



The socio-political context of migration and reproductive health disparities: The case of early sexual initiation among Mexican-origin immigrant young women



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ARTICLE INFO

Article history:

Received 12 October 2016

Received in revised form

2 March 2017

Accepted 6 March 2017

Available online 9 March 2017

Keywords:

USA

Adolescents

Reproductive health

Mexican-origin immigrants

Gender

Sexual initiation

ABSTRACT

Prior research often explains the lower risk of early sexual initiation among foreign-born Mexican-origin young women by a patriarchal and sexually conservative “traditional Latino culture.” This definition overlooks structural factors such as exploitation of migrant workers, and conflates gender inequality and sexual expectations. I use an intersectional framework and the theory of gender and power to explore how gender inequality and sexual expectations are both influenced by structural factors and affect reproductive health outcomes. I integrate data from qualitative interviews with 21 first and second generation Mexican-origin women in 2013–2014 with data from discrete time hazard models with 798 Mexican-origin young women in the National Longitudinal Study of Adolescent to Adult Health. Qualitative results demonstrate that gender inequality and sexual expectations in Mexican-origin immigrant households are associated with structural factors. Gender inequality occurs more often in households with family instability, greater poverty, and among parents who migrated independently. Qualitative data also demonstrate that parental gendered expectations are sometimes at odds to what parents are actually doing in the household. Finally, contrary to assumptions that a patriarchal “traditional Latino culture” protects against early sexual initiation, qualitative and multivariate quantitative data suggest that household gender inequality increases risk of early sexual initiation. These findings challenge the utility of a culturalist approach that views culture as determining health behavior among immigrants and demonstrate the need to incorporate an intersectional framework that includes structural factors. This approach may reduce stereotypes and identify meaningful interventions to reduce reproductive health disparities.

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1. Introduction

Public health and medical research often theorize that a “traditional Latino culture” explains distinct reproductive health outcomes among Latina and Mexican-origin adolescents in the U.S., such as later ages at sexual initiation among the foreign-born (e.g. Driscoll et al., 2001; Guarini et al., 2011; Killoren and Deutsch, 2013; Lee and Hahn, 2009; Russell and Lee, 2004). This culturalist approach, that culture determines behavior, inadvertently perpetuates the stereotyping of Latino families as patriarchal, pronatalist, and sexually conservative by describing a “traditional Latino

culture,” without attention to structural factors, such as restricted access to economic resources and employment exploitation, within the socio-political context of migration. In this paper, instead of a culturalist approach, I build upon the work of social scientists (García, 2012; González-López, 2005; Hirsch, 2003) who consider culture and structure as intertwined and mutually reinforcing to examine reproductive health. I use an intersectional framework with an innovative mixed methods approach integrating qualitative data from 21 in-depth interviews with first and second generation Mexican-origin women with quantitative data from Mexican-origin women in the National Longitudinal Study of Adolescent to Adult Health (Add Health) to address two research aims: (1) to explore how migration patterns, family stability, and socioeconomic status (SES) are associated with gender inequality and sexual expectations within Mexican-origin immigrant families, and (2) to then examine how these factors influence reproductive

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health behaviors of Mexican-origin young women.

2. Background

2.1. Reproductive health literature

First and second generation adolescents have later ages at sexual initiation (Guarini et al., 2011; McDonald et al., 2009), but are less likely to use contraception than third (U.S.-born to U.S.-born parents) generation adolescents (McDonald et al., 2009). Investigations into the risk of adolescent birth remain inconsistent; some studies have found no difference (McDonald et al., 2009), others found U.S.-born Latinas have the highest risk (Minnis and Padian, 2001), and another found foreign-born Latinas have the highest risk (Manlove et al., 2013). Reproductive health outcomes also differ by country of origin. Sixty-four percent of the Latino population in the U.S. is of Mexican-origin and although there is cultural and economic variation within the Mexican-origin population, they are more economically disadvantaged than many other Latino groups and they bear the brunt anti-immigrant policies (Golash-Boza and Hondagneu-Sotelo, 2013; Stepler and Brown, 2016). Moreover, Mexican-origin adolescents have a higher birth rate than Puerto Rican and Cuban adolescents (McDonald et al., 2009).

