

Listening to the voices of Latina women: Sexual and reproductive health intervention needs and priorities in a new settlement state in the United States

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Abstract:

Latina women in the United States are disproportionately affected by negative sexual and reproductive health outcomes. Our community-based participatory research partnership conducted in-depth interviews exploring sexual and reproductive health needs and priorities with 25 Latinas in North Carolina and identified themes through constant comparison, a grounded theory development approach. Participants described individual-, interpersonal-, and clinic-level factors affecting their sexual and reproductive health as well as potentially successful intervention characteristics. Our findings can be used to inform culturally congruent interventions to reduce sexual and reproductive health disparities among Latinas, particularly in new settlement states in the southeastern United States

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Article:

Latina women in the United States are disproportionately affected by negative sexual and reproductive health outcomes. Our community-based participatory research partnership conducted in-depth interviews exploring sexual and reproductive health needs and priorities with 25 Latinas in North Carolina and identified themes through constant comparison, a grounded theory development approach. Participants described individual-, interpersonal-, and clinic-level factors affecting their sexual and reproductive health as well as potentially successful intervention characteristics. Our findings can be used to inform culturally congruent interventions to reduce sexual and reproductive health disparities among Latinas, particularly in new settlement states in the southeastern United States.

The Latino population is growing rapidly in the United States, particularly in southeastern states such as North Carolina. In these new settlement states, bilingual and bicultural infrastructure and resources to meet the growing Latino population's needs are less developed (Barrington, Messias, & Weber, [3]; Glen, [14]; Painter, [23]; Song et al., [31]), compounding significant health disparities experienced by Latinos. Our community-based participatory research (CBPR)

partnership qualitatively explored the sexual and reproductive health needs and priorities of Latinas in North Carolina and gathered specific recommendations on intervention delivery and content to promote sexual and reproductive health among this population. These findings will be useful to researchers and practitioners working to improve sexual and reproductive health, facilitate use of sexual and reproductive health services, and reduce sexual and reproductive health disparities among Latinas and other vulnerable communities such as ethnic/racial minority and immigrant women.

Between 2000 and 2010, the Latino population increased by 43% in the United States and by 111% in North Carolina. Currently, North Carolina has the sixth fastest-growing Latino population in the country (Ennis, Rios-Vargas, & Albert, [11]). Latino populations are disproportionately affected by negative sexual health outcomes, including HIV and other sexually transmitted diseases (STDs). Nationally, rates of HIV among Latinos are three times higher (Centers for Disease Control and Prevention [CDC], [6]) than among Whites and more than double for chlamydia, gonorrhea, and syphilis (CDC, [7]). Compared with their counterparts from other ethnic/racial groups, Latinas also have the second highest cervical cancer incidence and death rates (U.S. Cancer Statistics Working Group, [34]) and are less likely than White women to have ever had a Pap test (American Cancer Society, [1]; Martinez, Chandra, Febo-Vazquez, & Mosher, [19]; Shi, Lebrun, Zhu, & Tsai, [30]). These disparities are more pronounced for foreign-born Latinas, who experience screening rates 25% to 40% lower than U.S.-born Latinas (American Cancer Society, [2]; Tsui, Saraiya, Thompson, Dey, & Richardson, [33]). Additionally, Latinas are less likely to receive family planning services compared with White women (Martinez et al., [19]), and over half of pregnancies among Latinas are unintended, compared with 40% among White women (Masinter, Feinglass, & Simon, [20]).

Recognizing these health disparities and perceiving a lack of sexual and reproductive health resources for Latinas locally, members of our longstanding NC community-based participatory research partnership (e.g., Rhodes et al., [27]) advocated for a focus on Latina health. Through this study, we built on our partnership's experiences with Latina sexual and reproductive health (Cashman, Eng, Simán, & Rhodes, [5]; Mann, Foley, Tanner, Sun, & Rhodes, [17]; Rhodes et al., [25]) and with *Hombres Manteniendo Bienestar y Relaciones Saludables* (Men Maintaining Wellbeing and Healthy Relationships; HoMBReS), HoMBReS-2, and HoMBReS Por un Cambio, efficacious interventions designed to reduce HIV risk among Spanish-speaking Latino men in North Carolina (Rhodes, [24]).

