Sex education and cultural values: experiences and attitudes of Latina immigrant women

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The paper aims to further explore the role that culture plays in the provision and assimilation of sex education among Latina immigrants in the USA. To accomplish this, researchers conducted focus groups and interviews with 30 women from Central and South America who have lived in the USA for at least five years. Participants were asked to reflect on their experience with sex education in their home country and in the USA, and to assess how their attitudes towards sex education may impact their behavioural choices as parents and as sexually-active women. The findings demonstrate a wide range of views that did not follow patterns by common demographical proxy variables, suggesting that such variables are not enough to predict adoption of new cultural values that are different from their family’s traditional norms. Instead, adherence to traditional cultural beliefs appeared to be a better predictor of attitudes and behaviours.

Keywords: sex education; Latino immigrants; attitudes; acculturation

Introduction

Sex education is a venue for the delivery of information that shapes the attitudes and beliefs about the self-identity, relationships and intimacy in an individual’s life. Topics that are included in sex education range from sexual development, to reproductive health, affection, and gender roles (United Nations Population Fund 2011). In the Latino community, sex education is one of the most important issues facing Latinas in the USA, who account for one in every seven females of reproductive age in the USA (Anachebe and Sutton 2003). Hence, sex education should be an important aspect in the sexual development of Latino women. However, the effectiveness of sex education tailored to the Latino women can be questionable as health behaviours of Latinas are still contributing to healthcare disparities. For instance, the teenage birth rate among Latinas is the highest of any race or ethnicity and nearly double the national average (Ryan, Franzetta, and Manlove 2005), and they also have higher infection rates for HIV and other sexually transmitted infections (Bourdeau, Thomas, and Long 2008). Latinas are also less likely to accept contraceptive methods and engage in fewer self-protective behaviours when sexually active (Padilla and Baird 1991). Furthermore, Latinas are particularly disadvantaged in sexual communication and negotiation as they generally have less control over their sexual relationships than men (Villarruel 1998). Additionally, high levels of discomfort in discussing a perceived taboo topic may prevent young Latinas from thoroughly discussing sex and reproductive health issues with their parents or teachers.
(Aarons and Jenkins 2002). Hence, cultural and familial factors may play an even more important role in predicting sexually protective behaviours than just access to services or information (Padilla and Baird 1991).

The purpose of this paper is to explore how a cohort of 30 immigrant Latina women received sex information in their lifetime. In a series of three focus groups and five interviews, participants reflected on their experience with sex education in their home country and in the USA and assessed how their attitudes towards sex education may impact their behavioural choices as parents and as sexually-active women. This study shows how acculturation varies among individuals regarding sex education topics, which could be contributed by adherence to Latino cultural practices and/or adaptation to mainstream cultural values. The study was funded as part of a project for Planned Parenthood of Greater Miami, Palm Beach and Treasure Coast, to assist them in setting policy and advocacy priorities.

**Literature review**

**Cultural attitudes and acculturation**

Culture plays a pivotal role in shaping the attitudes and beliefs of people. Cultural practices emerge from repetitive behaviour in social interactions. These learned patterns of thinking and behaviour can explain how people act and the reasons why they act in certain ways. These patterns are reinforced by individuals’ experiences and their political, social, historical, economic, and spiritual realities (Perilla 1999). Through social learning, people form beliefs about which behaviours are appropriate for certain situations, which behaviours bring rewards, and which bring punishment (Bandura 1991). Clearly, the first behavioural models that most people encounter are in their own families, their neighbourhoods, and their schools. These are the most important influences in a child’s behavioural norms.

Culture change takes place when adults immigrate to a new country and interact with different cultural norms. In these situations, they are faced with different rewards and punishments regarding what will be acceptable behaviour. Adapting to a new culture requires observation of the new culture in order to understand what kind of actions are rewarded and which are punished; which will bring positive outcomes and which could cause harm. The adaptation process of assimilating new cultural values is called acculturation. Acculturation can be studied under uni-dimensional and bi-dimensional perspectives. Under the uni-dimensional approach, individuals tend to assimilate the mainstream culture in a way that replaces their own cultural beliefs and practices. The bi-dimensional approach, on the other hand, acknowledges the maintenance of cultural beliefs by merging them with beliefs of the host country (Verkuyten and De Wolf 2002). During this process, individuals can react in four possible ways. Minorities can retain their cultural practices and be separated from the mainstream culture. Minorities can also fully adapt to US culture or become acculturated. They can also assimilate and practice both cultures, thereby becoming bicultural. Lastly, they can neglect both cultures and become marginalised (Berry 1980).

