



Part 1

Clinical pediatrics in the Mexican immigrant community

Insight into the impact of culture on
the health of Mexican-American children.

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The US continues to be a country of immigrants. As of 2006, roughly 37.5 million immigrants (documented and undocumented) were living in the US, accounting for 12.5% of the total population. Of these, 30% were from Mexico.¹

These new immigrant families bring with them their language, culture, and religious beliefs. And they also bring some health issues specific to the region from which they originated. As pediatricians, it is important to be aware of how these issues impact our clinical practice—whether it is in formulating a differential diagnosis, performing a physical examination, or communicating a diagnosis or treatment plan. Failure to do so can significantly impact the quality of health care received by these patients.

In Part 1 of this series, we will review alternative

approaches to health care, popular medications, as well as nutritional beliefs found in Mexican culture. Although some of the cultural beliefs relating to health may be affected by educational level and socioeconomic status (SES), many of these practices and beliefs transcend SES.³

It is important to note, however, that not all the beliefs and practices discussed in this article are followed by all Mexican-American families.

Editor's note: Statements regarding beliefs, practices, and behaviors without citations have been included when such beliefs, practices, and behaviors have been regularly noted by the author and her colleagues practicing at a community health center, where over 95% of patients and/or their families are Mexican-American immigrants.

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tion with Reye's syndrome. They may be more likely to give aspirin for pain and fever relief, or may give their children aspirin-containing medications, such as bismuth subsalicylate (in Kaopectate and Pepto-Bismol) or acetylsalicylic acid (in Alka-Seltzer).

Views on nutrition

With fast food and soda heavily advertised and readily available, it is often difficult for any parent to guide proper food choices and to set limits for their children. Immigrant families also face these issues.

In general, when families immigrate to the US, they often want to give their children "American food." Some believe that this includes the regular consumption of fast food, sodas, sports drinks, and other sugar-laden "juice" beverages.¹¹ In our practice within the Mexican immigrant community, we have observed infants being offered sugary drinks in bottles. Therefore, practitioners should consider inquiring about sugary drink consumption in early well-child visits.

The importance of familismo

Immediate and extended family ties are very important to the Latino community—otherwise known as familismo. The mother, father, grandparents, aunts and uncles may come to their children's doctor visits, and all may have some say in how the child will be cared for. Grandmothers (*la abuela*), in particular, often play a strong role in how their grandchildren are cared for, both in what they are fed as well what remedies are used.

The importance of the extended family in decision making, particularly when discussing serious medical conditions, must be kept in mind when caring for many Mexican-American families. Allowing for family meetings to include important extended-family members when discussing serious medical conditions is of utmost importance to ensure that medical decisions, treatments, and plans will be followed.¹⁰

In many Latin American countries, the degree of respect (*respeto*) paid to a physician may translate into the desire to not offend that physician. Some families may not want to question the doctor, even if they do not believe or do not understand some aspects of the diagnosis or plan. They may be used to a more paternalistic doctor-patient relationship.

It is important to be aware of this potential dynamic, and to attempt to provide a non-threatening open environment where families are encouraged and supported to ask questions. Latino families also expect to be shown respect by their physicians, in the form of a handshake both at the beginning and end of a visit, a greeting (eg, *buenos días* [good morning], *buenas tardes* [good afternoon]) as well as being addressed in the more formal "you" (*usted*) as well as *Señor* (Mr.) or *Señora* (Mrs.).¹⁰

Initiation and duration of breastfeeding in Latino immigrant populations vary considerably by degree of acculturation. In the Mexican immigrant population, with increasing years of residency in the US, there is a shorter duration of breastfeeding as well as less exclusive breast feeding.¹² It is unclear why this is the case; the cause is probably multi-factorial.

Given that most US-made powdered formulas come with instructions in English only, it is also important to address proper formula mixing to parents within this community as well. Water may also be given to newborns and young infants because of the perceived need for more liquid than breast milk or formula can offer. Therefore, practitioners should query parents whether they are supplementing with water, and if so, to assure them that breast milk or formula is all that the baby needs.





Similarly, some mothers seem concerned that their newborns are not satisfied with only breast milk (*no se llena* [she/he does not fill up]) and feel obligated to excessively supplement with formula. One study looked at reasons why Latina mothers decided to supplement with formula, or not breastfeed at all.¹³ Some who supplemented with formula believed that they were providing their infants with the benefits of breast milk as well as the “extra” vitamins offered in formula. Others were embarrassed by having to expose their breasts in public.¹³

The cultural belief of *susto* may also contribute to a Mexican/Latina mother’s decision not to breastfeed. Followers of *susto* believe that if a frightening or emotionally disturbing event is witnessed, for example, by a breastfeeding mother, this event taints the mother’s milk supply. As such, the mother would need to abstain from breastfeeding her baby for a given period of time until the fright has passed, so as not to pass on the tainted milk.

Some mothers also believe that if they are sick with an illness, such as an upper respiratory infection, they need to stop breastfeeding so as not to pass the infection to their infant.¹⁴ If these perceived needs to not offer breast milk exceed more than several days, milk production will diminish. At minimum, Latina mothers should be provided with extensive lactation support, education, and breast pumps. This way, if they are able to breast feed, they might be more successful.

Initiating solids in infants may also occur earlier than recommended within this population.¹⁵ Some families start by giving “tastes” of foods to their child as early as 2 to 3 months of age, while others are given soups (*sopas* or *caldos*), broth mixed with cooked vegetables and/or meat. Yet another portion are fed pre-made instant soups

(*sopa huevona*—“lazy soup”). It is important to discuss infant nutrition with parents, and ensure that they offer a variety of soft vegetables, fruits, and meats without extra ingredients.

Lastly, the continued obesity epidemic of our youth, and the increased prevalence of type 2 diabetes in the Latino community,¹⁶ makes it imperative for clinicians to address dietary issues on a regular basis. Interestingly, studies have shown that the longer Mexican-American immigrant children live in the US, the more likely they are to be obese.¹⁷ □

Look for Part 2, on infectious diseases and folk illnesses and remedies, in the March 2009 issue of Contemporary Pediatrics.

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