Methods

Participant recruitment

In December of 2013, we recruited 25 study participants. Inclusion criteria included being ≥ 18 years old; being female; self-identifying as Hispanic or Latina; and speaking Spanish. Participants were recruited via snowball sampling. We specifically interviewed Latinas who were connected to the implementation and evaluation study of the HoMBReS Por un Cambio intervention (Rhodes, Leichter, Sun, & Bloom, [26]) through their male partner, relative, or friend, as these women would have a context to provide insights about existing health behavior interventions. A Latino man who participated in HoMBReS Por un Cambio identified Latinas

and invited them to participate, and participants also referred other female friends and relatives to the study. Interviews were conducted in participants' or their friends' homes, based on preference and convenience. Each participant signed a Spanish-language informed consent form and received \$40.00 (U.S.) for her time. The Wake Forest School of Medicine Institutional Review Board approved all study protocols.

In-depth interviews

Individual in-depth interviews were conducted; qualitative methodology was selected as it allows for an exploration of participants' insights and experiences. The interview guide was created with careful consideration to wording, sequence, and content (see Table 1).

Interviews ranged from 45 to 90 minutes, were audio-recorded, and were conducted in Spanish by one of two bilingual and bicultural members of our research team who were trained in qualitative data collection and sexual health research. One interviewer was a native Spanish-speaking man from Nicaragua and the other was a white U.S.-born female, fluent in Spanish; therefore, each shared interview participants' perspectives in some respects but differed in other ways (i.e., gender and ethnic/racial identity). Through differences between interviewers and participants, researchers can uncover responses that are often omitted as common knowledge if an interviewer and participant share the same attributes or experiences. Similarities between an interviewer and participant can increase the level of comfort that participants feel, resulting in increased disclosure (Lett, [16]; Seal, Bloom, & Somlai, [29]; Thomas, [32]).

After each interview, the interviewer listened to the recording and took detailed notes to document content (e.g., transcribing quotations verbatim). Interviewers also noted observations about potential emerging themes and topics to emphasize in subsequent interviews. Participant demographic data to describe the sample were collected using a brief interviewer-administered Spanish-language written assessment.

Data analysis and interpretation

Interview data were analyzed using constant comparison (Charmaz, [9]; Glaser & Strauss, [13]; Miles & Huberman, [22]), an approach to developing grounded theory. Data were inductively analyzed with particular attention to sexual and reproductive health needs, experiences, and intervention recommendations. After all interviews were completed, our research team created a data table to summarize and refine codes (Glaser & Strauss, [13]). We came together to compare and contrast broad content categories based on each member's interpretation of the data table and to develop and revise themes and subthemes using an iterative process. During this process, we identified the social-ecological model, which emphasizes the interrelations between individuals and their environment and recognizes the factors that influence health at multiple levels, as a useful framework for structuring and understanding findings (Bronfenbrenner, [4]; McLeroy, Bibeau, Steckler, & Glanz, [21]). Two members of our team applied the finalized codes to the interviews and completed a matrix to compare between and within individual similarities and differences; the matrix was then reviewed by six of our team members representing multiple universities and a local Latino-serving community-based organization to allow for triangulation of findings (Miles & Huberman, [22]). There was high consistency among raters, and

discrepancies were resolved by discussion. Quotations have been translated into English and edited for readability and clarity. We explored sample characteristics with descriptive statistics using SPSS 21.

Table 1. Domains and abbreviated sample items from in-depth interview guides.

