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Prevention of Unintended Pregnancy and HIV/STIs Among Latinos in Rural Communities: Perspectives of Health Care Providers

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Latino women in the United States are disproportionately at risk for unintended pregnancy, HIV, and sexually transmitted infections (STIs). We conducted nine focus groups with health care practitioners who provide reproductive health care to Latinos in rural areas of the Northwest. From the practitioner perspective, we explored barriers and facilitators to the acquisition and use of contraceptives and to the prevention of HIV/STIs among rural Latinos. Suggestions for improving reproductive health care included Spanish-language resources/materials and convenient contraceptive methods. Findings provide context to the complex issues related to unintended pregnancy and disease prevention among Latinos residing in rural communities.

The adverse consequences of unintended pregnancy are serious and wide ranging for women, families, and society (Brown & Eisenberg, 1995). Rates of unintended pregnancy are higher in the United States than most other industrialized countries, and they vary dramatically by race/ethnicity and income (Lottes, 2002). Although women from diverse backgrounds experience unintended pregnancies, Latina women are disproportionately at risk. In

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2002, 40.1% of Latinas aged 15–44 reported ever experiencing an unwanted or mistimed pregnancy, compared with 26% of non-Hispanic White women (Chandra, Martinez, Mosher, Abma, & Jones, 2005). Poor Latina women (with incomes below the federal poverty threshold) have the highest rate of unintended pregnancy of any group (Cohen, 2008). Latinos are also disproportionately affected by STIs including HIV/AIDS. In 2007, Latinos represented 15.1% of the U.S. population, but they accounted for 20% of the total number of new AIDS cases (U.S. Census Bureau, 2008). For that year, the AIDS case rate among Latinos was the third highest of any racial/ethnic group in the United States and 3.3 times higher than for Whites (Centers for Disease Control [CDC], 2008). Moreover, in 2007 Latinos were reported to have the second highest syphilis rate and third highest chlamydia and gonorrhea rates among all ethnic minorities (CDC, 2008).

Family planning clinics and community health centers have a central role to play in addressing the disparities in unintended pregnancy and STI rates among Latinos through the delivery of affordable contraceptives and reproductive health care. In 2006 alone, publicly funded clinics provided contraceptive services to nearly 5 million family planning users, 25% of whom were Latino (Fowler, Gable, & Wang, 2008). Few researchers, however, have explored the experiences of health care practitioners in the provision of contraceptive and reproductive health care to low-income Latino women and their families. Even fewer have focused on the experiences of health care providers whose Latino clients live in rural areas.

Between 1990 and 2000, the Latino population in the United States increased by 58% (Cresce, Scmidley, & Ramirez, 2004). As part of this dramatic growth, nontraditional settlement areas in the southeast and northwest parts of the United States experienced rapid increases in the number of Latino residents, a disproportionate number of whom migrated to rural areas (Kandel & Cromartie, 2004). For example, the population of Latinos in six southeastern states (Alabama, Georgia, North Carolina, South Carolina, and Tennessee) increased by more than 300% on average between 1990 and 2000 (Painter, 2008). In the same period, Latino populations in the northwestern states of Oregon, Washington, and Idaho increased by 316%, 268%, and 178%, respectively (Painter, 2008).

Adequate health care is a problem for rural populations, in general, and for racial/ethnic minorities in particular (Probst, Moore, Glover, & Samuels, 2004). New Latino immigrants in rural areas face a number of unique challenges in accessing health services as compared with their urban counterparts, including lower levels of education, higher rates of poverty, and a lower likelihood of having health insurance. In 2003, 47% of rural Latino adults lacked a high school diploma compared with 14% of their Non-Hispanic White counterparts (Kandel, 2005). One in every four rural Latinos in the United States lives in poverty, and they are less likely to have health

insurance than their urban counterparts (Probst et al., 2004). National studies indicate that Latinos are more likely to have unmet health needs, are less likely to have a regular provider, and are more likely to report fewer visits to a physician than their White counterparts (Probst et al., 2004). Finally, although Latinos represent the fastest growing segment of the population in nonmetropolitan counties in the United States, rural America is still predominantly White (Kandel, 2005). Rural Latinos may, therefore, face a number of challenges in accessing health care and obtaining culturally competent services.