Previous research on the bi-dimensional model has used these categories to evaluate the acculturation levels of immigrants (Magafia et al. 1996; Nguyen and von Eye 2002). However, this model is more descriptive than explanatory in nature. For instance, it lacks the ability to predict why some risk or protective health behaviours increase in certain groups whereas other groups may show a decrease in the prevalence of these behaviours (Verkuyten and Wolf 2002). Hence, it is possible that acculturation can be influenced by individual cultural practices that can be grounded by the value system of the family structure. Furthermore, the relative importance of cultural values for behaviour can also
depend on the type of issue at hand. Some health issues are more culture-bound than others. Issues that relate to perceptions of morality and religion, family, self-identity and social roles, sexuality and gender, or traditionally taboo topics are considered highly culture-bound, since specific beliefs and attitudes about these themes are greatly determined by a person’s cultural background and history.

*Latinos and sex education*

Conversations regarding sex topics are often left to the parent matching the child’s gender. Mothers are seen to be the primary communicator when it comes to sexual topics, indicating that what little information is passed on is most often channelled through the mother (Miller et al. 1998). As sexual education is seldom addressed verbally within the family structure, the admonitory approaches of the church and school systems are predominant (Pavich 1986). Birth control is considered taboo as premarital sex is essentially forbidden for women and children are hoped for and expected after marriage (Pavich 1986). Indeed, it has been shown that lower levels of acculturation are linked to less risky sexual behaviour, including more habitual condom use in both males and females and fewer sexual partners in females (Trejos-Castillo and Vazsonyi 2009).

Public schools in the USA tend to approach sex education in one of two ways: abstinence-plus and abstinence-only. Abstinence-plus promotes abstinence but also provides information about contraception, sexually transmitted infections, HIV/AIDS, and even abortion; while abstinence-only informs students about abstaining from sex without additional conversation about protection (García 2009). García’s study revealed that many young Latinas described their experience with middle school sex education with frustration; when they tried to ask questions and gain information, they were likely to be cut-off or chastised. The enduring idea that they should be ‘good girls’ or ‘young ladies’ persisted (García 2009). The women were told they needed to understand the information provided in the sessions but that if they were being good girls, then the information was not necessary (García 2009). Girls who were already sexually active were demonised as ‘those kind of girls’. Participants in the study indicated bias in the presumption that they were too ignorant to protect themselves from teenage pregnancy or sexually transmitted infections (García 2009).

Sex and sexuality are topics that are very much ingrained in cultural values. Indeed, cultural values are often misguidedly used to justify many forms of risk behaviours and to reject recommended behaviour changes (Unger and Molina 2000; García, Hurwitz, and Kraus 2005). To change culturally-rooted behaviours, it is not enough to know the behaviours but one must understand the related attitudes so that they can be targeted in sex education interventions. Understanding the influence of cultural values that underlie health beliefs is important for the design of effective culturally-appropriate interventions (Villarruel 1998; García-Moreno and Stöckl 2009).

**Methods**

This study used qualitative focus groups and in-depth interviews to assess attitudes toward sex education among recently-immigrated Latinas in South Florida. Three focus groups and five in-depth interviews were conducted in different geographical areas of Dade County with a high density of Hispanic residents: Homestead, Kendall, Hialeah and North Miami. The researchers asked open-ended questions about participants’ sexual health education in their home countries and after arriving in the USA. Participants who were part of the focus groups were not included in the in-depth interviews.
Participants for both focus groups and in-depth interviews were selected by using a purposive sample. By doing so, participants who were eligible to participate were women who were born in Central and South America as well as in Spanish-speaking Caribbean countries and who have lived in the USA for at least five years. Participants were recruited through fliers and word of mouth, with assistance from local clinics. Written informed consent was obtained prior to the focus groups/interviews. Focus groups lasted between 75 and 110 minutes, and the individual interviews ranged from 20 to 43 minutes. All participants received US$20.00 in cash at the end of their participation in the study.

The conversations were tape-recorded with participants’ permission and then transcribed for analysis. Content analysis was conducted by following a five-step process developed by Ryan and Bernard (2003) and Arndt and Bigelow (2000). The first step to analyse the qualitative results was to identify recurring themes and statements in the data. Secondly, researchers got together to compare grouping categories. Thirdly, researchers used the categories that were agreed to organise the data. Fourthly, each researcher placed statements into the categories that were agreed upon. Lastly, researchers got together with a third party to further develop subcategories and finalise findings. A total of 30 women participated in this study and the average age of participants was 37 years. The majority of participants \((n = 28)\) reported speaking Spanish at home.