- Background
 - What is life like as a Latina woman in North Carolina?
- Health priorities
 - As a woman, what are your main concerns related to your health?
 - What does sexual and reproductive health mean to you?
 - What is an important concern that you have related to your children's sexual or reproductive health?
- Access to services
 - How frequently do you get medical check-ups?
 - If you were sick, where would you go to receive medical attention?
 - How does immigration status affect Latina women in seeking health services?
- Protecting sexual and reproductive health
 - What do you do to maintain good sexual or reproductive health?
 - Which tests or exams have you had (i.e., HIV tests, STD tests, Pap test, mammogram)?
 - What have been your experiences with family planning? With pregnancy?
 - What do you know about the sexual health education that is provided to children and youth?
- Sexual and reproductive health needs
 - What are the challenges that make it hard for you to take care of your sexual or reproductive health?
 - What is a topic you would like to learn more about related to sexual or reproductive health?
 - What would help you to keep your children healthy?
- Communication about sexual and reproductive health
 - What have you learned about sexual or reproductive health from other Latina women? How much do you trust this information?
 - What has been your experience talking with your partner about sexual or reproductive health?
- Social networks
 - What types of things do Latina women do to support and help one another?
- About the HoMBReS Por un Cambio intervention
 - What do you know about HoMBReS Por un Cambio? What is your opinion of the project?
- About an intervention for Latina women
 - If you were to participate in an educational program about your body and how to take care of your sexual or reproductive health, what should it be like (i.e., session number and length, location, facilitator)?
 - What would be the best way to recruit Latina women like you for the program?
 - What would be some of the barriers that would make it difficult for Latina women to participate in this training? What would be some solutions?
 - How would you feel about participating in an educational program about sexual or reproductive health with your daughter? With other women from your family?

Results

Participant characteristics

Participants were between the ages of 21 and 47 (mean = 33) years. All participants were born in Mexico, and participants reported living in the United States for an average of 13.5 (range = 5–19) years. The majority spoke only Spanish (60%), and none of the participants had a valid state-issued driver's license (used as a proxy for immigration status; at the time of data collection, NC Department of Motor Vehicles had not issued driver's licenses to individuals without social security numbers since 2006; Gill, [12]). All participants had children, and 80% were married or partnered. Few participants had a high school diploma or more (16%), were employed (16%), or had health insurance (12%). Select characteristics are summarized in Table 2.

Table 2. Sample demographic characteristics (N = 25).

Characteristics	Mean (SD; range) or n (%), as appropriate
Age in years	32.74 (6.57; 21–47)
Years in U.S.	13.47 years (3.96; 5–19)
Years in North Carolina	11.60 years (4.35; 4.25–19)
Marital status	
Single	4 (16%)
Partnered	10 (40%)
Married	10 (40%)
Separated	1 (4%)
Number of children	3.13 (1.12; 2–6)
Living with ¹	
Spouse or partner	20 (80%)
Child(ren)	21 (84%)
Other family members	2 (8%)
Highest level of education	
Less than high school	21 (84%)
HS diploma or equivalent	3 (12%)
4-year college degree or more	1 (4%)
Current employment status	
Full-time or part-time	4 (16%)
Not employed	21 (84%)
Language most comfortable speaking	
Only Spanish	15 (60%)
More Spanish than English	5 (20%)
Both equally	5 (20%)
Language most comfortable writing	
Only Spanish	19 (76%)
More Spanish than English	1 (4%)
Both equally	4 (16%)
More English than Spanish	1 (4%)
Physical health rating	
Excellent	7 (28%)
Very good	2 (8%)
Good	12 (48%)
Fair	4 (16%)
Poor	0 (0%)
Has valid state-issued driver's license	0 (0%)
Does not have health insurance	22 (88%)
Has doctor or health care provider	8 (32%)

¹Participants selected all answers that applied to them.

Qualitative findings

Participants described specific factors that affected their sexual and reproductive health (see Table 3), which are grouped according to an adapted version of the social–ecological model that includes individual, interpersonal, and clinic levels. Recommendations about characteristics for sexual and reproductive health interventions for Latinas also emerged (see Table 4).

Table 3. Multilevel factors influencing sexual and reproductive health among Latinas in North Carolina, USA.

Individual factors

- The immigration experience causes changes in Latinas' lives and affects their ability to address their sexual and reproductive health needs.
- Limited health-related knowledge affects health behaviors such as use of sexual and reproductive health services and decisions about HIV/STD and pregnancy prevention.

Interpersonal factors

- Sexual and reproductive health information, social support, and other forms of assistance are sought from a range of resources (including health providers, other community members, and the Internet), with varying degrees of trust.
- A range of positive and negative factors, including partners' behavior, serve as motivators to take care of sexual and reproductive health.

