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REVISIONES

# Contraception in immigrant women and the role of the nurse: a literature review

Métodos anticonceptivos en las mujeres inmigrantes y el papel de la enfermera: una revisión bibliográfica

*Solana Morete, Álvaro **González López, José Rafael

*Degree in Nursing. University of Seville. **Ph.D. International in Health Sciences. Associate Professor, Faculty of Nursing, Physiotherapy and Podiatry. Department of Nursing, University of Seville. Spain. E-mail: joserafael@us.es

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Palabras Clave: Migración Internacional; Anticoncepción; Planificación Familiar; Salud de la Mujer; Cuidados de Enfermería

## ABSTRACT

**Introduction:** There were a total of 6,259,137 foreigners in Spain in 2013, 49% of which were women. This leads to the reproductive health of this collective supposing an important problem in the field of Public Health in Spain, since it is one of the most demanding groups in certain health services. **Objective:** To describe the current situation of contraceptive methods of immigrant women in Spain in recent years (2005 onwards).

**Methodology**: A literature review was conducted in the first half of March 2014, it was limited to articles and literature reviews published since 2005 in English and Spanish. The databases used were PubMed, IME, SCOPUS, CINAHL, CUIDEN, WOS, Cochrane Library and TESEO databases.

**Results:** The nurse plays a key role in the knowledge and use of new contraceptive methods by immigrant women, with the IUD being used by Maghrebi and Eastern European immigrants, the condom is the most used by the Latino immigrants, Asians know all the methods but prefer the traditional Chinese medicine, while the Sub-Saharan is the one who has the lowest rates of contraceptive use.

**Conclusions:** The variability of contraceptive methods used by immigrant women in Spain depends on their religion and/or culture. The nursing professional must know these peculiarities, in order to provide a transcultural care to the patient and her partner in order to promote effective family planning.

## RESUMEN

**Introducción:** En España en el año 2013 había un total de 6.259.137 extranjeros, el 49% eran mujeres, esto da lugar a que la salud reproductiva de este colectivo suponga una preocupación importante en el campo de la Salud Pública en España, ya que es uno de los grupos más demandantes de determinados servicios sanitarios.

**Objetivo:** Describir la situación actual del empleo de métodos anticonceptivos de la mujer inmigrante en España en los últimos años (2005 en adelante).

**Metodología:** Se realizó una revisión bibliográfica en la primera quincena de marzo de 2014, se limitó a artículos y revisiones bibliográficas publicadas a partir del 2005 en inglés y español. Las bases de datos utilizadas fueron PubMed, IME, SCOPUS, CINAHL, CUIDEN, WOS, Cochrane Library y TESEO.

**Resultados:** La enfermera juega un papel fundamental en el conocimiento y uso de nuevos métodos anticonceptivos por parte de la mujer inmigrante, contando con que el DIU es más utilizado por la inmigrante magrebí y de Europa del Este, el preservativo es el más usado por la inmigrante latinoamericana, la asiática conoce bien todos los métodos pero prefiere la medicina tradicional china, y la subsahariana es la que tiene menor índice de uso de métodos anticonceptivos.

**Conclusiones:** Existe una variabilidad de métodos anticonceptivos por parte de la mujer inmigrante en España según su religión y/o cultura. El profesional de Enfermería, debe conocer dichas peculiaridades, con el fin de ofrecer un cuidado transcultural a la paciente y su pareja al objeto de favorecer una planificación familiar efectiva.

## INTRODUCTION

The phenomenon of migration has been constant in the social nature of humanity. Countries and continents have developed thanks to this phenomenon; the contact with other cultures is the one that has shaped the basis of their identities [(1)]. Spain is one of the destinations chosen by migrants when emigrating [(2)]. Immigrants mainly from Latin America, the Maghreb, sub-Saharan Africa, Eastern Europe and Central Asia have increased in recent years, while the feminization of the migrant population is a fact worth noting [(3)]. During the first decade of this century, immigrants in this country increased from 1.8% of the total resident population in Spain to 12.2%; according to origin, 40% of the foreigners came from Europe, followed by 31% South America [(3-5)]. In 2013, there were a total of 6,259,137 foreigners, men and women residents in Spain, according to the Ministry of Labor and Social Affairs, 49% of which were women [(6)].

Depending on the country of origin, the culture, customs and conceptions of health-disease binomial, amongst others varies. These factors are important when attending these populations and their participation in the National Health System. Immigrant women have a number of shared characteristics, despite their origins; it is worth mentioning the low educational level, greater risk of health problems in the psychic sphere (depression, anxiety), lower attendance at health services due to their lack of knowledge thereof and they are more vulnerable to domestic violence [(7)].

