Hispanic Women’s Expectations of Campus-Based Health Clinics Addressing Sexual Health Concerns

DIONNE P. STEPHENS, PhD  
Florida International University, Miami, FL, USA

TAMI L. THOMAS, PhD  
Emory University, Atlanta, GA, USA

Although the number of Hispanic women attending postsecondary institutions has significantly increased in the past decade, knowledge about their use of campus health services to address sexuality-related issues remains low. Increased information about this population is crucial given that sexual health indicators have shown Hispanic women in college to be at a greater risk for negative sexual health outcomes compared with their white counterparts. In this study, we conducted individual interviews with Hispanic women to explore their sexual health concerns and identify the roles they see campus-based health clinics playing in addressing these issues. Study findings suggest a need for health providers to provide sexual health skills that empower Hispanic women, the importance of creating a sense of comfort and trust with the health provider, and illustrating respect for cultural values. Campus health centers can play an important role in providing culturally appropriate sexual health information to Hispanic and other ethnic/racial minority students.

KEYWORDS Hispanic, women, campus, sexual health

The majority of universities and colleges in the United States offer health services as part of a long-standing commitment to primary health care concerns, including the promotion of students’ physical and psychological well-being. Although these young people come to student health care...
centers with many of the same problems that are seen in a general medical practice, some conditions present more commonly in the college-age population.

Sexual health concerns are of particular importance for campus-based programming and services. For example, studies suggest that while the majority of female college students in the United States have had sexual intercourse (e.g., Downing-Matibag & Geisinger, 2009), many engage in high risk sexual behaviors (e.g., Eisenberg, 2001; Inungu, Mumford, Younis, & Langford, 2009), use contraceptives inconsistently (e.g., Corbett, Mitchell, Taylor, & Kemppainen, 2006), and are vulnerable to sexual coercion/violence (e.g., Basow & Minieri, 2010; Brener, McMahon, Warren, & Douglas, 1999). For these reasons, there has been a long-standing emphasis among campus-based services targeting women’s sexual health needs. This can range from the marketing of special sexual health education programs to the creation of women’s only health clinics.

Although numerous studies have examined experiences of sexual violence (e.g., Basow & Minieri, 2010; Brener et al., 1999), HIV/AIDS and sexually transmitted infection (STI) risk (e.g., Espinosa-Hernandez & Lefkowitz, 2009), condom use (e.g., Gurman & Borzekowski, 2004; Jemmott, Jemmott, & Villarruel, 2002), and sexual decision making (e.g., Kerns et al., 2003; Stephens, Fernandez, & Richman, in press) among Hispanic college women, few studies have examined this specific population’s perceptions of campus-based health centers as sexual health service providers. Further, most of these studies focus on Hispanic women whose familial origins trace to Mexico or Central America; this ignores the unique experiences of those Hispanic women of Caribbean and South American descent. This is particularly true in the southeastern United States where there has been the most significant growth in Hispanic populations over the past decade (Passel, 2011). As Hispanics are the largest ethnic minority in the United States and the number of Hispanic women attending universities is increasing (Harvey, 2002; Maton, Kohout, Wicherski, Leary, & Vinokurov, 2006), there is a clear need for research specifically examining this population’s sexual health concerns and use of campus-based health services. The goal of the present study was to identify the perceptions of campus-based health clinics in addressing sexual health issues among Hispanic women attending college in the southeastern United States. To explore these phenomena, we examined the following research questions:

1. What are Hispanic college women’s perceptions of their sexual health needs?
2. What role would these women like campus-based health services to play in addressing these sexual health needs?
REVIEW OF THE LITERATURE

Although the number of Hispanic women attending postsecondary institutions has significantly increased in the past decade, knowledge about their sexual health needs and use of campus health services remains low. This increase in campus population diversity challenges administrators to explore how culture influences an individual’s protective sexual health practices and the potential contributions of college services to this process. This is a particularly important charge given that sexual health indicators have shown Hispanic college-age women to be at greater risk for negative sexual health outcomes compared with their white counterparts (see Espinosa-Hernandez & Lefkowitz, 2009; Gurman & Borzekowski, 2004; Villarruel, Jemmott, Jemmott, & Ronis, 2007). For example, Hispanic youth and young adults are at a disproportionate risk for HIV infection. Hispanics in this age group represented 20% of the cumulative reported AIDS cases among youth and young adults, although they accounted for only about 12% of the total U.S. population of this age (Centers for Disease Control & Prevention [CDC], 2002a). Young adult and teen Hispanic women have higher rates of chlamydia and gonorrhea than non-Hispanic white teenage women and are less likely to use a condom at first intercourse (CDC, 2002b). Researchers point to factors such as cultural norms, discrimination, poverty, and limited access to health care as contributors to these outcomes. These unique experiences highlight the importance of examining the experiences specific to Hispanic college women.