Clinical factors

- Latinas find the U.S. health care system costly and challenging to navigate, at times experiencing discrimination while seeking sexual and reproductive health services.
 - Processes such as insurance access, appointment scheduling, and intake protocols challenge ability to access sexual and reproductive health services.
 - Success in navigating the health care system is usually focused on addressing sexual and reproductive health needs related to family planning, pregnancy and prenatal care, and children's health.
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Table 4. Recommended characteristics for potential sexual and reproductive health interventions for Latinas in North Carolina, USA.

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- Address gendered sexual and reproductive health experiences.
 - Be broad and comprehensive, focusing both on knowledge and communication about sexual and reproductive health.
 - Use face-to-face intervention delivery methods.
 - Be flexible in terms of scheduling, utilizing multiple short sessions.
 - Employ facilitators who are Latina or Spanish-speaking women.
 - Be multigenerational (e.g., include children or skills related to discussing sexual and reproductive health issues with children).
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Individual factors

A number of individual-level factors shaped participants' experiences and health behaviors.

Immigrations

Participants described their personal experiences as immigrants as affecting their ability to address sexual and reproductive health needs. For many participants, difficulty finding employment, low wages, fear of deportation, and lack of insurance access (e.g., no employer-based health insurance was available to participants and participants' immigration status restricted eligibility for government-funded programs providing health care coverage) limited care-seeking behaviors. For example, a participant reported: "We don't have many opportunities [that] others have. No Social Security Number to be able to work, no [driver's] licenses, no health insurance" (Participant [P]2). Another participant added: "Many Latinas are afraid of being asked for documentation they don't have. They are afraid of being deported" (P11).

Shifting family dynamics were also discussed as part of the immigration experience that affected health priorities and ability to access services. Although individual circumstances varied, participants described how the roles and responsibilities of being a woman in the family were different for them in the United States compared with when they were living in their country of origin. Several participants, for instance, had begun working outside the home for the first time

and reported a range of experiences in their new roles; working outside the home was positive (e.g., enjoyable and useful to be contributing to the family finances) for some and negative (e.g., allowed less time to focus on their family's needs such as health care and perceived by one participant as the reason that her husband began having sex with other women because she was not available to spend as much time with him at home) for others.

Knowledge and beliefs

Limited health-related knowledge was identified as affecting health behaviors, including use of sexual and reproductive health services. Participants reported that they and their peers had limited awareness about where to seek services: "[Latinas] are not informed; they don't know where to go, especially the recently arrived from Mexico" (P5). Further, there was a range in perceptions of the effectiveness of various HIV/STD and pregnancy prevention methods. Beliefs about methods were often complex. A participant endorsed the use of condoms for prevention of HIV/STDs, noting, "A condom is the most effective for not transmitting a disease because you can take pills and injections to not have babies, but they don't protect you against diseases" (P17). Noting that condom effectiveness can be reduced by inconsistent use, however, this participant also supported hormonal pregnancy prevention methods.

Interpersonal factors

Participants also described relational factors with their families and communities that influenced their context for caring for their sexual and reproductive health.

Sources of information and social support

Participants reported discussions with partners; female relatives such as mothers, sisters, or adult daughters; health care providers; and friends about sexual and reproductive health. Some participants shared openly about their health concerns, whereas others did not trust or were embarrassed to talk to friends and family, preferring instead to speak with partners or health care providers or, among younger participants, using the Internet for information and communication (e.g., Google and Facebook).

Although they served as important sources of health information, conversations with family and friends at times contributed to participants' confusion. The perceived accuracy of advice varied, and participants sometimes received contradictory information. One participant reported that a friend had told her that hormonal birth control was more effective than condoms, while other participants described hearing that condoms were preferable to other methods. Despite variation in levels of trust and comfort with discussions about sexual and reproductive health, participants also described how female friends and relatives assisted in meeting other needs (e.g., socializing, helping in times of hardship, and providing rides to jobs or clinics).

Participants also discussed the ways in which, together with their peers, they negotiated self-care in the context of limited access to formal health care services due to the individual factors described (e.g., financial concerns, lack of insurance, and limited knowledge). These efforts

sometimes involved the use of contingencies that participants acknowledged as risky, such as self-diagnosing and sharing medications.