Several studies have helped researchers document barriers to accessing and utilizing health care and family planning services among groups of Latino immigrants. Commonly perceived barriers to health care include the high cost of services and lack of health insurance, communication difficulties, legal status questions, fears of discrimination, and lack of transportation (Cristancho, Garces, Peters, & Mueller, 2008). In addition to these barriers, access to family planning services may be influenced by cultural norms and expectations and limited information about contraception and disease prevention (Rhodes et al., 2007; Sable, Campbell, Schwarz, Brandt, & Dannerbeck, 2006).

Providing reproductive health services to this population requires meeting language needs and developing culturally sensitive practices (Russell, Lee, & the Latina/o Teen Pregnancy Prevention Workgroup, 2004). That is, service providers need to respond to cultural values and beliefs that likely influence decisions to access and use sexual health services as well as influence decisions to use or discontinue use of methods to prevent unintended pregnancy and protect against HIV/STI. More information is needed on the role of providers in these decision-making processes and how their interactions with Latino clients influence the use of sexual and reproductive health care (Foulkes, Donoso, Fredrick, Frost, & Singh, 2005). Improving cultural competence in the delivery of health care calls for input from providers who serve as gatekeepers to these services. Because of their daily work in these communities as well as their experiences with the administrative challenges of providing services in a rural environment, health care providers are a valuable source of insight into the complex issues that influence unintended pregnancy in rural Latino communities.

The present study is part of a larger project, the Latino Health Project/*Proyecto de Salud Para Latinos*. Our goal is to increase understanding of unintended pregnancy among young Latinos by examining factors that influence contraceptive use, sexual risk behavior, and HIV/STI prevention in four rural communities in Oregon that have experienced a high growth in their Latino population. In this article, we report findings from focus groups with health care practitioners who provide services to the target population. From the practitioner perspective, we explored the following (1) what factors impede the acquisition and use of contraceptives among Latino women

and men; (2) what are the barriers to HIV/STI prevention faced by Latino women and men; and (3) what might improve access to and use of reproductive health services for this population?

METHODS

Participants

We used focus group discussions to address our research objectives. Focus group methodology is a qualitative approach that involves observing, recording, and assessing phenomena from the participants' perspectives. The resulting discussions offer concentrated insight into participants' thinking and understanding of specific topics and are particularly well-suited to explore new research areas (Krueger & Casey, 2008; Morgan, 1988). Focus groups were conducted with health care providers from seven medical offices that serve four rural Oregon communities. Clinics were selected if at least one-third of their patients were Latino and if the clinics received funding from the following (a) Title X clinics (funded by the U.S. Department of Health and Human Services-Office of Population Affairs); (b) Family Planning Expansion Program (FPEP) sites (funded by Medicaid Title XIX); or (c) Federally Qualified Health Centers and Migrant Health Centers (funded under Section 330 of the Public Health Service Act). The majority of clients served by these clinics are from Mexico.

Focus groups were held at two county health departments, two federally qualified health centers, one migrant health center, and one midwifery group. In order to capture the diversity of experiences and perceptions about the delivery of sexual and reproductive health services to Latino men and women living in rural areas, we recruited health care providers from multiple disciplines (e.g., MDs, nurse practitioners [NPs], counselors) as well as office staff that interact with Latino clients (e.g., receptionists, translators, and outreach workers). The number of providers participating in each focus group ranged from four to 10. After conducting nine focus groups, all members of the research team agreed that we had achieved saturation (i.e., when no new information was being obtained; Krueger & Casey, 2008).

We planned the focus groups in consultation with our contacts at the clinics. Participants were invited to attend through flyers distributed to staff electronically as well as through the mail. The majority of focus groups occurred during lunch when most staff were available or during regularly scheduled staff meetings. We provided food and beverages to increase interest in participation.

