



## The Journal of Sociology & Social Welfare

Volume 23  
Issue 2 June

Article 3

June 1996

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### Recommended Citation

Sherrard Sherraden, Margaret and Barrera, Rossana E. (1996) "Poverty, Family Support, and Well-Being of Infants: Mexican Immigrant Women and Childbearing," *The Journal of Sociology & Social Welfare*: Vol. 23 : Iss. 2 , Article 3.  
Available at: <https://scholarworks.wmich.edu/jssw/vol23/iss2/3>

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# Poverty, Family Support, and Well-Being of Infants: Mexican Immigrant Women and Childbearing

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*Data reveal that despite high levels of poverty, Mexican immigrants have relatively few low birth weight babies. This unusual pattern suggests that there are "protective" social factors mediating the effects of poverty—perhaps especially family support. Our study, based on in-depth interviews with immigrant women in Chicago, finds that family support does protect some women from delivering a low birth weight infant but it does not protect women living in extreme poverty. Implications for services to Mexican immigrant women in childbearing years and their families are presented. These findings also speak to broad issues in social policy, especially the need for outreach and basic support to the very poor.*

The well-being of infants is considered a litmus test for overall life chances. Despite high per capita income and massive health care expenditures, the United States has a worse low birth weight rate than 30 other nations, and a worse infant mortality rate than 19 other nations (Children's Defense Fund, 1994). A great deal of attention and resources have been devoted to reducing rates of infant mortality and low birth weight (National Center for Health Statistics, 1991). Improvements have been made, but racial and ethnic disparities persist (Paneth, 1995, Singh & Yu, 1995).

Journal of Sociology and Social Welfare, June, 1996, Volume XXIII, Number 2

In these efforts, it is important to examine the unusual example of birth outcomes of Mexican origin babies. Data show that infants of Mexican descent have rates of low birth weight and infant mortality that are lower than more advantaged non-Hispanic white babies (Ventura, et al., 1994). For example, 1993 data show that the percentage of low birth weight infants of Mexican descent was 5.8, similar to that of whites (5.9 percent), and considerably less than that of Puerto Ricans (9.2 percent) or African-Americans (13.4 percent) (Ventura, et al., 1995). Among Mexican immigrants alone, the low birth weight rate is even lower (5.1 percent) (Ventura, et al., 1995). The pattern is surprising because babies of Mexican descent would be considered vulnerable by the most well-established risk factors—including poverty and access to health care.

This pattern of low birth weight has been called an “enigma” and a “paradox” by health researchers (Markides & Coreil, 1986; Williams, et al., 1986; Rumbaut & Weeks, 1994). It raises fundamental questions about the dynamics of poverty and ethnicity, and the relationship to birth outcomes. An examination of these patterns offers an opportunity to distinguish the most deleterious aspects of poverty and those that can be ameliorated. This would give us a greater insight into how to further improve birth outcomes among babies of Mexican descent and may lead to ideas for more effective services for other groups as well.

#### Factors Thought to Mediate Poverty's Impact on Birth Outcomes

Researchers have argued convincingly that poverty is associated with an increased risk of low birth weight (Ounsted & Scoll, 1982; Paneth, et al., 1982). However, how poverty affects birth weight and what factors may mediate poverty's most harmful effects are less clear (Hughes & Simpson, 1995). Researchers point to the possible role of education, prenatal care, and social services in reducing rates of low birth weight.

Regarding education, studies show that risk of low birth weight decreases significantly if the mother has at least 12 years of formal schooling (Erhardt & Chase, 1973). But educational attainment among women of Mexican descent is lower than most other groups (Velez, 1989), suggesting that formal education plays

a minor role in mediating the impact of poverty on birth weight in this population.

Access to prenatal care also has been shown to reduce the incidence of low birth weight and, therefore, could potentially reduce rates of low birth weight in poor communities (Institute of Medicine, 1985; Alexander & Korenbrot, 1995). However, studies show that Mexican origin women are less likely to receive prenatal care than other groups. The high cost of care, inability to pay, lack of medical insurance, and fear of using US health services contribute to low care (Treviño, et al., 1991). Therefore, it is unlikely that prenatal care is a key mediator of poverty for the Mexican immigrant population.

Combs-Orme (1988) has suggested that social workers and social services historically have played an important role in reduction of infant mortality. But studies suggest that Mexicans have relatively low social service utilization rates (Hayes-Bautista, 1989).

Thus, conventional explanations do not explain why the rate of low birth weight in the Mexican community is low compared to other high poverty populations. The inconclusive nature of research requires "unbundling" the reasons for low birth weight among specific populations. Is poverty somehow different for women of Mexican descent? We turn to recent debates on the nature of poverty to identify possible explanations for why Mexican immigrants have relatively positive birth outcomes.

William Julius Wilson, whose work has re-focused attention on urban poverty, proposes that economic restructuring has led to persistent and concentrated urban poverty (Wilson, 1987). Wilson and colleagues argue that poverty, particularly in the African-American community, is accompanied by weak attachment to the labor force, welfare dependency, female-headed households, incompleteness of high school, high rates of low birth weight, and high rates of infant mortality. Researchers examining the situation among Latinos (64 percent of whom are Mexican descent), point to low high school completion rates, high unemployment, poor earnings, and larger families as indicators of economic difficulties (Barancik, 1990; Chapa & Valencia, 1993).