College Women’s Sexual Health

It is often incorrectly assumed by some health education researchers that college students already have received basic sexual health education classes and that an acceptable level of sexual risk knowledge is gained through high school curricula (Downing-Matibag & Geisinger, 2009; Ehlinger, 2007). Although research has shown that effective sex education programs delay adolescents’ sexual onset and increase contraceptive use among adolescents who have sexual intercourse, the quality and effects of programs differ according to instructor, school, state, and program content (Coyle et al., 1999; Kirby, 2002). It is also important to note that while the percentage of high school-aged youth (freshman through seniors) reporting they have had sexual intercourse fell from 53% in 1993 to 50% in 1999 (CDC, 2002a), 71% of college students reported engaging in sexual intercourse (Eisenberg, 2001). Further, although “hooking up”/having multiple short-term sexual partners was found to be viewed as an accepted part of college culture (Downing-Matibag & Geisinger, 2009), only 41% of college women report consistent condom use (Eisenberg, 2001), with many holding incorrect perceptions
of their own and their peers’ susceptibility to STIs (Corbett et al., 2006; Downing-Matibag & Geisinger, 2009; Inungu et al., 2009). These findings indicate that college is a critical period for providing sexual health information to young adults.

Campus-Based Health Services

Campus health centers are in a particularly unique position to address young adults’ sexual health concerns. The presence of health centers on campuses has been found to have a significant positive effect on health outcomes since services were offered starting in the 1930s (Boynton, 1971). When services from these sites were made available, both male and female students were more likely to go in for preventive health services and have fewer sick days (Ehlinger, 2007). Sexual health services on college campuses have existed for more than 40 years and historically have provided information on health promotion and disease prevention (Sloane & Sloane, 1986). Staffed by general and specialized health educators, nurses, and physicians with training in human sexuality, psychology, and public health, these programs have been on the front lines of preventing the spread of sexually transmitted infections and promoting health for students on college and university campuses (Roddenberry & Renk, 2010). As these services are often available at a lower cost than traditional medical centers and can be scheduled around classes, many students prefer using these campus-based clinics to conveniently and quickly address sexual health concerns. For many students, the student health care center provides the first opportunity for independent health care decisions (Hicks & Heastie, 2008). Thus, these initial encounters with health care providers can also set the pattern for future use of health care centers and the larger health care system.

Hispanic Women’s Experiences

Unfortunately, few studies exclusively examine Hispanic college women’s use of campus-based services to address sexual health concerns; most have primarily examined outcome rates and programming that included Hispanic students. Most research on Hispanic women’s health service usage has relied primarily on community-based samples. This is problematic given that Hispanic college students have been found to often have unique life trajectories and differing access to support resources, including health services (Espinosa-Hernandez & Lefkowitz, 2009; Plunkett & Bámaca-Gómez, 2003). For example, young adults attending or intending to go to college have been reported as being more intentional about using contraceptives compared to noncollege-oriented young adults. Plunkett and Bámaca-Gómez (2003) found that Hispanic women enrolled in a four-year college
immediately after high school graduation were more than twice as likely to use condoms, more than twice as likely to use oral contraceptives, and over four times as likely to use multiple methods (condoms and another method) than their peers who did not enroll in college.

Clearly, there is a need to understand the specific sexual health concerns of Hispanic women in college settings and how these concerns can be addressed through campus-based health centers. The present study seeks to address these issues by examining the beliefs and attitudes of a group of women attending a predominantly Hispanic commuter university located in a southeastern urban center.

METHODS

Participants

PARTICIPANT RECRUITMENT

We employed purposeful sampling, which involved identifying participants who might give the most comprehensive and knowledgeable information about college-aged Hispanic women’s sexual health knowledge and service usage beliefs (Few, Stephens, & Rouse, 2003). Participants were recruited from a large Hispanic service institution located in the southeastern United States once approval for administering the study was received from the university’s Institutional Review Board. Participants self-registered for the study through a psychology research pool, known as Sona Systems; this is an online service through which psychology students register to participate in campus research for course credit. The age range of the women we recruited was intentionally focused so we could examine a broad range of attitudes related to campus-based sexual health services. Individuals interested in participating were screened for eligibility through the entering of ethnicity, age, and gender criteria in Sona Systems. Once they cleared these criteria, they were able to select an interview time from the choices provided in Sona Systems.