There are two problematic ways the public health literature examines reproductive health outcomes among Latina and Mexican-origin adolescents. First, most studies continue to use a culturalist framework, often a “traditional Latino culture,” to explain health disparities. Authors reviewing the immigrant health literature warn that this framework takes an individual perspective and simplifies complex processes such as gender and family dynamics and “... such studies ultimately revert back to an apolitical and ahistorical understanding of differences between populations that eschews social inequalities and social determinants of health” (Castañeda et al., 2015, p. 380). Quantitative studies rarely investigate cultural processes and instead rely on immigrant generation and language as proxies for cultural differences (e.g. Guarini et al., 2011; Killoren and Deutsch, 2013; Lee and Hahm, 2009). Moreover, the complex intersection of cultural, historical, social, and political processes cannot be captured by controlling for SES in quantitative models and some qualitative research has acknowledged but not thoroughly examined the association between SES and culture (e.g., Hyams, 2000; Romo et al., 2010; Talashke et al., 2004). Immigrant health disparities research may benefit by transitioning from a culturalist approach to one that addresses structural factors (e.g. Minnis et al., 2012).

Second, the definition of a “traditional Latino culture,” used in most studies, conflates gender inequality and sexual expectations by defining it as both patriarchal, women deferring decision-making to men, and sexually conservative, encouraging female virginity. This is despite the anthropologic approach of analyzing gender and sexuality as “separate systems which are interwoven at many points” (Vance, 1991, p. 876). Although qualitative studies often provide a more in-depth analysis of cultural processes and Latina reproductive health, most do not analyze gender inequality and sexual expectations separately (e.g. Gilliam, 2007; Talashke et al., 2004).

2.2. Theoretical framework

Public health’s use of a culturalist approach separates cognitive aspects of culture, i.e., expectations and norms, from structure and examines them as a “force” on health behavior. Schneider and Schneider (1996) warn in their book on fertility decline in rural Sicily that this approach stigmatizes reproductive health behaviors

among vulnerable populations. And Janes (2005) cautions epidemiological researchers against the use of culture as an independent variable to explain health outcomes because, in contrast to a culturalist approach, many social scientists view culture and structure as intertwined and mutually reinforcing. Indeed (Browner, 2000), explains that structural factors, such as access to resources, influence individual behavior both directly and through cultural expectations that “exist within specific contexts that are both social and historical (p. 774).” I also consider culture and structure to be mutually reinforcing. However, it is analytically useful to look at how cognitive aspects of culture, in this case parental expectations of gender and sexuality, are influenced by structural factors that oppress immigrants, in order to more accurately examine reproductive health of Mexican-origin young women.

A mixed methods approach informed by an intersectional framework is an ideal way to study health disparities among marginalized groups like immigrant young women, yet it is rarely used to study Latina adolescent reproductive health. Collins (1993) asserts that social inequality be analyzed through the intersection of race, class, and gender as “distinctive yet interlocking structures of oppression (p. 26).” And the theory of gender and power was developed by Connell (1987) to organize and explain structures that produce gendered inequalities. Social scientists have used this theory within an intersectional framework to analyze sexual expectations and gender inequality between men and women (García, 2012; González-López, 2004; Hirsch, 2003). Structures producing inequality among gender non-conforming individuals are important but beyond the scope of this paper. This theory examines gender inequality and its intersection with social inequality through three main structures: (1) the sexual division of labor, economic differences in the workplace and home; (2) the sexual division of power, relationship and institutional differences in power; and (3) cathexis, often considered social and cultural expectations and norms (Wingood and DiClemente, 2000).

Similar to many anthropologists, I examine gender and sexuality separately though connected. Sexuality and the interpretation of sexual acts, are influenced by gender inequality, in addition to other structural factors (Hirsch, 2003; Vance, 1991). I examine parental expectations of adolescent sexuality, a cognitive aspect of culture, in addition to adolescent sexual behavior. Thus, I use the concept of cathexis to analyze parental expectations of both gender inequality and sexuality.

The theory of gender and power must be situated within the socio-political context of migration to capture “structures of oppression” specific to immigrant families, in which both first and second generation adolescents are raised. These structures, produced by the political economy of immigration, impact individuals as social determinants of health. For example, while I do not directly analyze U.S. immigration policy, its impact is visible through the motivators and patterns of migration, as well as family stability and social disadvantage of immigrant families in the U.S., including restricted access to economic resources and employment exploitation. Hondagneu-Sotelo (1994) classifies three types of migration patterns: family stage, when married couples migrate in stages; family unit, when a family migrates together at the same time; and independent, when a single person migrates. These patterns are informed by family stability, SES, and gender inequality in Mexico and then inform these very same aspects once families are in the U.S.

2.3. Migration, SES, and gender

Public health studies often assume that Mexico to U.S. migration is a move from a traditional culture of gender inequality to a modern culture of gender equality. Yet this assumption does not

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