But others argue that the nature of poverty in Latino communities is different (Cuciti & James, 1990; Massey, 1993). Moore and Pinderhughes (1993) propose that economic restructuring has had

less negative impacts on Latinos than on Blacks. There is strong attachment to the labor force among Latinos and concentration of poverty has been less severe. (These arguments are framed in terms of Latinos as a whole and research on specific groups is needed; however, the authors make it clear that Mexican immigrants fit the overall patterns.) One of the factors that makes poverty different is a high rate of immigration that reinforces community social institutions, such as churches, businesses, local organizations, and self help groups. These provide resources and support that mediate some of the most pernicious effects of poverty (Delgado & Delgado, 1982; Valle & Vega, 1982; Sherraden & Martin, 1994).

Researchers have also documented that the poor utilize informal social networks to mediate poverty (Portes & Bach, 1985; González de la Rocha, 1994). They utilize social networks—especially extended families—to find housing and jobs, to incorporate several income earners, to reallocate work responsibilities, and to lower household expenses (Angel & Tienda, 1982; Mines & Massey, 1986; Anderson & de la Rosa, 1989).

Viable community-based institutions, social networks, and families may reinforce, in Hayes Bautista's words (1989), a "cultural vitality" that sustains "protective mechanisms that cushion Latina mothers against the effects of low income, low education, and low access to care" (see also, Dowling & Fisher, 1987). For example, Collins and Shay (1994) find that residence in extremely poor areas of Chicago has little effect on birth weight among Mexican immigrants, whom they suggest maintain a Hispanic cultural orientation and social supports that counterbalance urban poverty. Nelson and Tienda (1985) argue that ethnic communities can provide a basis for "social solidarity" that protects the community from the vicissitudes of poverty.

We propose that these factors—community institutions, social networks, and families—may help to mediate the effects of poverty and help to explain lower rates of low birth weight among Mexican immigrants. This study poses two questions: (1) How do Mexican immigrant women cope with poverty and childbearing? and (2) Are there differences between women with low birth weight babies and women with normal birth weight babies with

respect to poverty and factors that mediate the impact of poverty? The first question explores possible reasons why low birth weight among Mexican immigrant families may be lower than expected. The second question examines the relationship between poverty and birth weight in the Mexican immigrant population.

### Research Methods

In order to answer these questions, it was important to explore immigrants' social and economic situations, their pregnancy and child birth experiences, and their experiences receiving help and assistance from formal social services, community-based organizations, informal support networks, and families. We chose in-depth, ethnographically-informed interviews as the principal data collection method for several reasons (Becerra & Zambrana, 1985; Sherraden & Barrera, 1995). First, an exploratory and intensive methodology was called for given the nascent state of knowledge about the dynamics of poverty and pregnancy among Mexican immigrants (Merton, et al., 1990). There was no assurance that the questions in a survey format would be relevant for this population. Although some research instruments had been developed that could be utilized for some aspects of the research (e.g., social support, acculturation), coping strategies and care during pregnancy among this population were not well-understood. Open-ended questions, in particular, were a useful method in this situation, permitting the researcher to guide the interview without confining the respondent to certain response categories. For example, questions such as "how do you and your family get along financially?" and "how difficult is it 'to make ends meet'?" provided direction but, at the same time, encouraged exploration of issues from the women's point of view and experience. Open-ended questions also led to discussing topics we had not anticipated, such as the role of secret pregnancies that are described in this paper.

Second, although time-consuming and challenging to arrange, we believed that relaxed, in-depth interviews would increase trust and confidence between researchers and subjects. The practical difficulties of collecting reliable data among Mexican immigrants—particularly undocumented immigrants—are

well known (Cornelius, 1981; Marín & Marín, 1991). Informal interviews can relieve anxieties that are often associated with institutional settings and "official-sounding" interviews.

Third, because we wanted to learn about the social and economic contexts of the women's lives during pregnancy, it was important to locate ourselves where they spent most of their time during pregnancy—in their homes and communities. We feared that a different interview site, particularly a large institution such as a hospital or clinic, might make it more difficult for them to focus on their everyday lives and for us to appreciate the meaning.

Field work began in 1990 when we undertook preliminary interviews with over 20 health and social service providers, researchers, and community leaders in Chicago's Latino communities (Becerra & Zambrana, 1985). Research procedures were based on many of these providers' observations and suggestions, in addition to our own research and experiences in the community. Between 1991 and 1993, we conducted long interviews with 41 Mexican immigrant women in Chicago, a city with the third largest concentration of Latinos in the United States, and a major port of entry for Mexican immigrants.

Most of the women were recruited at Chicago's regional public hospital, where almost a quarter of all Mexican immigrants in the Chicago area delivered their babies in 1989. A few mothers were recruited at other facilities, including a federally-funded community health center, a teaching hospital, and a community hospital. Although not a random sample, our recruitment method provided access to a much more diverse group of women than the more usual snowball sampling employed in many studies with undocumented immigrants. The women lived in various areas of the city and suburbs, including all of the major Mexican-origin communities.