PARTICIPANT CHARACTERISTICS

The 26 study participants ranged in age from 18 to 24, with a median age of 20. All participants self-identified as Hispanic and heterosexual, and they were currently registered students at the university. Participants identified their familial national origins as Cuban (34.6%), Argentinean (23.1%), Mexican (15.3%), Dominican (11.5%), and other nationalities, including Peruvian, Puerto Rican, Panamanian, and American. Table 1 provides descriptive information about participants’ reported familial national origin, current residence, number of lifetime sexual partners, and current relationship status.
TABLE 1  Participant Demographics

<table>
<thead>
<tr>
<th>First reported familial national origins</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuban</td>
<td>9</td>
<td>34.6%</td>
</tr>
<tr>
<td>Argentinean</td>
<td>6</td>
<td>23.1%</td>
</tr>
<tr>
<td>Mexican</td>
<td>4</td>
<td>15.3%</td>
</tr>
<tr>
<td>Dominican</td>
<td>3</td>
<td>11.5%</td>
</tr>
<tr>
<td>Other (Peruvian, Puerto Rican, Panamanian, &amp; American)</td>
<td>4</td>
<td>15.3%</td>
</tr>
<tr>
<td>Residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living off campus with parents</td>
<td>18</td>
<td>69.3%</td>
</tr>
<tr>
<td>Living off campus alone or with friends</td>
<td>3</td>
<td>11.5%</td>
</tr>
<tr>
<td>Living on campus in dormitory</td>
<td>5</td>
<td>18.2%</td>
</tr>
<tr>
<td>Lifetime sexual partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has not had sexual intercourse</td>
<td>9</td>
<td>34.6%</td>
</tr>
<tr>
<td>1 partner</td>
<td>10</td>
<td>38.5%</td>
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<tr>
<td>2-3 partners</td>
<td>5</td>
<td>18.3%</td>
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<tr>
<td>4 or more partners</td>
<td>2</td>
<td>7.7%</td>
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<td>Current Relationship Status</td>
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<td></td>
</tr>
<tr>
<td>Currently not dating</td>
<td>8</td>
<td>30.8%</td>
</tr>
<tr>
<td>Dating but non- monogamous relationship(s)</td>
<td>8</td>
<td>30.8%</td>
</tr>
<tr>
<td>Dating monogamous relationship less than one year</td>
<td>6</td>
<td>23.1%</td>
</tr>
<tr>
<td>Dating monogamous relationship more than one year</td>
<td>4</td>
<td>15.3%</td>
</tr>
</tbody>
</table>

Data Collection and Analysis

INTERVIEW AND DATA COLLECTION

Informed consent was obtained from all participants after determining that they met the eligibility criteria and reviewed a letter of introduction that outlined the purpose of the study. A total of 26 interviews were conducted; each interview lasted approximately one hour. Demographic data were collected using a self-administered demographic questionnaire.

The interview questions were pilot-tested with three Hispanic women prior to study data collection. After these pilot interviews were completed, probes intended to solicit additional information were added to the interview question guide used with the study participants. The interview guide contained questions about campus health services and sexual health, including:

1) What do you think are the most important sexual health issues affecting Hispanic women in your age group today?
2) What do you think a practitioner needs to know about women your age to adequately address your sexual health concerns?
3) If you had to go back again to address a sexual health concern, how would you describe an ideal practitioner?
Each interview concluded with a question-and-answer period, at which time informational brochures about campus-based health services were provided and participants were encouraged to ask questions. All interviews were conducted in English by two research assistants who self-identified as Hispanic. For their participation, the students were given extra credit in their Introduction to Psychology course, which was recorded through Sona Systems.

Data Analysis

We sought to identify the range of participant perceptions in relation to addressing sexual health concerns on campus-based settings. Specifically, we wanted to explore women’s knowledge and beliefs about sexual health, cultural beliefs, current sources of sexual health information, and campus-based health center options. All interviews were audio taped and transcribed. The interviews were transcribed by three research assistants and then verified by one study investigator to ensure completeness, accuracy of the discussion content, and high quality transcription.

Themes identified in the data analyses were not specified a priori but rather were derived from the data. One lead investigator and a trained research assistant (D.S. and I.B.) read all the transcripts in their entirety, then coded and organized the data to identify key themes related to sexual health knowledge and attitudes, sources of sexual health information, and campus-based health services. Each then independently coded the data and created a comprehensive list of themes they identified in the data. The study investigator and three research assistants met to discuss and further refine each set of themes, resolve differences, and reach consensus on a coding scheme. Discrepancies were resolved by first revisiting and reviewing the data, and then through group discussion. To ensure validity, key themes were summarized, reviewed, and agreed on by all the study team members.

RESULTS

The results presented here are organized around three major themes identified in the analysis: 1) increasing knowledge and negotiation skills to empower women in sexual interactions, 2) creating a comfortable and trusting environment for addressing concerns, and 3) validating women’s experiences through displays of cultural competency.