Motivations to be healthy

Participants identified various motivators to take care of their sexual and reproductive health, many related to the influence of other individuals in their life. These motivators included positive factors such as following the advice of health care providers, partner encouragement to seek services, and wanting to stay healthy to care for their children. A participant stated: "I look at [my children] and start thinking, what will happen... if something happens to me?" (P24). Other participants reported being self-motivated to protect their own health: "I take care of myself because... I want to feel good... with myself, to love my body. I have to be well and my partner has to be well" (P19). Negative experiences also motivated participants; for example, women explained that they pursued screening after hearing about others' experiences being diagnosed with an STD or reproductive cancer.

Relationship factors also affected sexual and reproductive health, including concerns about partners' fidelity and communication with partners. As "everybody is at risk [and] people make mistakes" (P15), participants described "getting to know" one's partner well, monogamy, and condom use as important for avoiding HIV/STDs, but it was challenging. In particular, participants reported that condom use was often difficult to negotiate with partners within the context of disease prevention and easier when framed around pregnancy prevention. Condoms were also perceived as more important for "other" people to use (e.g., young people and those with multiple partners), and participants themselves reported inconsistent use.

Clinic-level factors

Participants discussed several factors related to the structure of the health care system affecting sexual and reproductive health behaviors, such as accessing screenings and other services.

Navigating the system

Many participants found the U.S. health care system to be expensive and challenging to navigate compared with systems in their country of origin. A participant stated: "One worries more about debts than illnesses" (P20). Other participants reported discrimination from clinic staff: "Sometimes they don't assist us like they should because we are Latinos. They leave us waiting longer. Sometimes they assist us with a bad attitude. They don't give us the time and attention... like everybody else" (P25). Such prior care experiences were identified as influencing continued attempts to access services because participants expected to encounter barriers in interactions at clinics and other agencies providing services.

Clinic access and procedures

Participants reported that aspects of clinic structures and procedures (e.g., fees and payment options, appointment scheduling, and intake forms) were challenging given their income, immigration status, insurance status, work schedules, and transportation options. For instance,

participants described how their only option for accessing sexual and reproductive health services at a local public health department required calling during a narrow time period each morning to make a same-day appointment. Some participants found these barriers to care too immense to overcome. A participant noted: "I would rather stay home and take something [medicine] on my own. I would only go if my children were sick" (P6).

Care-seeking experiences

Participants described some success navigating the health care system, typically related to family planning, pregnancy/prenatal care, and children's health. Participants reported a variety of experiences with HIV/STD and pregnancy prevention methods (e.g., condoms, hormonal methods, and tubal ligation), and many had a history of sexual and reproductive health screenings (e.g., Pap tests and HIV/STD testing). Often relying on word of mouth, participants identified specific clinics with extended hours and free/sliding pay scales, which increased their ability to use these services.

Pregnancy and parenting were described as unique opportunities for accessing needed services. For instance, most screenings that participants reported took place as part of prenatal or postpartum care. Many participants indicated receiving Pap tests on a routine basis, which were often first initiated as part of pregnancy care or family planning services. One participant reported: "For me, I feel that all those types of [screenings] are easy because it's the routine of all women" (P16). Frequently, participants maintained connections to the health care system because of their U.S.-born children's eligibility for government-funded health care programs like Medicaid.

Potential interventions

Although participants reported some use of family planning and HIV/STD prevention methods, they also provided recommendations to inform interventions to address barriers to caring for sexual and reproductive health on multiple levels—individual (e.g., health-related knowledge), interpersonal (e.g., partner and peer communication), and clinical (e.g., perceived barriers to accessing information and services).

Rationale for Latina-specific interventions

Participants reported that Latina-specific interventions would be helpful given gendered sexual and reproductive health experiences (e.g., power dynamics that make condom negotiation or seeing a male provider challenging). A participant confided that HIV/STD prevention within the context of a relationship was important, sharing, "Men are unfaithful; they don't know how to be faithful" (P20). Participants stated that women would benefit from interventions such as those that our team has developed for Latino men; as a participant concluded, "[Sexual and reproductive health] is for both. Because both have sex" (P19). They also noted that men are less likely to talk or less comfortable talking about health topics with other men and that women tend to take health issues more seriously. Thus, participants felt that it was important both that men learn about condom use and that women learn and practice strategies to facilitate use.