Participants included 66 health care providers and office staff. Fourteen percent of providers were physicians and 25% were registered nurses (RNs), certified nurse midwives (CNMs), or NPs. The remaining participants were

physician assistants (PAs; 3%), medical assistants or clerks (36%), or other administration staff such as receptionists or translators (22%). One quarter of participants spoke Spanish and English, with 27% reporting some Spanish language proficiency. The majority of participants were female (88%), and just less than half of the sample reported being Hispanic/Latino. The study was approved by the Oregon State University Committee for the Protection of Human Subjects/Institutional Review Board.

Data Collection

Focus groups were conducted in January and February 2007. At the start of each session, the focus group moderator explained the purpose of the project and asked each person to complete a written informed consent. Before the focus group sessions began, all participants also were asked to complete a short quantitative survey. The survey included demographic characteristics of the participating providers including his or her job title, years in the profession, spoken language/s, age, gender, and race. The survey also assessed providers' perspectives of potential barriers that Latino women and men may experience in acquiring and using pregnancy and HIV/STI prevention methods with a 23-item scale adapted from Sable and Libbus (1998). Providers were asked the extent to which they agree (using a 5-point scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*) that each of the 23 statements (see Table 1) described a potential barrier. Because group interaction is an explicit component of focus group discussions, the survey was intended to collect information from each provider individually prior to group interactions and discussions (Patton, 2002).

Trained members of the research team served as the focus group moderator and assistant moderator. Because of the composition of the groups, we asked moderators to pay particular attention to potential power differentials among participants (e.g., administrators, physicians, nurses, receptionists) and to encourage all individuals in the groups to contribute. The focus groups lasted for approximately 1 hour, and the moderator used a semi-structured topical guide to stimulate discussion. The focus group interview guide was designed to elicit providers' opinions about specific topics and used open-ended questions to stimulate discussion. Based on findings from key informant interviews, a review of the literature, and the researchers' prior work with this population, the focus group discussion guide included questions about the following categories: barriers to contraceptive use and HIV/STI prevention; methods used by Latinos to prevent pregnancy; cultural norms surrounding pregnancy and HIV/STI transmission; how acculturation affects unintended pregnancy and HIV/STI prevention; the effect of discrimination and medical mistrust on the ability of Latinos to access health care and family planning services; and how information and services ideally might be delivered to Latinos. All sessions were audio-recorded.

TABLE 1 Percent of Providers Who Agreed or Strongly Agreed That Selected Reasons Served as Barriers to Latino Men and Women in Acquiring and Using Pregnancy and HIV/STI Prevention Methods

	%
Access-related issues	
Clinic hours are not convenient for patients	36.9
Patients have no one to watch their children while they go to the clinic	67.7
There are no clinics close to where many patients live	34.4
It takes too long for patients to get an appointment to get birth control methods	12.3
There is too much waiting time at clinics	32.3
Provider–patient interaction	
Patients do not trust doctors and health care providers	15.7
Patients are suspicious of information from doctors and health care providers	12.7
Patients experience discrimination because of their race, ethnicity, or color when seeking health care services	35.5
Discussing birth control methods is embarrassing for patients	57.9
Going to get birth control methods is embarrassing for patients	56.3
Method attributes	
If women didn't have to get a pelvic exam, they'd be more likely to get pills	52.3
Injectables are hard for women to use because they have to return to the clinic every 3 months	30.3
Patients have concerns about the immediate side effects of birth control methods	73.0
Patients have concerns about the longer-term side effects of birth control methods	65.6
Cultural & partner norms	
Patients' cultural values are not supportive of using family planning or birth control methods	61.9
Patients' religious values are not supportive of using birth control methods or family planning	60.9
Patients' partners do not want them to use birth control methods	50.8
Knowledge	
Patients don't know where to get birth control methods	40.9
Patients don't know where to get condoms	24.2
Patients do not understand how to use birth control methods	48.5

Analysis

The qualitative data were analyzed using content analysis techniques (Neuendorf, 2002). Recordings of each focus group session were transcribed verbatim and reviewed for accuracy. The full research team, which included the principal investigator (PI), coinvestigator, and the project coordinator, independently read all transcripts. After this preliminary examination of the data, we identified major topics and developed related codes. Two members of the research team read and coded the transcripts, and identified: (a) factors that impede the acquisition and use of contraceptives; (b) barriers to HIV/STI prevention; and (c) suggestions for improving access to and use of reproductive health services among rural Latinos. Coders compared notes, aligned code names, and resolved any disagreements in interpretation through

discussion. The full research team then met and reviewed codes, discussed findings, and identified salient themes. Exact quotations were selected to illustrate each theme. Themes were selected if they were mentioned in 80% of focus group discussions. For the structured questions from the pre-focus group quantitative questionnaire, we used SPSS to examine the frequency distributions of participants' responses.