Due to the feminization of the immigrant population and the different conceptions of sexual and reproductive health, the use of contraceptive methods is influenced by the immigrants' country of origin [(3)]. From the nursing discipline, it is important to know what contraceptive methods they know, and whether they use any, in order to make recommendations about their reliability and use; knowing that it is essential to adequately inform them for their proper use or improvement in the performance

thereof as well as detecting risk situations. In short, health education is an important pillar for family planning, considering transcultural care [7].

As there has been a steady increase in immigration in the last decade, and this has been important both in diversity of origin and number, different training needs and information are appearing on all social agents, and especially in health professionals who are the first contact with our health system and supervisors of this patient population. All these sociological changes lead us to learn new skills, abilities and knowledge, while requiring a change in our attitudes and skills [8].

In general, we are talking about populations that are composed mostly of young adults of reproductive age. The fact of the feminization of the immigrant population and the previously expressed demographic characterization is dominating migratory flows in Spain, which ensures the survival of the group and, consequently, the emergence of new needs in reproductive health which have to be referred to in different ways depending on the country of origin, culture, traditions, rites; so care needs to be considered from a multicultural or transcultural point of view [3].

In the case of women who emigrate from their home country and come to Spain, despite being a heterogeneous group, it seems they all have many factors in common that make them a particularly "vulnerable" group to suffer unwanted pregnancies and interruptions with the consequent bio-psychosocial cost to them. The basic problem we face is to determine to what extent the health system, programs and professionals take into account the cultural beliefs that influence the health concept held by different groups of immigrant women living in the country, i.e., to what extent do they know what each culture and hereditary consistency understands for health[7].

Although Spain has a National Health System of universal coverage which gives registered foreigners the right to health benefits under the same conditions as the native population, as well as emergency, maternal and infant care until eighteen years in the case of non-registered immigrants, as is reflected in the Royal Decree-Law 16/2012 of 20 April [8]; inequalities between the native and immigrant population have been shown in relation to perceived health which is not explained solely by socioeconomic status and could be pointing to differences in access to health care [9]. Among the factors that create these inequalities in entering our environment and in countries with a more migratory tradition and similar health systems, there are cultural and language barriers, and the inadequacy of services to meet the specific needs of this population, in addition to the socio-economic conditions [10]. With regard to sexual and reproductive health, ignorance of the different existing methods of contraception is common in the immigrant population. Some cultures are reluctant to their use due to very different reasons, such as the overvaluation of fertility or lack of experience in using some methods; whereas other groups of immigrants will apply for such methods[3].

We hope to describe the current situation of immigrant women's contraceptive methods in Spain since 2005 in this literature review, to update the knowledge about it, and thus be able to open new lines of research intended for nurses to improve handling immigrant women and reduce healthcare costs.

## MATERIAL AND METHOD

A literature review was designed in which different databases were consulted, such as: PubMed, IME, SCOPUS, CINAHL, CUIDEN, WOS, TESEO and Cochrane Library. Describers such as "Emigrants and Immigrants" [Mesh] AND "Contraception" [Mesh], "contraception AND contraceptive method AND socio-cultural aspect", "immigrating *" Y "contraceptive *", "Immigrants AND contraceptive methods" used "nurse AND contraceptive methods "," Immigrants AND contraceptive "," Nurse * " " transcultural "and" transcultural" were used, as can be seen in Table 1. The search covered the period from 2005 to March 2014.

The scope of this work focuses on contraception methods in immigrant women in Spain. Many articles were discarded as they were studies from other countries that contributed nothing to this review as they focused on gender violence and other subjects which were a repetition of articles previously found in other databases consulted. Finally, the secondary references and the articles recommended from those found have been taken into account.

After reviewing the abstracts of all articles found, each author distinguished those that could be related to the purpose of the search, 25 were selected from a total of 215 items found. Controversies were resolved by agreement between the authors. To select the evidence, summaries, publication year which had to be as from 2005 and articles related to those found were taken into account.

**Table 1. Databases that was used with the describers employed in the searches.**

| Databases | Descriptors |
|---|---|
| PubMed | Emigrants and Immigrants "[Mesh] AND" Contraception "[Mesh]; contraception contraceptive method AND sociocultural aspect |
| SMI (Spanish Medical Index) | "immigra *" Y "contracep *" |
| SCOPUS | "Immigrants AND contraceptive methods"; "Nurse AND contraceptive methods" |
| CINAHL (Cumulative Index to Nursing and Allied Health Literature) | "Immigrants AND contraceptive"; "Nurse *" "transcultural " |
| CUIDEN | "transcultural" |
| WOS (Web Of Science) | "immigrant* Y anticoncep*" |
| Cochrane Library | "immigrant AND contraception", "immigrant* AND contracep*" |

## RESULTS

We will describe the results found in the literature review based on the women's region of origin.

