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ORIGINAL PAPER

Exploring Knowledge, Belief and Experiences in Sexual and Reproductive Health in Immigrant Hispanic Women

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Abstract This study examined the transformation of immigrant women's knowledge, belief and experience with regard to sexual and reproductive health after living in the US. Four focus groups (N = 24) were held with Hispanic women ≥18 years old. We identified two main themes (Fertility/Knowledge and Gender power) with five subthemes (Sex education, Contraception and unintended pregnancy, Men versus women, Intimate partner violence, and Immigrating to the US). Most of these women were raised in a very restricted family context where talking about sex was viewed as sinful. In spite of their own experiences of sexual silence and the consequences to their lives, women valued the positive changes achieved by immigrating to the US; they felt empowered to make their own decisions regarding reproductive health.

Keywords Acculturation · Hispanic women · Immigration · Reproductive health · Sexuality

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Introduction

Hispanics are the largest (16 % of total population) and fastest growing minority group in the United States [1]. Most of the nation's growth from 2000 to 2010 was due to Hispanics (56 % of total population growth) [2]. Of the 50.7 million Hispanics living in the United States, 49 % are women [3]. Hispanic women have the highest total fertility rate (2.4) of all ethnic groups [2]. Pew Hispanic Center [4] reported that 52 % of all Hispanic women in the US were born in other countries, and 60 % of the Hispanic immigrant (HI) women in the US were born in Mexico.

Mexican immigrant women are the most vulnerable group among HI women. Pew Hispanic Center reported in 2007 that Mexican immigrant women are less likely than other HI women to be naturalized citizens. The same report stated that 59 % of Mexican immigrant women have less than a high school diploma, compared with 19 % of HI women from South America. Mexican immigrant women are the least likely of all HI women to be employed, and have the lowest median weekly income [4].

Mexican immigrant women are more likely than other HI women to give birth (106 vs. 84 births per 1,000 women) [4]. This high birth rate among Hispanic women has been associated with lack of contraception use due to problems with accessibility [5, 6], pregnancy coercion [7, 8], concern about contraception side effects [9, 10], and the impact of acculturation [11–15]. Wilson [16] reported that Hispanic women born in the US were more likely to use contraception than immigrant Hispanic women. Of all Hispanics, Mexican women are less likely to participate in decisions about fertility. The National Institute of Statistics of Mexico reported that only 51 % of Mexican women participate in the decision regarding the use of contraception [17]. A study of Mexican pregnant women reported

than more than half of the women described the pregnancy as "unintended; however, most of the women in the study did not use contraception to prevent the pregnancy due to partner control about fertility [18]. Castro [19] proposed that in a typical Mexican couple's relationship, men develop control over women. Such controls decrease the autonomy that a woman has over her body. Castro [19] emphasizes "the partner seeks to get her pregnant … to express his power over her, to control her sexuality, and perhaps to assure her fidelity."

When a Hispanic woman immigrates to the US, she brings all her beliefs and previous experiences about sexuality and reproductive health care. There is a gap of knowledge about how previous experiences in their country of origin are affecting Hispanic women's health decisions. In this study, we used a qualitative approach to gain a better understanding of the process of transformation of immigrant women's knowledge, beliefs and experiences around sexual and reproductive health as a result of living in the US.

Methods

This study draws on qualitative data collected from four focus groups (N = 24) conducted during September to December 2011. The study used a convenience sample of primarily Mexican immigrant women in a large urban center in Kentucky. Hispanic women were recruited from two ESL (English as a second language) community centers and a public library. Flyers were posted at each site inviting Hispanic women to participate in a discussion group. Key staff members at each site collected names of interested women who were 18 years or older. Participants provided informed written consent. The women received a $15 gift card for their participation. Snacks and child care were provided during the discussions. The study was approved by the Institutional Review Board at the University of Kentucky.

Instruments

At the beginning of each focus group, participants were asked to complete a baseline survey of sociodemographic characteristics such as age, marital status, educational level, income, and length of time living in the US and Kentucky. The Short Acculturation Scale for Hispanics (SASH) was used to assess the degree of acculturation [20]. The SASH assesses participants' language use, media preference, and ethnic-social relations. Scores range from 5 to 25, with a low score representing a lower degree of acculturation [20]. The overall Cronbach's Alpha for this sample was .80, indicating that the scale maintains dependability, internal consistency, accuracy, and comparability [21].