RESULTS

Factors That Impede the Acquisition and Use of Contraceptives

Results From the Pre-Focus Group Survey

Responses from the pre-focus group survey are summarized in Table 1. We grouped items topically and report the percentage of providers who agreed or strongly agreed with each statement. The majority of providers agreed that access-related issues were significant barriers to rural Latinos getting or using contraceptives, specifically transportation problems in getting to the clinic (92.2%) and lack of child care during appointments (67.7%). Approximately one-third of the providers also identified inconvenient clinic hours, excessive distance of clinics, too much waiting time at clinics, and high costs of birth control methods as important barriers.

Provider–patient interactions also were identified as potential barriers, with over one-half of providers reporting that their Latino patients were embarrassed to discuss birth control and to get birth control. Over one-third agreed that experiencing discrimination when seeking health care services was also a barrier for rural Latinos. A high percentage of providers also reported that specific attributes of birth control methods were obstacles to their use. More specifically, providers perceive that patients have concerns about long-term (65.6%) and short-term (73.0%) side effects of birth control methods. Over one-half agreed that women would be more likely to get birth control pills if they could forgo the pelvic exam.

Cultural and partner norms also were perceived as barriers by the majority of providers. Nearly two-thirds reported that their patients' cultural and religious values were not supportive of using birth control methods, and over one-half agreed that their patients' partners were not supportive of using birth control. Health care providers also identified lack of knowledge about where to get birth control methods (40.9%) and how to use them (48.5%) as potential barriers for their Latino patients.

Results From the Focus Group Discussions

Based on analysis of the focus group discussions, we identified the following three thematic categories related to perceived barriers to the prevention of unintended pregnancy and contraceptive use: access-related issues; beliefs

about birth control; and cultural and partner norms. These categories parallel issues identified in the pre-focus group survey.

Access-related issues. When we asked providers to talk to us about what they perceived as barriers for rural Latinos to access birth control and family planning services, cost of birth control was one of the first barriers mentioned across all focus groups. Although participants reported that in many situations birth control can be obtained inexpensively, several providers explained that for many of the migrant farm workers that they see, even low-cost birth control is too expensive:

> I do think for a certain group of our population, money is an issue. Not during the summer when they are working, but during the winter where their savings have run out and the choice is "Do I feed my kids, or do I get my birth control?"

Despite the fact that programs are available to provide birth control to low-income individuals, providers in the majority of the groups noted that Latinos may be unfamiliar with these programs and face other challenges in "navigating the system." The "system" involves multiple obstacles such as where to go for services, how to pay, how to fill out required paperwork, and even how to deal with common medical office procedures like calling to make an appointment. Providers noted that these situations are daunting especially for people with low English proficiency and little formal education:

> One of the big factors that I see is ... navigating our system. It's so cumbersome. And some of the folks that I have seen, their level of education is really low and when they call in to a number and they are expecting to talk to a person, and when they get a recording they just hang up.

Concerns related to transportation were perceived as one of the major barriers in all focus group discussions, echoing the finding from the pre-focus group questionnaire. The opinion that it was harder for men and women who live in rural areas to get to clinics was mentioned in the majority of the focus groups. In addition, most providers felt that the primary issue was that many rural Latinas do not drive:

> One of the things is transportation ... to make an appointment. They call and make an appointment, but they don't drive. So transportation is a big issue for them. Usually, the spouse has to take time off from work to take the wife to get the birth control. Then they have the kid and now they have to find someone to watch the kid to take time off.