### Latin America

Latin American women are the largest group of immigrant women in Spain (7), they have 2 very distinguishing features, first it is a discreetly feminized immigration (56% on average in 2013) (11) in which they are the ones who initiate migratory adventure,

alone. Second, they often fill jobs in socially devalued services (domestic workers, child or elder care, sexual services), more than half of them are undocumented. In 2005 before the last regularization, 88% of Bolivians, 63% of Argentineans, 55% of Ecuadorians, 50% of Colombians 25% of Dominicans and 16% of Peruvians were undocumented. These figures justify the regularization of that year [12]. In short, the profile found by a study [13] on the Latin American woman working is; effectiveness at labor and social levels, savers, organized and constant in sending home money to their family. They tend to quickly fix their bureaucratic situation and regroup their family. Spanish families prefer them due to the language equality and certain cultural affinity [13].

There are high rates of abortions due to risky practices and the transmission of Sexually Transmitted Infections (STIs) due to promiscuity that these immigrants already had in their countries of origin, this promiscuity also causes many of these immigrants to have several children with different fathers, who they leave in the care of their family [4,14]. Most of these immigrants are sexually active young women (as from 15-16 years) who are not familiar or accustomed to using modern contraception. Discrepancies exist but generally they do not know how a universal health system works and because of cultural reasons they prefer to go directly to a specialist, which explains certain behaviors when reaching Spain. As they are not familiar with Spanish law and abortion is illegal in their countries, if they wish to terminate the pregnancy, they resort to "natural" and aggressive methods [4,7].

Contraceptive methods, that single women in these countries use, are inadequate since the rates of STIs are high among young people, while the condom is contraceptive method used less when young people have sex for the first time [15]. Oral contraceptives are known but are misused and without continuity. Parenteral contraceptives are also known due to their widespread use in Latin America. They may come with IUDs inserted in their countries which contain the beginning of copper "copper T" that is obsolete in our country and can cause bleeding, dysmenorrhea and difficulties for removal.

The demand for the post-coital pill has increased and sub-dermal implants arouse curiosity. In addition, an increase in VTPs (voluntary termination of pregnancy) is taking place [7]. The contraceptive method used most frequently in this population is the condom, followed by oral contraceptives, and IUD (16). The report published in 2012 by the Ministry of Health on VTP in Spain shows data on place of birth and residence of women. In Spain that year there were a total of 110.349 of VTPs of which 62% (68,902 cases) were to women born and living in Spain, compared with 38% (41,447 cases) of women from other countries and living in Spain . According to the distribution of continents VTPs 18,770 occurred in women from South America [6,17].

**Maghreb**

Their family life is conditioned by tradition, religion, culture, education of children, nutrition, hygiene habits and dress. They integrate and adapt to the host society with difficulty, as there is a very strong acceptance and internalization of socio-traditional and religious norms in their country of origin [4]. The Mudawana, or traditional family code governs relationships among family members, with the husband and other male relatives having absolute preeminence, and despite the fact that since 2004 a 'family code' has been in force in Morocco that theoretically proclaimed the equality of women

and men in marriage [4]. In Arab culture, women's issues are not shared with men, besides premarital virginity has a great value.

Maghrebi women show much modesty before men, which can cause problems as from the first visit. Therefore it is advisable to have the husband's consent and perform an examination whenever possible in the presence of another woman. All this will cause a delay in preventive activities and problems of attention [7]. Modern contraceptive methods were taboo until recently for these women, and even now in some countries they must prove they are married to obtain a contraceptive. As menstruation is perceived as taboo, methods that shorten menstruation (hormonal contraceptives) are better accepted than those that increase it (IUD). They resort to hazardous and traditional methods of abortion [4]. The average of 7 children per woman (1970) has evolved to 3 (2005) in all the Maghreb countries [4,7].

According to a study in Chefchaouen in 2011 the best known methods in the surveyed women are the ogino method (44.30%), the condom 26.16%, the pill has 86.50% of the total, IUD (59.49%) and diaphragm 24.05% [18]. Tubal ligation and vasectomy are prohibited; they are "haram" (unlawful). Yet in Morocco 50% of married women take oral contraceptives, 4% are sterilized and 1.4% use condoms. Despite their religious ideas, the choice of method is varied, when they come to our centers, they often opt for IUDs or oral contraceptives for fear of becoming pregnant again [7].