Providing Knowledge to Empower Clients

When evaluating their own sexual health knowledge, the majority of the women in the present study felt they needed more sexual health education.
In total, 23 participants made statements about their lack of sexual health education, knowledge, and skills. All had received some sort of sex education in high school, but 11 indicated an interest in taking an additional course or participate in an informal program on campus to increase their knowledge.

I think being in college it’s sad. . . . in a way [Hispanic women] aren’t as aware as they should be.

I actually went to a Passion Party² over the weekend and I thought I knew everything, and I realized I knew nothing. I was shocked by how little I actually knew, and I think education was something that was missing. I think that what’s taught in schools isn’t enough; it’s just kind of biased.

I need to get more information on how to protect myself. I mean in high school they say, just don’t have sex. And [women] are not going to listen to that- they’re going to do whatever they feel like doing. They’re not learning to use condoms; they’re just learning to not have sex.

I think that in high school they try to teach you as much as they can without telling . . . like they just give us statistics of what can happen.

All 26 women reported they received messages that men should be the position of power when it came to making decisions and initiating intimate relationships. Although none agreed with this perspective, 16 of the women’s narratives indicated that their male partners made decisions about what occurred in sexual interactions.

I feel that [men] think that they’re in control. I don’t see the 50/50 thing going with them. My friends don’t see it, either, I think it can be because [my friends are] used to it, or maybe they think they have control, I don’t know . . .

Um, with dating men have to be in control. With sexuality it’s like, the men can go out and have a good time and have sex with a lot of women. But with the women they really date seriously, they look for a different kind of person—someone who hasn’t had all those experiences.

Participants also wanted to gain skills that would help them negotiate safer sexual interactions. Although the women felt it would be difficult to impossible to challenge these attitudes about Hispanic men’s and women’s sexual roles in relationships, 12 thought that health providers can help them learn to better negotiate safer sexual interactions and improve relationship dynamics.

If you’re having problems with your boyfriend. . . . You need to talk to a doctor about how you can help the relationship sexually.

[Hispanic women] are not supposed to enjoy sex. . . . unless it’s with their [long-term] partner. And [we] do it just to please the man. [Health
providers] should help you know how to please him but also please
yourself.

Um, they need to understand that [Hispanic women] can feel shy, so they
should ask things because a woman may not volunteer the information.
Help us learn how to make decisions.

When asked where they would seek sexual health information, participants
listed a health professional, the Internet, and their friends as their top three
choices. When specifically asked about campus-based health clinics, 25
agreed that they would be ideal sources for accurate sexual health infor-
mation because of the accessibility to expert educators, service providers,
and reputable resources.

Well since it’s campus you assume that [the staff] is going to have the most
up to date information. They have access to libraries, there are always
people coming to campus for talks and with the medical school. I mean,
[campus health centers] are right in the middle of where knowledge is
being taught and made.

Doctors in the community may not have so much time to keep up or
attend things like they have to on campus. It kind of becomes something
they have to do because of the nature of where they work so you think
that [campus-based health providers] keep up and attend the events.

Comfortable and Trusting Environment

All participants were willing to use the campus-based clinic to address their
sexual health needs; for those who had not used these sites, reasons in-
cluded: a need had not arisen (N = 9), they had not thought about it (N =
11), or they already had a provider they were comfortable with (N = 12). All
the women believed that health care providers and educators on campuses
would have more experience working with young adults and related sexual
health issues. This was viewed as increasing the likelihood that the health
care providers and educators would be less judgmental, increasing these
women's comfort levels with using campus-based health centers.

Well I was raped so... To be honest, it's not something I talk about
with my friends. I guess it's one of those hush things where you don't
necessarily talk about it... But I went to the clinic at FIU. [The health
provider] checked on me after - I mean it's nice to get a phone call like
that. Usually you get a phone call when something is wrong... it was
nice to get a phone call; it made me feel like she was concerned about
my problems.

I want the doctor to make me feel comfortable, like I've heard stories
of other doctors and they scare me. So I think it's important that they
make me feel comfortable. Especially with it’s a women’s doctor - to have knowledge on women’s issues.

[Sexual health service providers] should console. Like for me if you’re pregnant and not married, my parents would kill me. I think [health providers’] first part should be consoling.

My regular doctor, who was around my dad’s age, I had asked him for full blood work. I wanted him to check everything, including STDs and HIV. And he said “Why do you need that? Are you a slut?” I was like “no, but I am not married.”