We attempted to contact all mothers of low birth weight infants (under 2500 grams or 5.5 lb.) identified in hospital and clinic records during the study period. Because there are relatively few low birth weight babies, the recruitment period was lengthy. Mothers of normal birth weight infants were chosen from lists of babies born over several months, preferably within six months of birth. Initial contact with most women was by telephone, although 12 women were also recruited during their hospital stay. Spending time explaining the project and getting to know the

women increased the women's' willingness to participate. Only four women refused, including one whose baby had died, one whose father would not let her participate, one who was too busy, and another who gave no reason.

Interviews were conducted in a minimum of two sessions, lasting four to five hours and often longer (McCracken, 1988). The approach was designed to maximize trust between the researchers and the women. We explained the research objectives in an understandable manner and tried to let the women know that they had important information and observations that might be helpful to others (Marín & Marín, 1991). We tried to help each woman feel comfortable and in control during the interview. Most women preferred to hold the interviews in their homes, when family members were absent, and in Spanish. All interviews were conducted by the authors. In recognition for the women's effort, we took small gifts for the babies and other children and paid the women \$20.

Because the women's upbringing and current circumstances were both likely to affect their behaviors during pregnancy, we talked about their lives in both contexts. The first half of the interview (two to three hours) was an open-ended discussion of the woman's life history, with a particular focus on migration history, household and family composition and well-being, and pregnancy experiences. We followed a memorized interview guide and did not take notes during the interview (Edin, 1993). We took only a tape recorder, business cards, and consent forms. We made time to get to know each other and for the women to bring up issues and concerns of their own. We started the tape recorder only after obtaining permission and establishing rapport. We reassured them that we would not use their names on tape and they gave the recorder little notice after the first few minutes (Laslett & Rapoport, 1975). Initially, assurances of confidentiality put the women at ease, but it was the process of going to their homes, spending several hours with them, talking about issues that really interested them, playing with the children, helping with referrals, or making dinner that, in the end, encouraged them to be forthright.

The second session contained more closed-ended questions, including scales of social support and acculturation (Barrera, 1980; Marín & Marín, 1991), information about the baby's father,



an assessment of the family's socioeconomic circumstances, additional demographic data, and service utilization. The structured questions provided a more systematic method of gaining information that could be interpreted and corroborated within the context of the previous open-ended discussion. Overlap in the first and second sessions allowed us to explore some of the most important material in slightly different ways. Occasionally, additional contacts or visits were made. Information about prenatal care and labor and delivery also was abstracted from medical records, although data were often sketchy or missing.

Analyses were conducted by coding the transcriptions of the first interview, and identifying themes and passages. Data were also quantified where possible and entered into a statistical program for descriptive and analytic purposes. The second interview and medical records data were coded and entered into the statistical program. We wrote a summary of key issues covered in the interview, including overall impressions and observations of the household. These summaries became the basis of "profiles" of each woman's experiences, which helped us to remember the respondent as a person. Analyses involved using the three sources—transcribed interviews, profiles, and statistical summaries—to identify themes and test findings. The quantitative data, while contributing to overall understanding, was not the primary mode of analysis.

## Findings

### *Background: Poverty in Mexico and the United States*

The median age of the women was 24 years. Sixty-six percent were married and seven percent were widowed, separated, or divorced (see Appendix A for a statistical description of the women). A substantial proportion, 27 percent, had never married. The women had an average of two children, far fewer than the average of almost nine children their mothers had. Half of the women said they planned to have no additional children and most others planned to have only one or two more.

Most of the women grew up in poverty. Two-thirds (68 percent) came from rural towns and villages. More than half of the women (56 percent) grew up very poor and twenty percent

remembered going hungry as children. Another 29 percent said their families had a little more money to cover some additional expenses, such as uniforms and books for school. Only 15 percent grew up in families in relatively comfortable economic circumstances.

Survival in Mexico depended, in most cases, on the economic contributions of several members of the household and extended family. Three-quarters of the women lived in close proximity to grandparents, many of whom provided daily child care or meals. A fourth of the women began working before the age of 18 years, including two who worked as domestic servants before the age of ten. Forty percent did not attend school beyond the sixth grade, and only a quarter graduated from the US equivalent of high school.

More than half of the women migrated in late adolescence and early adulthood, arriving in the United States during the 1980s. For most, this was their first US migration and Chicago was the only place they had lived in the United States. Only six came on earlier migrations and only six lived elsewhere in the United States before coming to Chicago.

Half of the women had never returned to Mexico and only five returned annually or biannually. Nonetheless, ties to Mexico and Mexican cultural heritage remained strong. Over half of the women maintained regular communication (either by telephone or letter) with relatives in Mexico, saving money by using relay calls and letters through other US relatives to relatives in Mexico. Only ten percent of the women had no contact at all with families in Mexico. Most continued to use only Spanish in their daily lives. Although they wanted their children to learn English, they also wanted them to maintain Spanish language and Mexican cultural values. Slightly more than half of the women expressed a desire to retire in Mexico, although several commented on how difficult it might be to move so far away from their children.