**Sub Saharan Africa**

These women come from societies where the respect a woman receives depends largely on the number of children. The highest rates of maternal mortality in the world are in West and Central Africa, ranging from 500 to 1,000 maternal deaths per 100,000 live births, compared to the mortality of 1-10 per 100,000 live births in developed countries [7]. Normally women have an inferior status to men. They are responsible for doing the work, caring for the family, the house and animals and getting food and water. Instead of the Western nuclear family, they are accustomed to the family clan. Marriages are very early, which determines that 50% of primiparous are less than 14 years old. In some cultures polygamy is common [4]. The World Health Organization (WHO) estimates that only 63% of pregnant women have access to antenatal clinic visits and only 42% of births are attended by trained health personnel in this population [7]. Fertility rates are very high, not only because of ignorance of effective contraceptive methods (men reject condoms), but also because the respect a woman receives depends largely on the number of children [4]. Understanding / communication between health workers and the community of sub-Saharan women not only has the difficult encounter of two different conceptions of health / illness but also the language, since neither part masters a common language, besides the difficulty in two very different cultural and socio realities coexisting [19].

Unwanted pregnancies are more frequent and abortions are more often requested, especially due to social and economic reasons. In the same vein there is less use of contraception, usually due to lack of information, as there is no specific rejection. Emphasis should be put on preventive activities in this field, taking care of the psychosocial aspects of the patient-health relationship as this is a particularly sensitive issue [7]. In the sub-Saharan population access to services and knowledge of contraceptive methods are inadequate, but this is not the main reason why it continues to be an unmet need in most cases. In western and central Africa, the ambivalence or even hostility towards contraception is a serious obstacle, but the broader issue is the

main concern for adverse health effects experienced by women who use certain contraceptive methods [20]. These are predominant, particularly pills and injections, in this immigrant population while interruptions by these two methods are also frequent. Between 20% and 30% of women who use them usually stop after a year due to concerns about their health effects or side effects [21]. One of the main causes of poor compliance is because women who have used one or both methods unsuccessfully had no other options in their home countries because they ignore the wide range of methods that exist [20].

**Eastern Europe**

Normally women from Eastern Europe are usually mothers when they are older than 23 years and have a smaller family [4]. In this collective, two groups of women were observed according to age: adults from family groups and young women without family ties and a higher level of education, often illegal, who decide to seek better living conditions and the possibility of expanding their professional horizons in Europe. They are aware of the difficulties they will find but their migration project is solid. The health-disease concept is not essentially different to that of Western women, although there is no custom of performing preventive activities regularly. The application for health care in Spain is conditioned by the legalization of residence (sometimes the patient does not go to the doctor for fear of repatriation), some labor issues (in itself absenteeism risks their salary or dismissal for any possible work absences due to diagnostic and therapeutic processes) and language (in some situations they prefer to wait to be attended in their own country). The use of home remedies is a general practice in these countries, and much more dangerous to the woman's life since there are many traditional methods and special care must be taken as far as contraception is concerned [7].

Neither religion (Catholic and Orthodox Christians mostly) nor culture presents difficulties for integration. 14% of women working in prostitution in Spain come from Eastern Europe and around 10,000 women a year suffer human trafficking in Bulgaria[7]. Contraceptives are used without difficulty, but only in recent years. Women from Eastern Europe use natural methods more frequently, followed by IUD. Although overall consumption of contraceptives is low, women from Eastern Europe know modern contraceptive methods and accept them. Induced abortion is common in their home countries. However, there may be more difficulties with regard to contraception with Romanian gipsy women as they are a group in which the traditions and customs are deeply rooted [4,7].

A low intake of oral contraceptives is observed in them. After natural methods, intrauterine devices are the most used. Women from Eastern Europe use natural methods and the IUD as contraception more frequently than others, it is important to highlight that women from these countries (Russia, Ukraine, Belarus and Romania) are the population with the highest VTP because they take contraception into account more [7,22]. Induced abortion is mainly responsible for the high maternal mortality. In recent years, a decrease in the rates of induced abortions, while an increase in the use of contraceptive methods [7] has been observed.

Although overall consumption of contraceptives is low, women from Eastern Europe know modern contraceptive methods well and accept them. However, there may be more difficulty in this regard with the Romanian Gipsy women as they are a collective

in those traditions and customs are deeply rooted and often reject all kinds of birth control [22].