Beliefs about birth control methods. Discussions about specific birth control methods focused on beliefs about method attributes that the

providers felt were widely held and perpetuated in the Latino community. Providers in almost all groups mentioned encountering people with stereotypic beliefs about certain methods (e.g., birth control pills cause cancer or sterility). Providers felt that along with the potential known side effects, these perceived side effects were barriers to women adopting or continuing to use new birth control methods:

> A lot of women think that I'm not having [a sex drive] because of the birth control. They blame everything on the birth control. In the big picture it's something else, but they want to get rid of the birth control first. It's really hard to get over that.

Providers commented that many of the concerns about side effects appeared to be commonly held among their Latino clients and that misinformation about side effects was difficult to correct. One provider, when asked about factors that affect the ability of Latino women to use birth control methods, responded:

> Fear of the method itself. Hearing what we call "wives' tales," hearing stories about a method from somebody else who had a bad experience, so they are fearful from the beginning. They are turned off from hearing any information; they just hear what they know.

Almost half of the providers also believed that lack of formal education among rural Latinos was a significant barrier to their use of birth control methods. As one provider explained, "[A major barrier is the client] . . . not understanding the information. We have the information and we explain it to them. Sometimes it takes two or three times for them to really understand the whole picture."

Cultural and partner norms. During the focus groups, we asked providers if they had encountered any cultural factors that they felt were barriers to the provision of birth control to their Latino clients. In response, providers in almost every group mentioned that in the Latino culture, people not talk openly about birth control, sexually transmitted diseases, or sexuality. Several providers noted a difference in comfort level between the first and second generations in discussing sex. The majority of the providers reported that this lack of open discussion had a direct impact on the contraceptive behavior of young Latinos. One provider felt that her Latina clients simply needed someone they could talk to about birth control:

> [Latinas need] . . . someone that they feel comfortable talking to about what is going on in their lives. They can't talk to their parents about it, because they'll just shut them down. Their parents aren't able to talk to their kids about stuff like that.

In addition to encountering a cultural reluctance to discussing sexuality, many providers reported lack of support for the use of birth control in some Latino families:

> What I have found in my experiences is that a lot of the young women that are already having a sexual relationship are afraid to try anything, and their boyfriends or their husbands are not encouraging them to try any kind of birth control method. And then I think also that in our culture, our upbringing, we are told that this just isn't the thing that you're supposed to do. So that kind of prohibits, you know, the young women to seek. I mean, they're afraid to come in and inquire about it.

Another impediment providers encountered when educating clients about effective birth control was, according to nearly every focus group, a high cultural acceptance of withdrawal as a birth control method:

> I think . . . that there is a real aversion to using condoms, and I think. . . . My impression is that in this Latino community, . . . they believe that withdrawal is more effective than other groups believe that withdrawal is effective. It's a very common birth control method.

> The form of birth control that I hear the most often when I go in to see a woman is, "My husband takes care of me." And then basically what they are meaning is that he's not ejaculating inside, he's ejaculating off to the side.

Male partners were also perceived as a road block to making birth control more accessible to Latinas. Almost half of providers said they felt that male partners may not want their female partner to use any birth control method. Providers also mentioned that many male partners do not have information about birth control methods and that others do not get involved at all and consider birth control strictly a woman's domain. Most comments regarding male partners and family planning however, were related to the high value providers felt that Latino men place on having children and large families and the use of withdrawal as a birth control method:

> I tested someone the other day, and I asked them some questions. On the questionnaire it asks what kind of birth control you are currently using. And this couple said, well, "He takes care of me." Well, I knew what the method was, so then I asked the guy, "How do you take care of her?" And he thought about it for [a few] minutes and said, "I can't answer that for you." I didn't want to push it anymore, but that is something we really need to focus on. How do we educate the farmers? That is something I am trying to do when I go out and talk to people. What birth control method is your partner using? Because most of the time in the Latino

community, the men will say, "Oh, the women is taking care of that. She's taking care of that."

Barriers to the Prevention of HIV/STIs

We also asked providers to talk about barriers they encounter in helping their Latino clients protect themselves against HIV and other STIs. "Education" was one of the first topics that emerged from every group. Many providers mentioned that particularly among first-generation Latinos, knowledge about HIV and AIDS was marginal, but especially low concerning other STIs:

> Immigrants who have not come through the school system here I think have very, very little information about HIV or STIs, probably less about STIs than HIV. They usually know, like, about AIDS but gonorrhea and chlamydia, it's like, "What's that?"

