children would your husband like to have?_____

4. Who mainly decides how many children you will have - you, your husband, both of you together, or someone else?
   1. wife
   2. husband
   3. both
   4. other

5. Do you know how to use birth control to prevent pregnancy? (If no, will stop interview)
   1. yes
   2. no

6. Are you currently using a method of birth control? (If yes, go to 6a) (If no, go to 7)
   1. yes
   2. no

6a. Who decided that birth control should be used - you, your husband, both of you together, or someone else?
   1. wife
   2. husband
   3. both
   4. other

6b. What kind of birth control are you using? _____

6c. Who decided what kind of birth control should be used - you, your husband, both or you
   1. wife
   2. husband

together, or someone else? (Stop interview)
3. both
4. other

7. Do you want to use birth control?
(If yes, go to 7a)
(If no, go to 8)
1. yes
2. no

7a. Who decides if birth control will be used - you, your husband, both of you together, or someone else?
1. wife
2. husband
3. both
4. other

7b. What kind of birth control would you like to use?_____

7c. Who decides what kind of birth control should be used - you, your husband, both of you together, or someone else? (Stop interview)
1. wife
2. husband
3. both
4. other

8. Why don't you want to use birth control?_____
_____

8a. Who decided that birth control will not be used - you, your husband, both of you together, or someone else?
1. wife
2. husband
3. both
4. other

9. Have you ever used birth control?
(If no, Stop interview)
1. yes
2. no

9a. What kind of birth control did you use?_____

9b. Who decided what kind of birth control should be used - you, your husband, both of you
1. wife
2. husband

9c. Why did you stop using birth control?_____

_____

9c. Who decided that you should stop - you, your husband, both of you together, or someone else?

1. wife
2. husband
3. both
4. other

Appendix B

Family Planning Decision-Making Survey in Spanish

Sujeto # __ __
Clinica _____
Fecha _____

1. Cuántos hijos tiene Ud? _____

2. Cuántos hijos desea tener en total? _____

3. Cuántos hijos desea su esposo? _____

4. Quién decide cuantos hijos va a tener - Ud., su esposo, los dos, o otra persona?
   1. mujer
   2. esposo
   3. los dos
   4. otra

5. Conoce métodos de cuidarse contra el embarazo? (Si no, pare la entrevista)
   1. Si
   2. No

6. Está usando un método de cuidarse ahora?
   (Si - va a 6a)
   (No - va a 7)
   1. Si
   2. No

6a. Quién decide si va a cuidarse o no - Ud., su esposo, los dos, o otra persona?
   1. mujer
   2. esposo
   3. los dos
   4. otra

6b. Cómo está cuidándose? _____

6c. Quién seleccionó el método de cuidarse - Ud., su esposo, los dos, o otra persona? (Pare la entrevista)
   1. mujer
   2. esposo
   3. los dos
   4. otra

7. Desea cuidarse contra el embarazo? 1. Si
(Si, va a 7a) 2. No
(No, va a 8)

7a. Quién decide si va a cuidarse o no - Ud., 1. mujer
su esposo, los dos, o otra persona? 2. esposo
3. los dos
4. otra

7b. Qué método desea? _____

7c. Quién seleccionó el método de cuidarse - Ud., 1. mujer
su esposo, los dos, o otra persona? 2. esposo
(Pare la entrevista) 3. los dos
4. otra

8. Por qué no desea cuidarse contra el embarazo? _____

_____

8a. Quién hizo la decisión de no cuidarse - Ud. 1. mujer
su esposo, los dos, o otra persona 2. esposo
3. los dos
4. otra

9. En el pasado se ha cuidado con algún método? 1. Si
(No - pare la entrevista) 2. No

9a. Cuál método se ha usado? _____

9b. Quién decidió cual método usar - Ud., 1. mujer
su esposo, los dos, o otra persona? 2. esposo
3. los dos
4. otra

9c. Por qué dejó de cuidarse? _____

_____

9d. Quién hizo la decisión de dejar de cuidarse - Ud., su esposo, los dos, o otra persona?

1. mujer
2. esposo
3. los dos
4. otra

Appendix C

Review of Instrument

Review of Instrument

1. Are the questions clear? If not, specifically which questions are not clear?

1a. Suggest other wording.

2. Do the questions adequately reflect who makes family planning decisions?

3. Are there any missing questions?

4. Are the questions listed in the correct order?

5. Do you forsee any problem(s) with this questionnaire?

Appendix D

Informed Consent Form

Oregon Health Sciences University Consent Form

My name is Sheryl Horwitz and I am a graduate nursing student at the Oregon Health Sciences University. I would like to invite you to join in a study looking at who makes the decisions about family planning. If you consent to be in the study, I will ask you a few questions that should take 5-10 minutes and will be done while you wait for your appointment. The information will be kept private. Your name will not appear on the form or in your clinic chart.

You may ask me any questions you might have about your participation in this study. You do not have to join in this study and may withdraw any time without hurting your relationship with the clinic or the university.

If you agree to participate in my study, please sign on the line below. Thank you.

_____ _____

Signature Date

_____ _____

Witness Date

Consentimiento

Me llamo Sheryl Horwitz y soy una enfermera en la universidad en Portland. Le invito a participar en un estudio sobre la selección de métodos de cuidarse. Si me ayuda con el estudio, le voy a hacer unas preguntas durante 5 o 10 minutos mientras se espera su cita. Guardaré sus respuestas en estricta confidencia. Su nombre no aparecerá en los papeles ni su record.