Participants also discussed their support for sexual and reproductive health education because of their roles as mothers and concerns about rising STD and pregnancy rates among adolescents. A participant noted that she wanted "to get it in to [her children's] heads that they have to take care of themselves, receive information... and, more than anything, to tell them the methods that they can use [to protect themselves]" (P21). Although participants strongly approved of sexual health education, most had limited knowledge about what their children were learning in school, in part due to varying levels of comfort communicating with their children about sex, particularly with younger or male children. Many participants expressed support for preventive measures for young people, including the HPV vaccine, and several participants reported that their children had received the vaccine. Because of their commitment to their children's sexual and reproductive health, participants indicated that they would benefit from interventions focused on knowledge and skills-building to improve their health as well as their families' health.

Intervention characteristics

Although participants' definitions of sexual and reproductive health varied, they were comprehensive and included concepts such as protecting oneself from HIV/STDs, fertility and pregnancy, getting regular check-ups, monogamy, getting to know and feeling safe with one's partner, being knowledgeable about health, teaching one's children to be healthy, and general hygiene and wellness. A participant summarized that sexual and reproductive health meant "[t]hat you don't have any type of infection... and to feel more secure/safe with your husband, spouse, [or] partner" (P16). Another stated that she stayed healthy by "tak[ing] control of [her] sexuality [and]... go[ing] to the doctor regularly" (P3). Participants suggested that interventions should be comprehensive to address these broad and varied conceptualizations of health.

Participants suggested that interventions should focus on knowledge (e.g., condoms for pregnancy and HIV/STD prevention) and reducing stigma associated with HIV/STD testing. A participant asserted: "[We need to learn] how to protect ourselves from diseases; there are lots of them [diseases] we don't know about" (P14). They also identified a need to develop skills for communicating about sexual health with partners and children.

Participants varied in their ideas about intervention structure. Some advocated for face-to-face delivery methods: "Sometimes they give somebody a brochure... and they don't start reading it and instead if people go and sit down to chat with them they do pay a little more attention, and it motivates you" (P21). Other participants highlighted the importance of flexibility with scheduling around jobs and family responsibilities (e.g., shorter, more frequent sessions) and noted that such interventions must offer childcare and transportation. Participants suggested utilizing existing social networks for recruitment and implementing in specific locations (e.g., homes of friends or family) to increase participation. Most participants thought intervention facilitators should be Latina, although some indicated a male facilitator or female facilitator who was not Latina but spoke fluent Spanish could be appropriate, provided that he or she was trained and knowledgeable about sexual and reproductive health. Finally, many participants deemed multigenerational interventions that include children—or skills related to discussing sexual and reproductive health issues with children—valuable. One participant noted: "I think it is a good idea. Because... you open up more with your daughter" (P18).

Discussion

Understanding Latinas' sexual and reproductive health needs and priorities is essential for researchers and practitioners in diverse disciplines to develop health services that are culturally congruent, meet Latinas' specific needs, and ultimately reduce disparities in sexual and reproductive health outcomes. Through our study findings we provide insights to the sexual and reproductive health of Latinas in new settlement communities such as in the southeastern United States and to inform interventions designed for these and other similar communities.

Similar to other studies, we found that health and access to services for participants was related to intersecting factors about experiences as immigrants and the U.S. health care system (Cashman et al., [5]; Chando, Tiro, Harris, Kobrin, & Breen, [8]; Cristancho, Garces, Peters, & Mueller, [10]; Marshall, Urrutia-Rojas, Mas, & Coggin, [18]; Rhodes et al., [28]; Vargas Bustamante et al., [35]). Recurring themes centered on low-wage employment, limited health insurance access, fearing potential deportation, discrimination, and shifting family dynamics that can be both empowering and challenging. Many participants also described health care processes as different from those in their home countries.

Accordingly, interventions for Latinas in new settlement communities should complement a focus on individual health behaviors with capacity building to overcome and engage in advocacy to reduce structural barriers. In interventions with Latino men, our CBPR partnership has found that, to address health care system factors, it is important to connect participants to existing service providers (e.g., public health departments) to facilitate continued access as needed in the future. Similar approaches could be used in sexual and reproductive health interventions with Latinas.