Seven women specifically expressed concerns about confidentiality of their visits and sexual health information when they visited health centers in their community. Utilizing campus-based health services was seen as decreasing the likelihood of this occurring, as it minimized the risk of seeing individuals connected to their family and friends. This was of particular concern to those women who went to the same health provider as other members of their family.

You have to think about who knows you. [My mother’s friends’] sister was working at the same [doctor’s] office where I used to go and when I asked her for blood work she didn’t say anything. But I know she was thinking . . . and probably would say something.

It’s like [the doctor] may slip up to my mom next time we go and forget she doesn’t know I went in for a test. Not that he would do it on purpose but it happens. Or [the receptionist] is friendly with my mom and may slip up something. So you just want to be sure.

Cultural Values and Stereotypes
These participants spent a considerable amount of time discussing their familial values about female sexuality. The messages they received from their family and broad Hispanic culture reinforced traditional sexual values that reinforced submissiveness, virginity, and silence. Nineteen of these women made statements illustrating that these messages had a significant impact on their decision-making processes.

I think it’s harder for a [Hispanic] girl to bring a guy home and have them give you their opinion and when it comes to the topic of sex, that is just unheard of until you get married, you know you’re not supposed to leave the house ‘til you get married, you’re not supposed to have sex until you get married.

I mean, I have sex, I have safe sex but it’s not what my parents would approve of, and I don’t agree with what they say because I think that
sometimes you need to have sex before you get married. Just to have an idea of what you're going to do. I think it's ok to fool around...

I should be able to talk to my parents about [sex] but I can see their face, they would be so disappointed. I'm sure they know but they're in denial. They don't want to talk about it, think about it, so I have to sneak around and lie to them. And I mean I come home knowing what I've just done and I feel bad. It shouldn't be that way, you do something out of love and you feel bad about it. I feel sometimes that I should be able to talk to them about it if I have a problem or anything.

Even though I had some sexual experiences growing up, my parents always told me that if I go to bed with a man before I marry them, then I can't expect anything long term because by doing that I'm ruining my chances in being with them because they won't want me. They still tell me that and I'm 21!

These women acknowledged that they had to face stereotypes that framed Hispanic women as hypersexual and sexually permissive. Eight women reported that the external cultural messages were easily consumed through the mass media, peer and familial discussions, and in observations of others on a daily basis.

I think a lot of people think that Hispanic women are horny all the time. Like I've heard that they think that they're more sexual and into their sexual side and freaky, at least that's what I've heard.

You also have to be hot - like you see on TV or ads that we're hot and sexy. Like [Hispanic women] have fire in the blood - so we're hot in the bed. There's that pressure too.

Learning how to negotiate these messages about what they felt was appropriate sexuality verses external messages was considered important to these women. When asked how sexual health service providers and educators could contribute to this process, 18 women suggested increased cultural competency in discussions of sexual health. Their statements clearly showed that they felt it was important that health providers not only acknowledge that these stereotypes existed but also validate their influence when providing information/services Hispanic women can use to navigate healthier sexuality outcomes.

I think [health providers] need to be aware of different cultures and the misconceptions that go with each one. Also, the ignorance that somebody has that they are exposed to. And the fact that it also takes um, more to have open conversations with your partner who is also Hispanic. You know, it would be so helpful if they rolled this into one. See how it is
to be a Hispanic woman, give me my birth control and teach me how to deal with my boyfriend so we’re both safe.

I think they should learn the basics about different ethnicities. I don’t know but maybe take classes would help them learn about different cultures. Like they may not be aware if they’re Hispanic to ask certain questions in certain ways. They also should know that they may not want to answer certain questions for fear of getting in trouble.

**DISCUSSION**

**Knowledge as Empowerment**

Although only nine women in the study reported not having had sexual intercourse, the majority (N = 16) reported that they were not as sexually knowledgeable as they would like to be. The majority of the participants (N = 19) reported that they could benefit from more sexual health education from campus-based services. The university was seen as an ideal site for this information because of the perceived level of sexual health expertise and resource availability.

In addition to providing knowledge, the participants felt it was important that sexual health service providers and educators assist them in learning to negotiate their sexuality concerns within intimate relationships. As found in prior research, all the women reported that they received messages that women should rely upon their partner to define appropriate intimate actions. In a study on Hispanic women’s sexual decision making, Sugar (1995) reported that women “found it easier or less embarrassing to engage in an unwanted or unprotected sexual encounter than to openly discuss their sexual desires or preferences” (p. 136). This is of concern as Hispanic males were less likely to use condoms than their white or African American peers (Gurman & Borzekowski, 2004), with only half reporting ever using condoms (Taylor-Seehafer & Rew, 2000).