**Results**

**Cultural taboos and information about sexual health**

All participants came to the USA from Central and South American countries, and had their first contact with sex education in their home country. Most indicated that their first contact with reproductive health services occurred close to the time of marriage, when seeking either assistance with birth control or prenatal care. Societal taboos and religious value of sexual abstinence until marriage could explain the late access to services for the interviewed women:

You get that information when you are preparing your wedding or when you are already married. It’s like a myth; everything is very closed, like a taboo.

They tell you that you have to be responsible to have children, but they didn’t give me any more details.

[All they told me was that] people have children when they get married. When I got married I learned along the way.

There were also participants who received reproductive healthcare services only after they had their first child. In one case, the participant never received any serious explanation of the reproductive process even after having had a child. She said that she ‘kind of figured it out by the time I had my second baby’.

Another participant received information from a doctor, rather than her mother, only after she presented with a problem:

When I was 17, I did not get my period for 2 months. My mom was upset because she thought I was pregnant and I had no idea why she thought that. They did the pregnancy test and it was negative, and they prescribed birth control pills. That’s when I learned that when you have (sexual) relations you can become pregnant, and how to prevent it.

The barriers to seeking information and explanations of anything regarding sexual or reproductive health carried over after immigration to the USA. One participant recalled her first Pap smear and breast examination by a physician, which came as a surprise to her:
I went to one of those cheap clinics where you pay $40, because I had a pain in my knee. After asking me all the questions they suggested I get it done and I said OK. I thought they were going to do a knee exam, until they gave me the paper robe and time to get changed and I figured it out. I didn’t have a lot of time to decide, I didn’t understand what was going on. So they did the Pap smear and everything else. And they even did the breast exam – aaaaah! I don’t know, they told me I had to do it every 6 months, but at that time I was only 24.

Another participant explained that even after moving to the USA she still prefers to seek information on her own rather than asking a physician about sexual or reproductive issues: ‘If I have questions I look it up in books, more than asking the doctor.’

In the interviews, it was implicit that fear and embarrassment of inquiring about these issues are very present in the daily lives of some Latino women after migrating to the USA:

I think my 14-year-old daughter knows perfectly how the whole thing (sex) works. From school and from what my husband and I discuss and from television. But I’ve never talked to her about it directly.

**Cultural taboos and sex education**

Another important theme addressed in the focus groups and interviews was how women received information on reproductive and sexual issues in their home country. Most participants had received some sort of sex education while in school. However, most of them reported that the education focused mainly on how the reproductive system works and excluded information related to sexuality:

In school they taught me later what the reproductive organs are.

They taught me [in school] what is HIV and sexually transmitted diseases.

In school I learned about the rhythm [method of birth control].

In school the nuns talked about that, in one class, they talked to us about the period.

I knew what the period was before I got it.

About one-quarter of the participants reported that either their mother or a close relative spoke to them about sex and informed them of the reproductive process:

Since the period, they start telling you that you are a woman and they start with sex education. My parents, the school … they oriented me. But I never got any [reproductive health] services until I got married.

My sisters told me I had to behave like a lady, that I had to limit my activities, what I did as a girl, like riding a bike. I didn’t exactly understand, they talked about it very superficially. I knew about [sexual] relations only theoretically.

Those who did not receive information about reproductive health in school or from family members often did not seek any information themselves until they began menstruating. Some sought out information at that point, usually from friends or female family members:

Others knew because they had older sisters, no it was not so traumatic as it was for me.

I have seven brothers, so when I got my period it was my sister in law who explained to me what was happening and told me I should tell my brothers to buy me pads.

I learned about having sex from my friends, they explain it better than mothers.

My mom never told me, see, I started bleeding there and my friend told me it was the period.

I thought having a period was something bad … After three years, I told my mother.
Reactions to sex education in US schools

Another topic that emerged from the focus groups was participants’ reaction to sex education in the USA. During the focus groups, some participants expressed opposition to what they saw as the sexuality-centred approach to health education in the USA (which, as stated earlier, was considered positive by other participants). One participant who was in her early twenties had attended middle school in the USA and was opposed to the sexual content of health education in her school. She recalled with distaste that they were shown a video that talked about sexual feelings related to puberty. Another participant also felt sex education in school is too open for her taste. She complained that, ‘They told my eleven year old daughter how children are born. . . . They told her that in a class!’ She added:

In eighth grade I learned, but I found it vulgar. They put on a movie; it was very vulgar, with a sexual tone. When I went to high school it was more educational.