Procedure

Focus group questions were prepared in both English and Spanish, but all focus groups were conducted in Spanish. Focus groups were held in private rooms at the ESL Center and the public library. At the beginning of each session, "ground rules" pertinent to study participation were explained. These included the need for confidentiality regarding information shared by all participants throughout the study, the importance of avoiding discussion of personal health conditions and the health status of specific people, and the need for mutual respect among participants. Focus groups lasted from 1 ½ to 2 h. The researchers took turns as facilitator and note-taker. At the end of each session, both researchers were available for questions and allowed ample time for responses.

Data Analysis

Data from the sociodemographic survey and the SASH were analyzed using SPSS. Focus group recordings were professionally transcribed verbatim and checked for accuracy by the researchers. Digital recordings, transcripts, and notes from the focus groups were used to develop the resulting themes. ATLAS/ti® was used for coding, text retrieval, data management and context analysis of data. The analysis focused on emerging themes across focus group discussions. Themes were independently checked for accuracy by each of the researchers. Overall, there was high agreement between investigators.

Results

Participant Characteristics

Demographic data are described in Table 1. All respondents were HI; the majority were Mexican (87.4 %). Most of the participants (91 %) had lived at least 5 years in the US; however, all women had a low level of acculturation (SASH Mean score 7.96, $SD \pm 3.15$). The majority (61 %) spoke only Spanish. Only one woman stated that she spoke English and Spanish equally at home and watched TV programs mainly in English. In speaking with their friends, 69 % of participants spoke only in Spanish, and 43 % stated that their close friends were only Hispanics (Table 2). We identified two main themes: Fertility/Knowledge and Gender power; with 5 subthemes: Sexual education, Contraception and unintended pregnancy, Men

Table 1 Descriptive characteristics of participants (N = 24)

Characteristics	# of women	% of women
Country of origen		
Mexico	21	87.4
Peru	1	4.2
El Salvador	1	4.2
Guatemala	1	4.2
Live with partner		
Yes	19	79.2
No	5	20.8
Currently employed out home		
Yes	14	58.4
No	10	41.6
Income per week		
< $250	8	33.3
$250–$350	4	16.7
Refused	12	50.0
Education[a]		
Elementary school	8	36.4
Some High school	8	36.4
High school	5	22.7
Some college	1	4.5
Total time living in the US[b]		
≤5 years	2	8.7
5–10 years	12	52.2
>10 years	9	39.1
Total time living in Kentucky[b]		
≤5 years	6	26.1
5–10 years	12	52.2
>10 years	5	21.7
Health insurance[b]		
Yes	1	4.3
No	22	95.7

Mean age: 33.4 (SD ± 8.4)

[a] Data missing for two participants

[b] Data missing for one participants

versus women, Intimate partner violence, and Immigrating to the US.

Fertility and Knowledge

Sex Education

The prevailing opinion was that the quality of sex education these women received in their country of origin was poor. Sex was viewed as a sinful in their hometown and family environment. Most women learned about sex outside of the home, and heard about contraception and sexually transmitted diseases at school and with friends:

> "I learned about pregnancy and avoiding pregnancy when I completed an assignment at school; it was about AIDS. That's where I learned everything about contraception–natural, chemicals, injection, and condoms."
>
> "My Mom was harsh, and she never sat with me and never told me, look girl this could happen to you, if you have sex with your boyfriend, you'll get pregnant. No, my Mom never told me that, she never taught me. Then I learned at school and with friends."

Participants said that the message they received from their family was "fear of becoming pregnant," but they did not identify ways to prevent pregnancy. Adult family members' use of threats as tactics is clearly expressed by one participant's words:

> "The only thing that they told me was if you become pregnant you leave the house."