In Chicago, most women continued to live in poverty. Two-thirds (68 percent) lived below the official poverty line including 22 percent who lived below 50 percent of poverty (Appendix A). The majority (62 percent) of those above poverty were near-poor and had incomes between 100 and 150 percent of poverty. Median monthly income was approximately \$920 (during pregnancy) in-

cluding wages, AFDC checks, food stamps, and other direct financial assistance from family and other sources. (These estimates are high because we included *all* sources of income. We wanted an accurate picture of the amount of financial resources available to the women and their immediate families during their pregnancies. Income of other extended family members in the household was not included because it typically was accounted for separately. In the case of unmarried women with no outside income who were living with their parents, parents' income was used.)

Non-employment among the women was common. Half of the women (51 percent) did not work at least part of the time during their pregnancies and 76 percent did not work at the time of the interview (this number is high in part because a high proportion of the women had infants with health problems associated with low birth weight). Fifteen percent of the babies' fathers were not employed, and another 10 percent were out of touch. The women said that lack of immigration documents, lack of English, and poor job opportunities contributed to difficulties in obtaining jobs.

Turning to perceptions about economic well-being, most women (61 percent) said their families found it very difficult to meet basic monthly expenses, and a few (10 percent) found it impossible. Others (29 percent) reported that they could afford basic expenses of food, housing, clothing, transportation, and baby care items, but they had to plan their consumption very carefully in order to save a little money for emergencies or a few non-essentials (e.g., toys for children). A mother of two (neither was low birth weight) explained when we asked her whether she had enough money for food:

Well, sometimes we can afford meat or sometimes nothing but vegetables. As far as other things, for example, clothes or a toy or something like that, we can't afford them all the time. If there is a little left over money and I don't have to pay something, then we'll buy something simple.

None of the women said her family was financially secure. Many of the women worried and were anxious about their financial situation. As another observed:

The Mexican community suffers a lot. . . . more than anything else it is the worry we have here, above all because of the economic

situation . . . . You make money only to survive, eat and pay the rent. Nothing else.

### *Poverty and Low Birth Weight*

Women having the most difficult time financially also had more problems with their pregnancies. Women who had low birth weight babies expressed considerably more difficulty making ends meet during their pregnancies than those who had normal birth weight infants. For example, a 23 year-old woman with a low birth weight baby lived in a basement apartment with her husband and six people who shared one bedroom. She said she was unable to afford enough food all of the time. Another mother of a low birth weight baby said she was very worried about having enough money. She and her husband were unemployed and undocumented. Another young mother, a 19 year-old woman living in the suburbs alongside a noisy freeway, said she tried to save a little money in a tin can for emergencies. Because her husband worked only four hours a day at a hamburger joint, she said they had to spend all of their money on food. Her mother-in-law used to help them through the bad stretches, but she had recently been laid off her job.

Living below poverty was not statistically associated with having a low birth weight baby, but there was marked tendency in that direction (Appendix B). However, using other indicators, the poorest women were more likely to have low birth weight babies (Appendix B). Of the nine women living below 50 percent of poverty, eight had low birth weight babies ( $p < .05$ ). Women with monthly median incomes of less than \$900 (including all sources) were more likely to have low birth weight babies ( $p < .05$ ). Significantly, women who perceived their economic situation as very precarious were more likely to have low birth weight babies ( $p < .001$ ).

There is other evidence of the relationship between extreme poverty and birth weight. Women who were unable to save money or to send remittances to families in Mexico (a very common practice among immigrant families) were more likely to have low birth weight babies ( $p < .01$  and  $p < .10$  respectively). Finally, women with less than eight years of education were also more likely to have low birth weight babies ( $p < .001$ ). Although these data refer to a small sample and the analyses are bivariate, the

fact that quantitative data consistently agree with the qualitative findings strongly supports the negative impact of *extreme* poverty on birth outcomes.

But the interesting question is *why* does extreme poverty make such a difference in these cases while moderate poverty does not? The lower incidence of low birth weight among the moderately poor suggests that the effects of moderate poverty may be ameliorated or mediated in some way. The higher incidence of low birth weight among the poorest of the women suggests that it may be difficult to overcome the effects of poverty when there are too few resources. We turn now to examining the dynamics of poverty and how some poor immigrant women may avoid the negative impact of poverty on birth weight. Following the suggestions of prior research, in the next sections we examine the roles of formal social services, community based organizations, and family support on birth weight.

**The Role of Formal Social Services.** We found that most social services were not utilized by these families. Only seven of the families received Aid to Families with Dependent Children (AFDC) and only ten of the women received foodstamps, even though most of the children and some of the adults in the households were eligible. Ironically, women with low birth weight babies were most likely to receive AFDC and food stamps (Appendix C). We found that this is explained by the fact that pregnancy complications brought more of them to the attention of medical providers, who encouraged them to apply for government assistance.