Along with increasing their sexual health knowledge, these women wanted to gain skills that would help them negotiate safer sexual interactions. Sexual health service providers were seen as ideal sources for this kind of information because they were seen as knowledgeable and experienced in working with people their age. Prior research has shown that campus-based health providers have been extremely successful in preventing the spread of STIs because of the providers’ accessibility to students, access to appropriate knowledge resources, and experiences with commonly occurring sexual risks among college students (Hicks & Heastie, 2008; Roddenberry & Renk, 2010).

Gaining sexual health discussion skills and being empowered to use them has important implications for behavioral outcomes Prior research has found Puerto Rican young adults’ ability to talk with a partner about sexual risk was associated with increased condom use (Whitaker et al., 1999). Similarly, young adult Hispanic women who felt skilled in talking with
a partner about initiating pill use were more likely to continue pill use compared with those who felt unable to talk with their partner (Kerns et al., 2003). Clearly, if campus health centers can provide sexual health services that empower women to be more engaged and proactive in addressing their sexual health concerns with their partners, it can decrease the potential for risky behaviors and negative outcomes.

Comfort and Trust

These discussions and skills building efforts need to take place in a context where the women feel safe and comfortable. These women expressed concern about having individuals they were familiar with, including family or friends, know that they were discussing sexual health issues or receiving related services. The privacy from friends and family that a campus-based clinic offered was viewed positively and seen as an environment where they could be comfortable discussing their concerns. This supports prior research which has shown that when patients feel assured their privacy and confidentiality has not been compromised, they felt more inclined to trust and follow their health providers’ recommendations (Ayatollahi, Bath, & Goodacre, 2009; Pannell & Elliott, 2010).

Tied in with respecting confidentiality and privacy, the women in this study felt they should be respected as individuals, no matter what issue they presented. Research on Hispanic health care has referred to this as in “simpatía”; this describes a cultural preference for smooth social relations based on politeness and respect, as well as avoidance of confrontation and criticism (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Concerns included health providers might see them as “bad” women for choosing to have sex or getting “caught” (including pregnancy, STD, or nonvoluntary intercourse), labels that are viewed as negative for women in Hispanic cultures. Four women gave specific examples where their physician directly used derogatory verbal and nonverbal communication when they sought their help with intimate sexual health concerns. The women in this study noted that if a sexual health service providers or educator was respectful, nonjudgmental, and caring, it contributed to the building of trust and comfort with the providers, which would in turn increase the likelihood of them using campus-based health clinics. This is important, given findings that show patients who trust their health providers are usually more satisfied with their care, more likely to follow the medical advice provided, and more likely to see an improvement in symptoms (Ferguson & Candib, 2002; Pannell & Elliott, 2010).

Validation of Cultural Values and Challenging Stereotypes

Toward creating a space where they felt comfortable and could trust their health provider, the participants wanted to know that who they were as
Hispanic women was respected and validated by practitioners. As pointed out in prior research, family, Hispanic culture, and religious values were viewed as important influences on these women’s sexual health beliefs and decision-making processes. Messages from these sources included the pressure to conform to traditional gender role expectations in behaviors, discussions, and knowledge-seeking contexts while challenging negative stereotypes (Gurman & Borzekowski, 2004; Raffaelli & Ontai, 2001; Stephens, Fernandez, & Richman, in press; Villarruel, 1998). The women in this study specifically reported being told that it was important to retain one’s virginity while celebrating male sexual conquests, act reticent while placing men’s pleasure at the center of a sexual scenario, and being too knowledgeable about sexuality would make one appear to be potentially sexually promiscuous.

These women were also concerned about stereotypes that framed Hispanic women as hypersexual. Studies have found that the “hot blooded,” “sexually aggressive,” “exotic” stereotypes used to characterize Hispanic women’s sexuality are widely disseminated and normalized in cultural representations (Mastro & Behm-Morazvifz, 2005; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Stephens, Fernandez, & Richman, in press). Although this image is directly opposite from familial and cultural messages, it was viewed as a framework others employed when envisioning Hispanic women’s sexuality. While the response to this stereotype was mixed, these women all recognized its existence and felt it affected others’ perceptions of their sexuality.

While research suggests the degree to which these contradictory messages are stressed and enforced across social classes and subgroups differs, they still impact Hispanic women’s sexual identity and skills development. Further, the conflicting pressure to be sexually reticent yet also available is of great concern as it can potentially decreases Hispanic women’s ability to negotiate safe sex practices (Dworkin, Beckford, & Ehrhardt, 2007; Logan, Cole, & Leukefeld, 2002; Thomas & Stephens, 2009). Therefore, traditional sexual messaging can undermine positive sexual health outcomes among Hispanic college women.