Providers in most groups also reported the prevalence of myths in their Latino client population about how STIs are transmitted:

> I've heard women say that, "My husband says I got it off the bathroom, off the toilet seat." They have no concept of how it is spread through contact, contact with, you know, bodily fluids. They take it for what they say. It's just . . . a lack of education.

Denial from some of their Latino clients that they have, could have, or are even at risk for an STI also commonly was cited by providers as a barrier to people protecting themselves and their partner from disease: "What I keep hearing from the clients is the denial. The strong denial that you won't have it." "They also think, 'It will never happen to me . . . not me! I'm careful, I know who I'm sleeping with! They don't look ill!"'

Providers also reported that male and female clients had different perspectives about their risk of contracting an STI. In several cases, providers referred to women's denial that they could have been infected by their husbands. One medical translator explained:

> I've interpreted for a few cases where the female comes in and, "Oh my God, I'm having this symptom, itching and this burning sensation, and all this," and I have to translate. "Well it's not what you think you have, you have an STD." And they go, "Well, what's that?" and [I say] "It's a sexually transmitted disease, and this is what you have," and they're, like, shocked. "The only one I've been with is my husband," you know, and . . . this and that . . . and then they will tell [the provider], "My husband hasn't been with anybody, you know, . . . I must have got it from a toilet seat."

Condoms and condom use among couples were discussed at great length in the focus groups. Not surprisingly, when we asked providers if their Latino clients were using condoms to protect themselves and their partners from HIV and other STIs, the resounding answer was "No." Providers in nearly all groups reported that men do not like to use them because sex does not feel the same, and, as one provider said, "Condoms aren't sexy." Many providers also felt that the younger generation (younger than 18) were using condoms more than Latinos in the 18–25 age range. As one provider observed, "Some of them [are using condoms], but it's mostly a younger person thing."

Providers also noted that condom use among married couples or people in long-term relationships was exceptionally rare. Providers repeatedly mentioned that in their experience of talking to clients about condom use, condoms represented trust, and that if either member of a couple wanted to use a condom it could signify unfaithfulness:

> I think it goes both ways. If a woman says, "Let's use a condom," then it's, . . . "Why?" And if the man says, "Let's use a condom," and then it's the same thing, . . . "Why? Do you not trust me? Are you doing things behind my back?" It just goes to the lack of communication and education in the community that we really need to work on.

Facilitators to Improving Access to and Use of Reproductive Health Care

When we asked providers to talk about some of the things they felt could facilitate access to reproductive health care, several main themes emerged. First and foremost, patient education was mentioned by all groups; providers felt strongly that women and men should be educated about pregnancy and birth control at an earlier age. Providers advocated for Latino parents to be educated on these topics as well, in the hopes that it might foster a more open environment for talking about issues related to sexuality. Providers also felt that some barriers to reproductive health education could be addressed simply by having more educational materials in Spanish, and having more Spanish-language resources available: "I wish somebody would put out a birth control pill that had Spanish instructions right on them." "One page pieces of [bilingual] information that were. . .well done would just be fantastic."

Convenient birth control methods were also frequently mentioned as a facilitator. Most providers described "convenience" to mean methods that do not require maintenance, refills, or multiple visits to a clinic. The IUD in particular was mentioned in every group as a method that potentially could meet the needs of many of their Latina clients in terms of convenience. Providers also noted that, in many instances, they were able to provide the Mirena IUD free of cost through a nonprofit foundation.

It was clear that all of our discussants were dedicated to providing the best services possible to their Latino clients; generally, the provider groups we spoke with felt strongly that their clinic was very effective in making reproductive health care particularly accessible to rural Latinos. When asked how they thought clinics could improve access for this population, common threads that emerged from the groups included encouraging women to come into the office and routinely offering birth control at their 6-week postpartum visit; developing and maintaining a trusting relationship between providers and clients; and having Spanish-speaking providers and translators available at clinics.