More important sources of government assistance were Medicaid and the Food Supplement Program for Women, Infants, and Children (WIC). Most of the women who received Medicaid (41 percent) were enrolled with the assistance of health providers sometime in the course of pregnancy. The others paid for pregnancy care and childbirth with cash (46 percent) or paid through workplace benefits (10 percent) or were unsure how they paid (2 percent). The Medicaid program allowed many women to receive prenatal and birthing care without carrying the large debt that others incurred with the baby's birth. Almost all of the women (81 percent) received WIC coupons but most were enrolled late in pregnancy or upon delivery and, therefore, the program helped

most with infant, rather than maternal nutrition. Many women expressed appreciation for the WIC program, saying that the baby formula made it easier for them to make ends meet.

**The Role of Community-Based Support.** Researchers also point to the potentially important role of community-based organizations, especially in immigrant communities. We asked the women about help they may have received (e.g., financial, nutrition, housing, legal, counseling, or health) from community-based organizations, such as non-profit social service agencies, churches, schools, or neighborhood associations. We found that few had links with community-based social service agencies. Only seven women remembered ever receiving services other than the financial and health services already discussed. Among these, six received counseling (three at health centers, two at schools, and one at a mental health agency); two received legal assistance (non-profit agencies); one child was enrolled in Headstart; and one disabled child utilized transportation to a special school.

Participation in informal community support groups was not common either. Only 33 percent of the women attended church at least once a week, 13 percent attended monthly, and 55 percent attended less than monthly, usually on church-related holidays and festivals. Very few suggested that organized religion played an important role during their pregnancies. One family belonged to an evangelical denomination and their lives were dominated by church activities, but the remainder, while typically religious, were not involved in broader church activities. A few (12 percent) were involved in occasional school activities. Less than seven percent were engaged in any sports, politics, or ethnic organization activities. Even among the women who were involved in activities outside the home prior to pregnancy, many curtailed these activities when they became pregnant. Thus, low participation among the women in community-based organizations may reflect a number of issues (e.g., gender or stage in life cycle) that deserve further investigation.

**The Role of Family Support.** However, most of the women were deeply involved with their families. All but three of the women said family member gave support during their pregnancies. Almost all gathered with family members on a regular basis. Over a third of the women said they received no support of

any kind from friends (including *compadres*). More than half the women said they rarely or never socialized outside of family.

Moreover, our conversations with the women pointed to the key role played by family and friends in helping them make ends meet economically. In Mexico, families survived in the absence of government financial assistance with the help of extended families. To pay for migration, money was saved for the expensive and risky trip up north, usually to be repaid or reciprocated at a later date. In Chicago, reliance on family continued.

The women spoke about in-kind resources, financial assistance, and exchanges. For instance, one woman and her husband were making improvements on a small house owned by her father, who in turn charged them low rent. Her father's help and the small amount of pocket money she earned cooking and selling *tamales*, gave her a more optimistic view of their economic well-being than one would predict based on their income alone. Nine women rented their apartments from relatives (often a partitioned house), although not all received a reduction in rent.

These family support arrangements were often reciprocal. Families got help when they needed it, but they helped others when they were able. A woman (whose low birth weight baby had died) described how she always helped her family:

When I was single, I gave all my money to my father. . . . It was impossible [for him] to support all the little ones. Later, I gave half and kept half and [my husband and I] were able to start saving this January.

Another way that women said they coped financially was through pooling resources and expenses. Most of the women accomplished this by sharing housing with extended family or friends or living close to relatives. As one mother states, "A couple can't live alone [in an apartment] with the expensive rents and no jobs, so we have to live stacked up to be able to pay the rent." Another young mother of two, confiding that she did not eat well during her first pregnancy because of a lack of money, told how she and her husband decided to share an apartment with friends:

[In our own apartment] we had to save on food. We didn't buy anything in order to pay the deposit. After that, we had to repay a \$100 loan. That's how we were, and it was in April that this guy,

who was giving my husband a ride, . . . said, "Why don't you get together and share a place?" And so we rented with two other guys.

Even the women who did not share housing with other family members often lived close enough to share baby-sitting, meals, transportation, and other daily chores. Thus, although one-third of the women lived in nuclear households, and seven percent lived alone with their children, three-quarters of them had family members living within ten minutes of their home, many in the same building, across the street, or next door.

Although these arrangements were often financially necessary, they were sometimes difficult and discordant. Not uncommon was one woman who lived with her husband and his father, recently arrived from Mexico. The father-in-law did not have a job and had no money to help with rent, but the woman wanted him to make some kind of contribution to the household:

I tell [my husband], "If your father was someone else, if he helped you fix up the basement, then I wouldn't want to charge him, but all he does is eat and watch television. Tell your father to give some money for rent."

Many of the women we interviewed played important roles in keeping these shared living arrangements afloat. They cared for their own babies, and also for the children of working family members. They cooked, cleaned, dropped off and picked up children from school, shopped, arranged for one repair or another, transported and accompanied friends and relatives on errands, and took care of households' daily needs. A young woman who lived with her husband, her children, and her sister's family explained how they managed financially:

We go the cheaper stores where they have sales and discounts. And I say to my husband, "Don't worry about me." I don't go out of the house nor do I work, I keep busy with housework. I say to him, "You buy your sweater, jacket and tennis shoes, because you have to work. I will stay at home."