Despite believing these messages are problematic and often in conflict with their own beliefs, the women reported that they cannot or were not willing to simply ignore them. These women asserted that they did not want to appear to be rejecting their family or Hispanic cultural values. They felt it was important that their ethnic-based experiences and beliefs needed to be validated and acknowledged by Anglo-centric professionals. This means that health providers must recognize and integrate the values Hispanic women give to familial relationships and cultural values when providing sexual health services (Faulkner, 2003; Stephens, Fernandez, & Richman, in press). Specifically, the concerns or information being sought through campus services cannot be viewed in isolation from about familial
beliefs about sexuality (Faulkner, 2003; Raffaelli & Ontai, 2001; Villarruel, 1998). If parents hold traditional attitudes about sexuality, their daughters may be seeking ways to navigate these values around, with, and through collegiate norms and trends. As part of this process, health providers are being asked to help their clients negotiate these messages. This may require health providers to re-evaluate their own training and theoretical paradigms. Continuing education on cultural competence are essential for health care providers and educational professionals, as they are the first faces most of these young adults see as they enter the primary care office or campus-based care clinic.

Participants suggested that health providers should take time to discuss their specific cultural needs as women and Hispanic. This kind of individualized focus can increase the likelihood of Hispanic women receiving equitable care in campus health as it will decrease patient-provider miscommunication and improves cultural competence of the health care provider. This is a particularly important benefit of this personalized attention, as cultural competence is one of the most effective factors to decrease health care disparities (Ferguson & Candib, 2002; Thomas & Stephens, 2009). Further, these discussions also foster an environment of acceptance, privacy, and safety which may increase Hispanic women’s usage of campus services when seeking sexual health care (Thomas & Stephens, 2009).

**STRENGTHS AND LIMITATIONS OF THE PRESENT STUDY**

While our findings provide new insights, generalization of the results should be done with caution. Findings of this study may not be generalized to populations outside of this university population due to the small sample size. This study also utilized interviews that required self-reporting; participants may have chosen to limit the truthfulness of their responses or omit relevant information given the sensitivity of topics being discussed.

Also, careful consideration should be given the uniqueness of this sample. For example, all women in the present study self-identified as heterosexual and white-Hispanic. Drawing upon prior research, it is highly plausible that the findings would differ if the sample were larger and included a more diverse group of Hispanic women, such as Afro-Hispanics, bisexual, or lesbian women. All the women in the present study also had access to health services through campus-based sexual health educators or providers, subsidized student health insurance, and university-sponsored student health related programs and organizations. Whether women attending postsecondary institutions with fewer sexual health resources would have the same perceptions about campus health centers is an important issue to explore in follow-up studies. Finally, these women resided in an urban center and attended a university where more than 60% of the population self-identified as
Hispanic (Guzman, 2000; Passel, 2011). A significant portion of the campus support staff, including those in the various health clinics, identify as Hispanic. This is not the reality for the majority of Hispanic women attending postsecondary institutions in the United States. Thus, health providers and campus administrators must be attuned to the identification processes and needs of their Hispanic students, as they will differ according to geographic region and campus racial/ethnic composition.

Despite these limitations, findings from this study contribute new insights to the field’s understandings of Hispanic women’s perceptions of campus health service needs. Few studies have examined this phenomenon, and none has looked at populations outside of the southwestern United States. This is problematic given the increasing rate of Hispanic student admission to universities and growth of this population in the eastern parts of the United States. This study highlights the importance that a subgroup of Hispanic women gives to sexuality information and resources accessible through this space. As a population at risk for negative sexual health outcomes and continually growing in size both on campuses and surrounding communities, it is important to consider the role of campus health services when exploring Hispanic women’s sexual health issues.

APPLICATIONS FOR SEXUAL HEALTH SERVICE PROVIDERS AND EDUCATORS

As Hispanic young adult women report low levels of sexual health knowledge and education (Gurman & Borzekowski, 2004; Kerns et al., 2003; Villarruel et al., 2007), campus health centers can play a pivotal role in the transmission of information and skills that can protect them against negative sexual health outcomes. As this study’s findings indicate, sexual health care providers and educators have the opportunity to ensure that Hispanic female students have the necessary medical, social, and educational resources to have healthy sexual lives. To meet this population’s needs, sexual health educators and service providers should consider focusing on designing curricula relevant to Hispanic college women and building connections with cultural resources that can support these initiatives. These efforts will contribute to our efforts to successfully address concerns raised by the women in this study.