However, other participants were more accepting of how sex education is provided in the USA:

Here it’s more advanced, the sex education they get starting in school. To high school kids they give a pretend baby for a week so they understand the responsibilities. In my country there is a lot of scarcity.

In my son’s school they asked us for permission to let them see a video about sex education. I would recommend that they start with that information in middle school, they should start early but (the content should be) appropriate for their age.

My daughter gets [sex education] at school but she doesn’t really answer me when I ask about it – they talk about that and the menstrual cycle. I don’t know how much they talk about the fertility cycle. I know they talk about using condoms.

Other participants felt that there were not changes between sex education in their country of origin and in the USA:

Sex education is very similar (in my country and the USA). I can’t tell you that it’s better here. In Chile they talk a lot about it. Now people talk openly about sexuality on television. But that’s on television – not with the family.

Access to sex education in the USA for adult immigrants

Sex education among young adults was also another topic discussed in focus groups and interviews. Most of the participants indicated that access to information is easier here than in their home countries:

It’s easier here because of the Internet. In my country the information is not as complete.

Well, I think people here are more informed, but it’s not because of the health system, it’s cultural.

However, other participants did not see any difference between their home countries and the USA:

[Access to information] is the same here than in Argentina.

In my country they talk a lot about it. Now they talk openly about sexuality on television. Things have changed a lot; there are not so many hang-ups. But that’s on television, not with the family.

Given the barriers to interpersonal discussions about sex, mass media are seen as important sources of information to become aware of sexual health issues and where to get services. Respondents commented that:

On TV they give you information through programs or commercials about where to get mammograms, sometimes on the news.
[They give information about sexually transmitted diseases] on a TV show called ‘Salud es Vida’ (‘Health is Life’).

On TV I’ve seen the commercial for the vaccine for uterine cancer. Now I know I can vaccinate my daughter.

When it comes to increased access for the Latino community about sex education compared with their home countries, some participants showed a positive response:

There should be more information about where to get birth control and other services. Now I’ve learned, but women who just got here are embarrassed to ask.

However, others were more hesitant about the way the USA provides sex education:

Here it’s more liberal . . . [Here] society gives you permission to do whatever you feel like. Here the values of people, of the youth, the children start to have sex very early. There, nothing, well parents educate about how to protect themselves.

The family’s role in sex education and sexual health decisions in the USA

For Latinos, family plays an important role in decision-making and sex education, and sexual health decisions are not an exception. Participation in Latinas’ health decision-making can be seen as obtrusive, especially when parents and extended family are still dealing with strong cultural beliefs, evidenced in the following comments:

My family was outraged when I used contraceptives to prevent pregnancy. I stopped using them because of pressure from my family.

The man is the man. My mom told me that I was the one who had to take care of myself (i.e. use contraception).

Other participants were more receptive to changes in their cultural beliefs but still were confronted by other family members who did not agree with the mother’s advice. One participant commented:

When I started talking to my daughter, telling her she had to be careful, the father of my children thought I had opened the door to prostitution for the girl. But for me I was informing her. Now my daughter is informed. My husband wants her to be like a 4- or 5-year-old.

These comments indicate that although some participants are more open to adapt to US values of gender equality on reproductive health decisions, educating children about sex and contraception and other reproductive healthcare issues, there is still a need for Latina women to examine their own beliefs and question how these may enhance or impair health outcomes for them and their families.

Discussion

Attitudes are often formed passively through cultural and social cues, but changing these attitudes or beliefs once they are developed usually requires the use of persuasive interventions (Rokeach 1966). However, when people undergo an acculturation process after immigration to a new cultural context, attitudinal change can take many forms. As the participants in this study reported, sometimes attitudes change as taboo beliefs lose their relevance, or through exposure to new ideas through personal experience. These experiences can come from interaction with institutions such as school, or community agencies, or it can come from observing others following different norms.

An important consideration in understanding Latina immigrant women and their attitudes toward sex education is that the adoption of US cultural values varies from person to
person, and may even vary from situation to situation. In some cases, adoption of new values is perceived negatively by members of the original cultural community. Indeed the attitudes and adherence to taboo beliefs, as well as the woman’s ability to go against the traditional norms of the immediate family, seemed to be a determinant of new attitude adoption.

Taboo topics related to sex and reproductive functions may limit the opportunities for sex education within the family, and the possibility of discussing such topics openly. Some of the respondents welcomed intervention from the school and even mass media to help fill these gaps in sex education at home. However, others saw these interventions and messages as an affront to traditional values.