What happens in poor households when family is not available to help? It is difficult to exaggerate the importance of family, especially for women who lack legal immigration documents and speak only Spanish. One young mother described the difficulty



she and her husband experienced when they arrived in Chicago without family support:

When we arrived in Chicago we didn't even know where the airport was or what bus to take to see our cousins. We called and they didn't communicate with us, they had too much work, and were busy, they said they would call later. There were only Americans [around us], no one else. And we hardly ever went out . . . I was afraid of slipping on the ice and being seven months pregnant I couldn't.

Family support extends the limited economic resources of immigrant families, but how does that affect pregnancy and birth weight? There were indications that increased economic capacity through family support helped improve the well-being of pregnant women in several ways.

First, extended family households and families living in close geographic proximity shared cooking and provided food for one another. For example, one woman who said that she and her husband often did not have enough money, said that there was always enough for food because "we cooperate among all of us and although we don't have what we call great nutrition, there is enough." Another woman said that her brother gave her money for food early in her pregnancy:

"What do you eat? Only beans? That won't do your baby any good!" And I told him, "Well, [my husband] doesn't have any work." And he said, "Take this and go buy something to eat and I will eat when [your husband] finds work. Go on and buy fruit."

Second, by pooling resources and sharing housing, the women were able to afford better housing than they could have by themselves. This may have provided more women protection from cold winters and possible infections.

Third, some women were able to quit work or get help with housework when they experienced complications (such as bleeding) during their pregnancies because of the support they received from families. One woman said that her doctor:

told me that I had to quit working and stay home lying down doing nothing. So I quit working at six months. My mother-in-law took care of the older children.

Later, she had a normal birth weight baby, and although it is impossible to say whether quitting work prevented a premature delivery, it surely did not hurt.

Unfortunately, many of the women who experienced pregnancy complications had low birth weight babies even though they may have quit working in the course of pregnancy. But in some cases there were indications that poverty and lack of adequate family support may have delayed some women's decisions to leave work. For example, one woman described the onset of heavy bleeding in her second month of pregnancy. Her factory job required that she clean off large pieces of equipment, attach them to large hooks, and load them on a trailer:

That day I had to hook them because the other [worker] said she couldn't because her hand was hurt. So I had to handle the hook and put the 17 pieces on the trailer. . . . I said to the other *senora*, "Ay, this hurts me." My hips were trembling so much. . . . when I raised up, something burst. . . . I was bleeding and bleeding. . . . [She was taken to the emergency room] The doctor told me to rest for one week and I stayed at home for two days. . . . I returned to the factory and it happened again and then again another time.

At six months gestation, her baby was born. Her mother and siblings gave as much support as they could, but were not able to offer much financial help. With more financial resources to help support her large family, she might have been able to stay home after the first incident and possibly could have prevented a premature birth.

Economic arrangements in immigrant households typically resulted in daily contact among extended family members. For the pregnant women, this meant they received advice from family about how to care for themselves during their pregnancies. When we estimated the amount of advice that the women received during their pregnancies, we found that women who received more advice were more likely to have normal birth weight babies. Of the women who had normal birth weight babies, 17 (89 percent) received some or a lot of advice, while only 2 (11 percent) received little or no advice. Of the women who had LBW babies, only nine (43 percent) received some or a lot of advice, while 12 (57 percent) received little or none ( $p < .001$ ) (Appendix C).

This can be illustrated by a group of particularly extreme cases. We interviewed five women who had what we call "secret pregnancies." They told no one about being pregnant until they "showed" at five or six months or later. In four of these cases, the women were unmarried and were afraid or embarrassed to tell their families. In another case, a woman told her husband but did not tell her sister until she was seven months pregnant—*por pena*—because she was embarrassed to talk about it. Although each of these women eventually joined family members in Chicago, they were very socially isolated compared to other women interviewed. One young woman despaired "because no one knew [about the pregnancy] and I felt very poorly and asked myself 'what am I going to do?'"

Not only did women with secret pregnancies lack advice, they also did not receive prenatal care. Because most women we interviewed located prenatal care through family and friends, those who kept their pregnancies secret did not know where or were hesitant to seek care. All five of the women with secret pregnancies started prenatal care late, including one who did not go at all. One young woman said that the couple whom she lived with at the time "didn't know that I was pregnant. And when I was nine months they noticed. . . . Then, when they knew that I was pregnant, they took me [to the doctor]." Another woman, who began prenatal care at seven months, said she did not go earlier because

nobody knew that I was pregnant. I was alone. And my sisters and brothers didn't notice. . . . When I was seven months pregnant, my sister told me to go to the doctor.

Significantly, four of the five women with secret pregnancies had low birth weight babies.

### Summary and Conclusions

Research on birth weight has pointed to a persistent relationship between poverty and low birth weight. But the impact of poverty on birth weight appears to differ among various groups. Babies of Mexican descent are relatively less likely to be born low birth weight compared to other groups with low incomes. Babies whose mothers were born in Mexico—who are likely to have even

less income—are even less likely to be born low birth weight. It has been suggested that Mexicans have been able to “beat the odds” in part through the support of formal services, community support, and family support. The results of this qualitative study suggest that family support, and to a lesser extent, medical and nutrition services, do make a difference.