The design of cross-cultural curricula and educational materials that adequately address Hispanic women’s distinct needs, both on college campuses and in their communities, should be a priority for sexual health educators. Sexual education that empowers Hispanic women should integrate culturally competent skills that embrace intimate relationship beliefs reflective of familial and community values. Such programs, if thoughtfully designed and well
implemented, can provide Hispanic college students with a solid foundation of knowledge and skills. Humans sexuality researchers across disciplines emphatically agree interventions and programs that fail to recognize the unique cultural messages that influence these processes are likely to fail in their efforts to achieve changes in negative sexual health outcomes among racial/ethnic minority populations (Aguilera, 2005; Bajaj, 2008; Kis, 2010; Thomas & Stephens, 2009). By using culturally appropriate and empowering approaches, sexual health centers serving Hispanic college women will be better able to encourage positive sexual health behaviors and address contextual issues that may put these populations at risk. Health centers that use an integrative approach that gives equal value to Hispanic cultural and sexual health issues will be successful in their efforts to provide these women a space to feel empowered. For example, a HIV-prevention program tailored for Hispanic youths’ cultural values was found to decrease their engagement in sexually risky behaviors. Hispanic youth were randomly assigned to complete a program that either focused on HIV prevention or general health promotion (Villarruel, Jemmott, & Jemmott, 2006). In the end, those in the Hispanic-focused HIV group were less likely to report having sex at all in the previous three months, less likely to have multiple partners, more likely to say they used condoms consistently, and reported fewer days of unprotected sex (Villarruel, Jemmott, & Jemmott, 2006). Further, it is important to understand how research contributions expected to improve STI health and wellness outcomes are practiced in “real-world” settings. Connections between sexual health concerns and all other aspects of individual Hispanic women’s concerns (e.g., gender role expectations, social status, interpersonal identities, beliefs about sexuality) and interrelated social and environmental issues (e.g., poverty, access to health care services, interpersonal violence, community resources, sexual health issue stigmas) must be integrated into these health center sexual education efforts.

To ensure that these activities remain current and accurately reflect the needs of Hispanic college women, it is important that campus health centers maintain communications, networks, and collaborations with those with Hispanic culture expertise. Given that information changes quickly, sexual health educators must seek out resources and expertise from other educators and organizations to stay current. Building a team that extends beyond the health center’s walls and campus community is not only useful but is also becoming more and more a necessity given the diverse populations campuses are serving today. Local and national Hispanic health organizations, in particular, can play a collaborative role in the developing and promoting culturally appropriate materials for sexuality education on campuses. For example, the National Latina Institute for Reproductive Health (NLIRH) provides numerous resources intended to help others engage and educate Hispanic communities through community-based participatory action research and training (see http://latinainstitute.org). They also make a
concerted effort to build partnerships with other organizations through their National Latina Advocacy Network (LAN). The National LAN serves as one main way to mobilize Hispanic women and involve them in both local and national reproductive health campaigns. Becoming aware of and connected with initiatives such as these will be critical to the success of campus health centers at the level of the institution, and for individual Hispanic women students.

CONCLUSION

Clearly, this is not a definitive study on Hispanic college women’s use of campus-based health clinics for sexual health services; however, the findings represent an important step toward adding to what is currently a small body of literature. These results suggest that heterosexual emerging adult Hispanic women develop identifiable and distinctive values pertaining to sexuality and health-seeking behaviors. Sexual health service providers and educators can play a positive and significant role in meeting these needs. Although exploratory, these findings also provide new insights into the importance of validating and identifying Hispanic women’s sexual health concerns specifically on college campuses. Furthermore, the roles that campus-based sexual health clinics can play in terms of promoting positive sexual health development and decreasing risk outcomes are identified.

With this in mind, sexuality educational professional and health service practitioners can begin to conceptualize service delivery and resources that meet the needs and experiences of Hispanic women. Specifically, university-based sexual health center professional may gain insights into Hispanic students’ sexual health needs and unique cultural values in campus environments. By understanding this population’s sexual values and desired services, we may yield a richer understanding of the importance of providing diverse culturally appropriate service. This will, in turn, improve our ability to address broader physical and psychosocial sexual health issues among Hispanic women on campuses across the United States.

NOTES

1. We recognize that there is a debate between the use of the terms Hispanic and Latino. The term Hispanic was created by the U.S. government to identify people “who speak, are affected by or are Spanish-like” (Suro, 2006). It is incorrectly used to also identify other non-Spanish speaking nationalities such as Brazilians; this lack of cultural appropriateness is one of the critiques raised about the term Hispanic. However, as the interviews for the present study were conducted in an urban center where the majority of residents, including the study participants, primarily self-identify as Hispanic, we use this term in the present paper.
2. Passion Parties are a type of “Tupperware” party where adult toy and sex toys are sold. A Passion Party company representative brings the products to the hostess’ home, explains how they are used, and then encourages guests to purchase these items via preorders.

REFERENCES