Puedo contestar cualquier pregunta que tenga acerca de este estudio. No es mandatorio participar en el estudio y puede retirar cualquier momento sin afectar su relación con la universidad o la clínica.

Si quiere paraticipar en mi estudio, favor de firmar abajo. Gracias.

_____ _____

Firma Fecha

_____ _____

Testigo Fecha

Appendix E

Demographic Data

Subject # __ __
Clinic _____
Date _____

Demographic Data

__ __ 1. Age _____

__ __ 2. Years of education _____

__ 3. Your birthplace:

__1. U.S.A.; __2. Mexico; __3. Other; __4. Don't Know

__ 4. Birthplace of your mother:

__1. U.S.A.; __2. Mexico; __3. Other; __4. Don't Know

__ 5. Birthplace of your father:

__1. U.S.A.; __2. Mexico; __3. Other; __4. Don't Know

__ 6. Birthplace of your husband:

__1. U.S.A.; __2. Mexico; __3. Other; __4. Don't Know

__ 7. Birthplace of your mother-in-law:

__1. U.S.A.; __2. Mexico; __3. Other; __4. Don't Know

__ 8. Birthplace of your father-in-law:

__1. U.S.A.; __2. Mexico; __3. Other __4. Don't Know

__ 9. Length of time in United States:

__1. Less than 1 year; __2. Between 1 and 5 years;

__3. Between 6 and 10 years; __4. Greater than 10 years

__ 10. Language preference:

__1. English; __2. Spanish; __3. English & Spanish

__4. Other

__ 11. Employed outside of home: __1. Yes __2. No

__ 12. % Pay; __1. 0%; __2. 25%; __3. 50%; __4. 75% __5. 100%

__ __13. Number of times you've been pregnant_____

Sujeto # __ __
Clínica _____
Fecha _____

__ __ 1. Edad _____

__ __ 2. Años de educación _____

__ 3. Lugar de nacimiento (Ud.):

__1. EEUU; __2. Mexico; __3. Otra; __4. No sabe

__ 4. Lugar de nacimiento (su madre):

__1. EEUU; __2. Mexico; __3. Otra; __4. No sabe

__ 5. Lugar de nacimiento (su padre):

__1. EEUU; __2. Mexico; __3. Otra; __4. No sabe

__ 6. Lugar de nacimiento (su esposo):

__1. EEUU; __2. Mexico; __3. Otra; __4. No sabe

__ 7. Lugar de nacimiento (su suegra):

__1. EEUU; __2. Mexico; __3. Otra; __4. No sabe

__ 8. Lugar de nacimiento (su suegro):

__1. EEUU; __2. Mexico; __3. Otra; __4. No sabe

__ 9. Tiempo en los Estados Unidos:

__1. < 1 año; __2. Entre 1 y 5 años; __3. Entre 6 y 10 años; __4. >10 años

__ 10. Lengua preferida:

__ 1. Inglés; __2. Español; __3. Inglés y Español

__ 4. Otra

__ 11. Trabaja afuera de la casa: __1. Si; __2. No

__ 12. % pagar; __1. 0%; __2. 25%; __3. 50%; __4. 75%;

__5. 100%

__ __13. Número de embarazos en total _____

Appendix F

Letter of Agreement

Salud Medical Center
347 N. Front
Woodburn, OR 97071

February 20, 1987

Sheryl Horwitz, RN
3463 SW Alice St
Portland, OR 97219

Dear Sheryl,

This letter is to give you permission to collect data for your Master's Research Project here in the clinic. I understand that you will be requesting the voluntary participation of Mexican American patients presenting for six week postpartum examinations and/or gynecological services. This participation will involve an interview regarding who makes the decisions about family planning. Per your request, you may interview women at variable times during clinic hours beginning March, 1987.

Sincerely,

[redacted]

Robert Keller, M.D.
Medical Director

AN ABSTRACT OF THE THESIS OF

Sheryl Lynne Horwitz

For the MASTER OF SCIENCE IN NURSING

Date of Receiving this Degree: June 12, 1987

Title: DECISIONS REGARDING BIRTH CONTROL AND FAMILY SIZE IN MEXICAN AMERICAN FAMILIES

Approved:

[redacted]

Virginia P. Tilden, R.N., D.N.Sc., Thesis Advisor

This study explored who makes the decisions regarding birth control and ideal number of children in Mexican American families. The study was based on a conceptual framework that incorporated the relationship between Mexican American culture and the belief of machismo. Machismo is one traditional belief that emphasizes male domination over the family including control over fertility. In a review of the literature regarding Mexican American family planning decision-making, however, there is disagreement as to whether or not the belief of machismo ever even existed.

Thirty female subjects of Mexican American heritage constituted a convenience sample of patients waiting for postpartum or gynecological services at a clinic in Western Oregon. Subjects were interviewed in either Spanish or

English regarding demographic information and type of birth control used as well as who in the marital dyad makes family planning decisions. The data were analyzed descriptively.

In general, the subjects were in their late twenties, were poorly educated, had lived in the USA for several years, desired three or four children, and had limited financial resources. Joint decision-making was most evident in reference to decisions about the couple's ideal number of children and the decision to use birth control. Decisionmaking regarding selection of birth control method was most often made by women alone. Oral contraceptives were the preferred method of birth control.

This study supports the research indicating that family planning decisions are most often made by both members of the marital dyad in Mexican American families rather than by the male alone. In addition, unilateral decisions by women regarding the type of birth control they use suggests that women frequently make their own decision regarding fertility. Health care providers should discuss family planning issues with those who are responsible for making the decision, be it the woman, the man, or the couple together.