Contraception and Unintended Pregnancy

In every focus group, women discussed how lack of sexual knowledge at home contributed to unintended pregnancies. Although women learned from friends at school that having sex may lead to unintended pregnancy, the majority of them initiated a secret intimate relationship without protection. Women stated that they were too uncomfortable asking for contraception:

> "It was not easy to go to a pharmacy and ask, sell me the pills, because in my town that was too much…everybody would know, you know we were young, and then it was something like a scandal of the town."
>
> "Even though I knew that I was at risk [of pregnancy], I couldn't go, I was ashamed to buy contraception. I got pregnant, and it was too late to regret it."

Women stated that after having a partner/spouse, they did not talk with them about contraception. Some women also said that their partner did not want them to use contraception and most women complied without complaint; even when they disagreed. Participants agreed that they learned more about contraception and were encouraged to use it when they had contact with a health care provider after immigrating to the US:

> "My husband and I never talked about it [contraception]. I delivered my first child and a year after my second child was born, and I never had information. I didn't know about pills, but when I had my baby here (U.S.) they gave me pills and told me to take it. I didn't know how to do it, but they taught me."

Table 2 Women participants' itemization of short acculturation scale for Hispanics (N = 23)

Language usually:	Only spanish		Spanish more than english		Both equally		More english than spanish		Only english	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Read and speak	14	61	9	39	0	0	0	0	0	0
Speak at home	19	83	3	13	1	4	0	0	0	0
Speak with friends	16	69	5	22	2	9	0	0	0	0
Watch TV programs	11	48	3	13	4	17	4	17	1	4
	All Hispanic		More Hispanic than American		Both equally		More American than Hispanic		All American	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Your close friends are	11	48	6	26	4	17	2	9	0	0

Some women had already had a tubal ligation. Women stated that the decision about tubal ligation was made based on the inability to use other contraception methods: due to partner control over fertility; tubal ligation was seen as the only way to stop having children. Some women got this procedure as young as 19 years old. They made the decision without a deep understanding of the consequences of tubal ligation:

> "My husband was very irresponsible and my pregnancies too close together and I had no experience, no one to help me. They knew (health providers from the country of origin) I had no information, nothing, and then the doctor told me, if you want the surgery sign here, I was desperate so I signed. I was 19 years old."

Gender Power

Men Versus Women

Most of the women were raised in a patriarchal environment. In their hometown, boys had more opportunities to study and progress. Most of the time men were allowed to go to school while women stayed home. Participants emphasized the belief that men are different from women: if a man has different partners he will gain prestige in the Hispanic community; if a woman has different partners she will gain a bad reputation.

Intimate Partner Violence

Most women described psychological, physical and sexual abuse by their partner. They described as stressful the search for a "good" partner. Women were taught by their mothers that after partnering with a man they must continue the relationship no matter the cost. Consequently, if a woman was abused; she accepted the burden of abuse as normal and hid its consequences. Her family did not offer support to end the relationship:

> "My mom told me, if you got married, then you hold out."
> "My mom said, no one told you to choose him as a partner, so now if he abuses or says ruthless words, you hold out, you cannot leave him, he is the father of your children."

Some examples of partner abuse included forced sex when the woman did not want it, pregnancy coercion, control over the use of contraception, insults and intimidation to leave the woman if she did not become pregnant, or threats to abandon her if she did not deliver a baby of a particular sex. Although these experiences resulted in diminished self-esteem, in most cases women continued with the relationship until they came to the US:

> "Men are 'machista,' he yelled at me that I was using contraception to have the liberty to have sex with others."
> "He was furious and said if you do not have a baby boy I'm going to have him with other women."
> "He abandoned me because a baby boy was born and he told me he wanted a girl. I was left alone with my baby."

Immigrating to the US

In general women expressed the belief that immigrating to the US changed their life and their partner's behavior. Being in the US empowered them and made them feel more liberated to talk about sexuality and other topics such as contraception, family planning, and prevention of sexually transmitted diseases. Women stated that they came to the US to work and to provide children with better opportunities. Most of them did not want to become pregnant and felt that to be a suitable provider, the number of children should be limited:

> "Here [in the U.S.] it's not like give birth to all the children that God sends…here you need to provide for your children. I would rather raise one that I know I will provide food for, and not raise several than may starve. Although we are in a country of opportunity, unfortunately, if you don't work, they [home landlord] kick you out into the street and your children pay the consequences."