Family support appears to have two important effects. First, it mediates the effects of moderate poverty. Economic survival strategies, such as mutual aid, sharing household expenses, and using in-kind resources, “stretch” incomes for these families. Family support plays a particularly important role in nutrition, housing, and physical well-being. Second, “sticking together” economically also means that women are less socially-isolated during their pregnancies. Family members are in a position to provide advice and guidance to the women during their pregnancies. The women receive advice about physical (especially nutritional) and emotional well-being. It is also important to note that the numbers of family members or people who give advice is not nearly as important as the quality of those relationships, including geographic and emotional proximity and available resources.

The potential impact of family support is illustrated clearly in the case of women with secret pregnancies. Women with secret pregnancies did not receive family support. Therefore, they did not receive emotional support during their pregnancies, nor did they receive advice about how to care for themselves in pregnancy. Finally, they did not receive encouragement from family and friends to seek prenatal care. Among those who had secret pregnancies, almost all had low birth weight babies.

Family support, however, does not help all women avoid having low birth weight babies. We find that the effects of more extreme poverty are difficult to overcome. Oakley (1992) observes that “the health-promoting effects of social support cannot cancel the health-damaging effects of poverty” (p.326). We find that this is particularly true for the women who were the poorest.

These results underscore the important role that social service providers can assume in identifying and assisting childbearing women who find themselves in extreme poverty without support from family members. For example, medical social workers, who are increasingly concentrating their efforts on discharge planning,

the back end of health care, could move to the front end where they might play a significant role in prevention. A relatively efficient method of preventing low birth weight among Mexican immigrants might be for social workers to develop a relationship with the women during their *initial* pregnancy screening visit. Although many women do not attend prenatal care visits regularly, most seek a pregnancy test fairly early (Sherraden & Barrera, forthcoming). It is important to develop mechanisms to reach the women who may show up infrequently. For women who are assessed to be vulnerable (the very poor and the socially-isolated), initial interviews could be followed by home visits with community outreach workers. Home visits would further build trust and permit an assessment of the women's situations. Where poverty and social isolation make it difficult to maintain healthy pregnancies, needed services and support can be arranged. Without such efforts, there is little that would bring the most vulnerable women to the attention of service providers until a pregnancy complication occurs.

It is a greater challenge to reach women who do not seek care within the first two trimesters of their pregnancies, especially those with secret pregnancies. Improving access to prenatal care is important, but probably would not attract women who are actively keeping their pregnancies secret. Community-based organizations (such as churches or social service agencies) that provide a variety of outreach and support services to young immigrant women are one possible way to reach women in this situation. Unfortunately, we have seen in this study that many pregnant immigrant women are not linked to community-based organizations. It is important to point out that community-based supports—especially churches—may play a more notable role in the lives of other family members (at different life stages, perhaps) that contribute to the ability of family members to support pregnant women. One way to reach young mothers is to utilize their social networks. In this study, we find that family networks are the principal social contacts for pregnant women. Community-based organizations could use contacts with extended family members in order to reach others. Additional research and outreach efforts are needed to explore ways that these young women are connected to community-based supports and ways that they can be reached successfully.

Among women who are already in contact with the health and social service sectors, it is important for providers to acknowledge and help sustain support that women are receiving from family. For example, during a woman's pregnancy, providers should take into account the possibility—indeed, the likelihood—that family is involved in mediating the impact of poverty on pregnancy. Considerable care should be taken to understand these relationships and to sustain valuable family support.

Social workers should be concerned about the relatively small role played by formal social services in the lives of immigrant women in their child bearing years. Although not statistically associated with differences in birth weights, the availability of nutritional supplements, and prenatal and birthing care took a certain financial burden off of families. But high levels of poverty and low levels of assistance overall suggest the need for greater attention to the basic needs of these families, perhaps especially after their babies are born. The political and cultural circumstances of Mexican immigrants require that policies and programs be given close scrutiny, and adapted to meet particular needs. Unfortunately, in the current US political climate, we cannot be hopeful about increased attention to services for immigrants, especially undocumented immigrants.

Although caution must be taken not to generalize our findings to all Mexican immigrants or to other groups, the relationships that emerge appear to be strong. Research with larger samples is needed to analyze the complex relationships among poverty, family support, and birth weight. Moreover, it is important to distinguish by level of poverty, especially among populations with high proportions living in poverty. Although standard poverty measurements can be useful, they also conceal important information about the economic well-being of certain groups. A more specific assessment of economic well-being may help to unravel the effects of poverty on birth weight and other health and social problems.

In addition, studies are needed that examine how Mexican women continue to cope after their babies' births and how succeeding generations of Mexican Americans cope with poverty and childbearing (Guendelman, et al., 1990). For example, Mexican American infants and children may be at higher risk for health problems, including mortality, during the first year of life because

of poverty conditions (Guendelman, et al., 1995). In addition, we may find that level of family support dwindles in succeeding generations, as acculturation increases. Over generations—as the children grow up in a US urban poverty environment—levels of family support may not have the same mediating impact on poverty.

The findings reported in this paper speak to fundamental issues in social policy—issues that are currently in the nation's agenda: What, if any, is the appropriate role of the state in the life and well-being of the family? It has become fashionable to say that social policy intervention can only interfere with "natural" family strengths and ultimately cause harm. But is this always the case?