DISCUSSION

In this study we explored, from the perspective of health care providers, barriers to contraceptive use, HIV/STI prevention, and access to reproductive health services for young Latino men and women living in rural communities in Oregon. Consistent with previous studies, we found that multiple factors contributed to limiting access to and use of contraceptives and health care services, including individual, interpersonal, and health care systems factors. In focus group discussions, providers identified the cost of birth control and concerns about side effects as major barriers to contraceptive use for Latinas. They also identified a general aversion to using condoms for pregnancy and HIV/STI prevention, particularly among couples in long-term relationships. These barriers have been identified in previous studies of contraceptive use in the United States and, thus, appear to be widely shared across cultural, economic, and geographic spectrums in this country (Espey, Cosgrove, & Ogburn, 2007; Harvey & Henderson, 2006; Noar, Zimmerman, & Atwood, 2004; Sable, Libbus, & Chiu, 2000; Trussell & Wynn, 2008).

Some of the barriers identified by providers in our study, however, appear to be specific to Latinos, especially rural Latinos. Lack of transportation and language barriers (insufficient Spanish-language materials and translation services) were among the chief obstacles identified by providers to accessing available contraceptive services. Providers in all groups felt strongly that providing additional education about particular methods of contraception, sexual health, and disease prevention would go a long way in overcoming some of the barriers in the Latino communities they served. These findings are consistent with previous findings with Mexican immigrants (Cristancho et al., 2008). Important research also currently is being conducted to address the creation of bilingual educational materials that are intended for a low-literacy audience and are presented in a culturally relevant format (Denny-Garamendi, Lopez-Rabin, Guendelman, & Schafer, 2007).

Cultural norms and the role of male partners also were highlighted as barriers to the provision and use of effective birth control methods. These

findings are consistent with earlier research that highlights the importance of male partners and relationship factors in use of contraceptives, including condoms among Latina women (Cabral, Pulley, Artz, Brill, & Macaluso, 1998; Grady, Klepinger, & Nelson-Wally, 1999; Harvey, Bird, Galavotti, Duncan, & Greenberg, 2002; Harvey, Henderson, & Casillas, 2006; Quadagno, Sly, Harrison, Eberstein, & Soler, 1998; Sable et al., 2000; Soler et al., 2000). In addition, many providers cited a reluctance among Latino families and couples to talk about birth control and sexually transmitted diseases as barriers to contraceptive use. This concern has been noted in other studies (Gilliam, 2007; Rios-Ellis et al., 2008) and highlights the need for men and families to be involved in prevention efforts. Open discussion of these topics can help to remove the stigma associated with condoms and STIs and invite conversation based on self-care and responsible parenting (Rios-Ellis et al., 2008).

Other barriers that were noted in the pre-focus group questionnaire were not significant topics in the focus group discussions. Among these were issues related to clinic access, such as inconvenient hours and long wait times, to which over a third of the providers agreed or strongly agreed were barriers to contraceptive access and use. Thirty-five percent of providers also had agreed that discrimination was an obstacle; however, none of the focus groups directly addressed the role of discrimination in the ability of their Latino clients to access services. This discrepancy is of particular interest because other research indicates that Latinos report discrimination as an important issue in health care. For example, in a nationally representative survey conducted by the Kaiser Family Foundation in 1999, 75% of Latinos reported that racism was a problem in health care, with 30% considering it to be a major problem (Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). In addition, over half of Latinos indicated that race/ethnicity has an effect on a person's ability to get needed routine medical care (54%), specialized treatments or surgery (51%), or health insurance (56%). Although providers in this study may have seen discrimination and waiting times as obstacles for Latinos in health care in general, they did not appear to see it as a problem within their own clinics.