Women believed that since coming to the US they developed autonomy over their own body. The prevailing belief was that contraception is more available in the US; as one woman said, "If you get pregnant here it's because you want it, because it's so easy to get contraception."

We asked the women for recommendations to improve reproductive health. They highlighted the necessity of having more health care providers with cultural and linguistic competence to promote sexual and reproductive health in women.

Discussion

This study examined, in a cohort of Mexican immigrant women, the transformation in knowledge, belief and experience about sexual and reproductive health as a result of living in the US. Most of the participants had lived 5 or more years in the US; however, their level of acculturation was low, denoted by a low level of English proficiency. Women reported feeling more comfortable in the company of friends of the same ethnicity, similar to Bacallao and Smokowski's [22] finding that Mexican adolescents often had a positive relationship with Hispanic peers, who were a valuable source of support.

This group of women had life experiences that influenced their decisions about their own fertility. The women were raised in a very strict family context where talking about sex was viewed as sinful. Their mothers used scare tactics to pressure them to avoid pregnancy. Gilliam [23] reported that this method is mainly used by Hispanic parents to keep their daughters innocent. Paradoxically, this tactic usually has undesired consequences such as the initiation of secret sexual activity without protection due to the inability to ask for contraception, resulting in an unplanned pregnancy. Restrictions against talking about contraception persisted in the relationship with their partners, facilitating an environment in which the partner controlled fertility. Several authors have described this tactic where the partner seeks to get the woman pregnant as a way to express his power over her, control her fertility, and assure her fidelity [7, 8, 19]. What makes Hispanic men feel powerful in their relationships has been described as traditional domains of relationship power; describing power as decision-making dominance and relationship control [24]. Desperate decisions were made as a result of this sexual silence and pregnancy coercion experiences. Some women agreed to tubal ligation as the only way to control their fertility. Rudzix et al. [25] reported in a study in Puebla, Mexico that the rate of tubal ligation was 42.2 %; with younger age and increased parity being associated with women's decision to undergo tubal ligation.

In speaking of their own experiences of sexual silence and the consequences that this brought to their life, women valued the positive changes associated with immigrating to the US. Women saw an opportunity for transformation when they arrived in the US, empowering them in their decisions about reproductive health. Women expressed that through health care providers in the US, they have obtained information about sexuality, contraception and sexually transmitted disease. This increased knowledge has helped them to make informed decisions about fertility and given them a sense of empowerment. Women also value the economic independence that they have achieved in the US; participants reported that women who are not able to work are more likely to be in an abusive relationship with a partner who manipulates their sexuality.

Our findings suggest that women view themselves as more communicative and open to talk about fertility topics with their partners and also willing to seek help from health care providers. While women value their previous experience, the transformation in knowledge and belief has triggered an open communication with their children [26].

A noteworthy finding was that a low level of linguistic acculturation does not mean a low level of assimilating health care practices. Rather, this group of immigrant women revealed a positive perception of contraception and valued the status of making their own reproductive health decisions. Some authors have described that a bicultural identity is developed in immigrants, helping them to maintain strong identity with their country at the same time they are exposed to US culture [22, 27].

PEW reported that about 34 % of Mexicans are without insurance coverage [28]. Even though method of payment could be a barrier to accessing preventive care [29, 30]; the majority of women (95 %) in our study reported access to regular annual check-ups in free clinics. Health system barriers, patient cultural beliefs, and life circumstances are more likely to prevent Hispanic immigrant women from seeking health care.

Conclusion

In spite of their own experiences of sexual silence and its consequences, women valued the positive changes achieved by immigrating to the US—not only improved

economic status, but also empowerment in their decisions about reproductive health issues.

Due to the small size of this exploratory study, and because the women in this study were predominantly Mexican, we cannot claim that the sample is representative of all Hispanic immigrants, or even of all Mexican immigrants. Nevertheless, the study provides a significant look into the experiences and attitudes of Hispanic immigrant women in Kentucky and how the experience of immigration changes attitudes about reproductive health. Future studies should address topics such as providing opportunities for Hispanic women to discuss culturally sensitive issues and to facilitate open discussions with their partners and children. We recommend increasing access to preventive care, building on educational interventions, and accessing places where Hispanics women usually visit such as ESL, churches, and libraries.

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