**Asia Central**

They are the fourth group of non-EU immigrants in Spain, 92% of the migrant population are ethnic "Han" and come from the province of Zhejiana [4]. They have a great respect for parents and elders as the family is a central pillar of their social life, whereas Chinese women's submission before men has been largely superseded. Their concept of disease is very different to the Western world, because everything is based on the "energy" flowing through their own channels; its excess (or overflow) or deficits create disease [4,7]. In general, the Asian immigrant community uses the Spanish medical or social services much less than immigrants from other areas and, of course, than the Spanish. This is explained by cultural factors such as the fact that the Asian patient usually relies on self-dispensable natural remedies including Chinese herbal medicine and massage therapy besides they are usually more long-suffering[4,7].

It is also explained by occupational factors as the Asian population tends to be working most of the day, they have little time to see a doctor; although perhaps the biggest obstacle is the language, this is logical if we consider that most of them would have serious difficulties in making themselves understood when explaining their symptoms, and they would also be very insecure wondering if they had understood how they had to follow the treatment properly. In the case of undocumented patients, the problem is accentuated even more, since in these cases they often turn to doctors who know their status (they think they are not going to report them to the police, unlike other doctors who do not know them) or emergency services of which they have some reference; the same as happens in patients from other ethnic groups, the absolute ignorance of how the health and social services function together with linguistic difficulty to communicate are crucial to gaining access to these service limitations. Thus, it is easy for an Asian patient to try home treatments or medication dispensed by the pharmacist before attending a consultation appointment [4,7].

In Asia it is not customary to visit the doctor unless they have a serious condition. So when the Asian immigrants have a medical review they are very demanding. Chinese patients and, in general, all Asians tend to be very direct and categorical when they explain their discomfort and disease. Opinions vary according to different studies, but usually Asian immigrants accept treatment well with either oral contraceptives or IUDs, abortions and other contraceptive methods, although traditional Chinese medicine takes precedence [4,7,22].

**Role of the nurse**

The nursing staff is a key element in the implementation, execution and continuity of family planning practices, with the nurse's capacity and competence being essential, they are able to give accurate information and respond to questions from users contributing to the autonomy of their clients; they possess sufficient technical, scientific and cultural knowledge in order to meet the need for sexual and reproductive health services of those who consult them, including the ability to provide information and communicate it appropriately. It is necessary that health professionals are aware of the needs of people that they attend entirely, promoting health and creating quality of life.
The nurse must guide, inform and educate the user about it[23]:

- Warning signs for which they should be consulted.

- Importance of check-ups: users should be informed about the importance of attending consultation for regular check-ups, so as to know whether it is necessary to change the method used at that moment or locate potential complications.

- Prevention of STIs (use of condom as a means of additional protection).

It is necessary that the information provided is correct and those women and their couples are not left with any doubts about the method chosen so as to ensure the effectiveness of said method. The effectiveness of contraceptive methods depends on the performance of health professionals, including nurses, as the information about the different methods and the proper way to transmit them are directly related to the conquest of the women's autonomy in the service of family planning and the safe use of contraceptives [23, 24].

Ultimately the nurse's role is to provide good information so that the user can choose the method depending on their characteristics and preferences, providing the ability to answer questions about the handling of the method, well scheduled consultations to assess tolerance to it or providing personnel to solve the doubts that arise with its use[25].

## CONCLUSIONS

Immigrant women, depending on their nationality, make different use of contraceptive methods, partly due to insufficient knowledge that they possess while often making bad use of the methods they use. Depending on the country of origin, they have different preferences about contraception which are influenced by their beliefs and customs. The IUD is used by North African and Eastern European immigrants, the condom is the most commonly used by Latin American immigrants, and Asian immigrants prefer traditional Chinese medicine, while the Saharan is the one with the lowest rate of contraceptive use. There is no updated information about the methods used by Asian immigrants and what little there is, is conflicting, so it would be interesting for future research work in this line. The use of contraceptive methods used by women immigrants in Spain in recent years has increased, but after this review, it is clear that these populations need better information to adapt it to their traditions and beliefs, as improper use of methods or lack of better alternatives is evident with this review. Nurses need training to broaden their knowledge in the different beliefs, customs and contraceptive use of women immigrants according to their nationalities, as they are key professionals in the information and guidance of these women in family planning clinics.

Finally we consider that, taking into account the aforementioned, for a good quality of care for immigrant women in family planning clinics by the nurse, it is essential that they have a transcultural vision of care.

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