Additionally, this study identified how different interpersonal factors shape sexual and reproductive health and care seeking among Latinas. Future intervention content should address the ways that peers and sexual partners can bolster health-promoting and reframe health-compromising behaviors. As participants described natural helping behavior among existing social networks of Latinas, a lay health advisor (LHA) strategy may be well suited for this community, particularly if community members serving as LHAs receive training to increase participants' trust in peers' knowledge and commitment to confidentiality.

Our findings also highlight how pregnancy and parenting often help connect Latinas to the health care system. Even after Latinas are no longer receiving prenatal or postpartum care themselves, they continue to interface with providers when their children receive services, potentially offering opportunities to have their own health needs met. Thus, interventions should leverage these connections and also reach Latinas who are not pregnant or who do not have children (e.g., women on birth control, older women with adult children, or women with children in their countries of origin), who may not be accessing screenings and other preventive care.

The ways that participants linked other aspects of sexual and reproductive health to their roles as parents are also worth noting. For example, many participants seemed more comfortable talking about condom use for family planning than for HIV/STD prevention, underscoring the importance of interventions recognizing the intersection of pregnancy and HIV/STD risk and the

opportunity to promote dual method use. Additionally, one way to start communication with Latinas about their own sexual and reproductive health may be through talking about their children's health. Participants wanted to build communication skills with children, particularly daughters, even when they themselves reported unmet sexual and reproductive health needs. Further, being able to stay healthy for the sake of their children was motivating for some participants who may not otherwise have sought sexual and reproductive health services. By beginning with a focus on children's health, it may be easier to broach topics related to Latinas' own sexual and reproductive health.

Our study also yielded findings related to intervention format, such as the desire for interventions with multiple, short sessions. For Latinas who want to build relationships and social support, such repeated contact may be key (Hurtado-de-Mendoza, Gonzales, Serrano, & Kaltman, [15]). This model also fits with work and family schedules (e.g., childcare needs). Based on use of the Internet for communication by younger participants, mixed LHA/online interventions could also be appropriate and allow for confidentiality in accessing sensitive information. This mixed approach may make it easier to tailor interventions to meet the needs of specific women or social networks, providing differing strategies to meet varied comfort levels with discussing sexual and reproductive health with others.

Limitations

The use of interviewers who were different from participants in some ways (i.e., one interviewer was male and the other was not Latina) may have been a potential source of bias; it is possible that some participants may not have shared their thoughts and ideas fully with the interviewer given that the interviews focused on issues that can be perceived as sensitive. These differences, however, were integral to our insider–outsider approach to data collection. Furthermore, both interviewers were members of a long-standing CBPR partnership that has high visibility and has built and maintained trust in the local community, and the Latinas who participated in the interviews were familiar with our partnership because of their relationships with participants in HoMBReS Por Un Cambio. Overall, participants shared detailed information with both interviewers.

Although interviewing Latinas who were already familiar with our existing HIV prevention interventions for Latino men allowed us to tap into concrete insights and suggestions regarding intervention approaches, the findings are situated within the context of a larger evaluation study of HoMBReS Por un Cambio and may differ from the perspectives of Latinas less familiar with sexual and reproductive health promotion who may participate in future interventions. Additionally, all participants were from Mexico, which may affect generalizability. The majority of Latinos in new settlement states such as North Carolina are from Mexico, however, and Latinas of Mexican origin in North Carolina may have overlapping social networks with and experience similar barriers to caring for their sexual and reproductive health as Latinas of other national origins. Thus, knowledge generated through this study may be useful for working with broader Latina populations in new settlement communities such as in the southeastern United States.

Conclusions

Through our findings, we have confirmed that Latinas in North Carolina need and want resources to support their sexual and reproductive health, and that sexual and reproductive health interventions for Latinas are a community priority. Understanding and addressing the individual, interpersonal, and clinic-level factors that affect Latinas' health behaviors are essential for informing culturally congruent interventions to reduce sexual and reproductive health disparities among Latinas, particularly in regions such as the southeastern United States with growing new settlement communities of Latinos.

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