Finally, the composition of our focus groups, in terms of occupation, is worth noting. Over half of the participants who responded to our recruitment efforts were nonmedical staff including medical assistants and clerks (36%), or other administration staff such as receptionists and translators (22%). Our recruitment was not targeted toward a particular provider group, but rather we encouraged anyone to participate who was interested in sharing their experiences about serving Latino clients. The fact that such a large percentage of nonmedical staff responded reflects the reality that multiple staff, not just medical staff, interact with and influence the experience of patients (Smedley, Stith, & Nelson, 2003). Front office staff set the stage for health care access, medical assistants may collect patient medical histories or run simple laboratory tests, while translators have a unique eye into the trajectory of the

entire visit; all of these staff are privy to clients' most personal information. Taken together, these individuals play as significant a role as medical staff in contributing to an experience that can promote or deter patients from health-seeking behaviors (Smedley et al., 2003). Future research needs to explore the dynamics of different staff members' interactions with Latino patients, and how to best ensure that staff is properly trained to be culturally competent, and preferably bilingual.

Some potential limitations should be noted. First, this was a qualitative focus group study. We recruited participants at clinics throughout the region in order to increase the likelihood of capturing a wide spectrum of viewpoints. Our relatively small sample size and limited geographic area, however, means that findings cannot be generalized to all providers who serve rural Latinos. In addition, we asked providers to complete our quantitative survey before the focus groups began. We thought it was important to hear from individuals before they engaged in the discussion so their answers were not influenced by others. It could be argued, however, that administering our survey prior to the focus group biased the discussions. Despite these limitations this study is one of the first to explore barriers Latino clients confront from the perspectives of rural health care providers.

Several recommendations to improve access emerged from our discussions. Many providers saw benefits to involving male partners in the provision of family planning services. Although much of the discussion around male partners focused on the barriers they represented, many providers did acknowledge that welcoming and encouraging men to play a more active role might foster a positive attitude toward family planning within a couple or family. Whether this involvement comes through education, programs targeted at Latino men, or by encouraging men to accompany their partners to the clinic, involving men in the process is likely an important step to overcoming some barriers experienced by Latinas in obtaining and using family planning services. This recommendation is particularly salient for providers in developing countries, where men play important and often dominate roles in decisions regarding contraception and family size (Bankole & Singh, 1998; Dahal, Padmadas, & Hinde, 2008; Ha, Jayasuriya, & Owen, 2005; Tuluro, Deressa, Ali, & Davey, 2006).

Providers were also enthusiastic about client education regarding contraceptive methods and their use. Making materials available at an appropriate reading level and in Spanish is an obvious first step that many providers favored. Spanish-language materials, however, are only a beginning when it comes to providing culturally appropriate services. To reach further into communities, dissemination of materials and messages will have to expand beyond the clinic. Outreach might include nontraditional providers, such as *Promotoras de Salud*. Numerous studies have documented the effectiveness of *Promotoras* in bridging the community with the formal health care system (Colombo, Freeborn, Mullooly, & Burnham, 1979; Myers, 2000; Ramos,

May, & Ramos, 2001; Rosenthal, 1998; Watkins & Larson, 1991). *Promotoras* act as liasons between medical clinics and the communities in which they themselves live, and their expertise is based on being able to connect with populations that are generally harder to reach, underserved, or in need of a particular service (Kohn, Hill, & Fenimore, 2004). In addition to providing reproductive and sexual health information, *Promotoras* could also serve as bridges to the health care system in rural Latino communities, helping community members access services and play a more active role in their health care.

Many providers noted that Latino cultural norms around pregnancy and sexuality are sometimes in conflict with the prevailing norms. For example, U.S. family planning programs tend to discourage early childbearing, promote smaller family size, and encourage couples to postpone childbearing until economic security has been attained. In Latino culture, however, the highest value is placed on family and motherhood, even at a young age (Foulkes et al., 2005; Russell et al., 2004). Providers, in order to effectively serve their clients, must recognize, respect, and incorporate cultural values and norms in practice. For example, Latino clients may appreciate information about the benefits of spacing children for the health of the children and the mother, but they may not welcome simplistic messages about pregnancy prevention that do not take their own fertility desires into consideration.

Our discussions with providers gave context to the complex issue of unintended pregnancy and sexually transmitted diseases in rural Northwest Latino communities. We hope that these exploratory accounts from the provider viewpoint will prompt dialog and complement the research we are currently doing with rural Latino men and women. Gathering and synthesizing information from multiple levels will generate the knowledge future researchers need to create successful interventions and services that address Latinos' reproductive health needs in the Northwest United States and beyond.

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