The findings of this study can inform future planning of sex education targeting Latinas and their children. Since adoption of US cultural values with respect to sexual health and education varies by individual, and is influenced by family context, interventions should be flexible and allow for differing levels of acculturation. Furthermore, intervention could be designed to target different family members promoting attitude change towards healthy sex education. This is important because acculturation levels may be different, and therefore changing one family member’s attitudes is unlikely to be enough – especially among Latino families, which tend to be collectivistic. Differences in acculturation levels between parents and children are an important consideration as well. For many reasons, children of immigrants adapt to the new culture quicker than their parents do (Wagner et al. 2008). Children learn the new language and the values of the host country before their parents. This often creates a disparity between the traditional family hierarchies parents are familiar with from their country of origin, putting a burden on the children to speak for them (Wagner et al. 2008).

While the women in this study showed initial changes in their attitudes about sex education and prevention, they felt that their male partners had more difficulty adopting new attitudes and beliefs imparted by mainstream US culture. Generally, changing one’s attitudes requires long-term commitment and ongoing practice of new behaviours in order to become more acculturated to a new culture. However, the level of acculturation varies according to the individual. Much like in sex education interventions targeting the mainstream or general population, interventions targeting Latinos cannot assume homogeneity of attitudes and beliefs, and must accommodate different levels of acculturation and even beyond acculturation, differing levels of adherence to ‘mainstream’ values depending on the structural and interpersonal context of each situation.

The study showed that participants have experienced different acculturation processes, which explain their willingness to change attitudes and behaviours. More acculturated participants felt more open and comfortable talking to their daughters about sex education, while other participants indicated their discomfort with the US educational system regarding sex education. These differences did not follow a pattern by age or country of origin, but rather by adherence to traditional cultural beliefs.

Study limitations and suggestions for future research
Changing an individual’s attitudes and behaviour may put them at odds with their culture, family and peers. More qualitative research is needed to find optimal ways to communicate violence prevention and reproductive health messages in a culturally-competent manner. Further cross-cultural research is needed to understand the most appropriate and effective messaging strategies to use in different contexts for the important messages to get through. It is not the goal of sex education to change cultural values, but in promoting safe sexual behaviours traditional Latino cultural attitudes are frequently challenged.
Country of origin seemed to play a role in exposure to sex education prior to arriving in the USA. Respondents from Argentina and Chile reported progressive sex education messaging at schools and in the media, while participants from Peru and Guatemala reported more conservative values and a higher level of taboo related to sex education. While there are not enough data in this study to draw a conclusion about differences in country of origin, this could be an area for further research.

Another area that requires further research is the assessment of attitudes among Latinos of all ages and genders. Gender roles and family hierarchy continue to play an important role when making decisions about health education and reproductive health. When there are differences in the level of adoption of US values, conflict is likely to arise. Many adult Latinas are still influenced by their parents’ and partner’s norms when making decisions about birth control or about talking to their children about sex. The diversity of attitudes may be related to these personal and contextual factors, and not to demographic variables or length of stay in the USA. There is a need for further research on multidimensional models of acculturation with respect to culturally bound topics, such as sex education and reproductive health, as well as other topics such as violence, parenting, school involvement, and so forth. These models must take into account the broad range of attitudes for each topic despite similar demographic characteristics.

Conclusion
Culturally-competent interventions are typically developed with the purpose of increasing access to services, and reducing healthcare disparities. Accounting for cultural values and mores when approaching sex education enables teachers and curriculum developers to understand their audience; this in turn allows for culturally-relevant strategies and messages (Perilla 1999). Designing culturally-competent interventions and services goes beyond tailoring them to a homogeneous Latino/Hispanic culture, but may also require the nuanced targeting based on countries of origin (Umana-Taylor and Fine 2001), as well as exposure to education, ties to extended family, adherence to traditional cultural norms about sex, and adoption of new values and behaviours that challenge traditional norms.

The diversity of views in this study’s relatively homogeneous cohort of Latina immigrants demonstrates that demographic variables such as age, language, country of origin, and years since immigration are not enough to predict adoption of new cultural values that are different from their family’s traditional norms. In this study, participants’ adoption or non-adoption of new values to education, interpersonal exchanges, personal experiences, having adolescent children, strength of ties with traditional family members, and other factors varied by individual. This study has therefore contributed to further the understanding of cultural beliefs on sex education and reproductive health by demonstrating how attitudes varied as a result of several factors and how they interact during the acculturation process.

References