The population in this study is characterized by many family strengths and is largely unaffected one way or the other by social policy. Social policies should by all means recognize and build on these strengths. Nonetheless, the poorest are not protected by family support. Families clearly cannot do everything in all circumstances. The results of our study underscore the importance of outreach and support to families who do not have the minimal resources to help themselves.

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An earlier version of this paper was presented at the Midwest Sociological Society Annual Meeting, St. Louis, Missouri, March 12, 1994. This study was generously supported by the Robert Wood Johnson Foundation and the University of Missouri. We are grateful for helpful comments and suggestions by Dr. Hector Balcazar, Dr. Pastora San Juan Cafferty, Dr. Steven Wallace, and anonymous reviewers for *Journal of Sociology and Social Welfare*. Thanks for the assistance and support of Richard Ferguson, Eva Hernández, Dr. Richard David, Dr. Howard Ehrmann, and Dr. Aida Giachello; Kathy Julio and Melissa Robinson who helped with transcriptions and data entry; and especially from the women who gave freely of their time to help us understand the dynamics of pregnancy care in the immigrant community.

## APPENDIX A

SOCIAL AND ECONOMIC CHARACTERISTICS  
OF MEXICAN IMMIGRANT WOMEN

(n=41)

	Number	Percent
Under 20 years of age	6	14.6
Rural origin	28	68.3
Migrated		
Alone	4	9.8
Under 17 years	8	19.5
Under 20 years	22	53.7
Undocumented	27	65.9
Time in U.S.		
Less than 1 year	7	17.1
Less than 5 years	22	53.7
Years lived in Mexico		
<20 years	22	53.7
<10 years	2	4.9
Never married	11	26.8
Non-high school graduate	31	75.6
Household composition		
Extended <sup>1</sup>	24	58.5
Nuclear	13	31.7
Single	3	7.3
Income under \$900/month	19	46.3
Below poverty	28	68.3
Below 50% of poverty	9	22.0

<sup>1</sup>Households that include members of extended family or friends (usually *compadres*).

**APPENDIX B**  
**SOCIOECONOMIC VARIABLES AND BIRTH WEIGHT**

	LBW <sup>1</sup> n=22 (%)	NBW n=19 (%)	N	X2
Currently not employed	77.3	73.7	41	0.07
Schooling <8 years	81.8	36.8	41	8.67***
Below poverty <sup>2</sup>	77.3	57.9	41	1.77
Below 50% of poverty	36.4	5.26	41	5.76*a
Income under \$900/month <sup>3</sup>	63.6	26.3	41	5.71*
Perceived poverty Extremely difficult/difficult	81.8	36.8	41	8.67***a
Never send remittances to Mexico	76.2	47.1	38	3.43#a
Never save money	90.5	52.9	38	6.83**a
Baby's father				
Not employed or unknown <sup>4</sup>	27.8	5.3	37	3.45#a
Undocumented	47.1	23.5	34	2.06

Chi Square probability: # < .10, \* < .05, \*\* < .01, \*\*\* < .001

<sup>a</sup>Chi Square probably is computed without requisite expected cell size.

<sup>1</sup>Under 2500 grams or 5.5 lb.

<sup>2</sup>Includes all sources of income.

<sup>3</sup>Official poverty line for 1992, calculated using all sources of income and number of dependents

## APPENDIX C

FACTORS THAT MEDIATE EFFECTS OF POVERTY  
ON BIRTH WEIGHT

	LBW <sup>1</sup> n=22 (%)	NBW n=19 (%)	N	X2
Formal social services				
No medical coverage	40.9	57.9	41	1.18
No AFDC	68.2	100.0	41	7.29**a
No food stamps	59.1	94.7	41	7.02**a
No counseling	86.4	73.7	41	1.04
Community-based support				
None or occasional church	61.9	50.0	39	0.56
Family support				
Extended family household <sup>2</sup>	68.2	47.4	41	1.82
Less than five social supports utilized <sup>3</sup>	54.6	36.8	41	1.28
Any substance use during pregnancy				
Cigarettes <sup>4</sup>	4.6	11.1	40	0.62
Alcohol <sup>5</sup>	22.7	11.1	40	0.93
Illegal Substance(s) <sup>6</sup>	0.0	0.0	41	—
Little or no advice <sup>7</sup>	57.1	10.5	40	9.53***

Chi Square Probability \* = .05, \*\* = .01, \*\*\* = .001

<sup>a</sup>Chi Square probability is computed without requisite expected cell size.

<sup>1</sup>Under 2500 grams or 5.5 lb.

<sup>2</sup>Households that include members of extended family or friends.

<sup>3</sup>Social supports utilized in the previous month (Barrera, 1980)

<sup>4</sup>Includes infrequent, occasional, or frequent smoking during pregnancy.

<sup>5</sup>Includes infrequent, occasional, or frequent alcohol consumption during pregnancy.

<sup>6</sup>Includes infrequent, occasional, or frequent use of any illegal substance during pregnancy.

<sup>7</sup>Qualitative measure of advice and availability of person during pregnancy.