

DISPLACED MATERNITY: PREGNANCY, VOLUNTARY ABORTION AND WOMEN'S HEALTH FOR IMMIGRANT WOMEN IN PORTUGAL

Maternidade deslocada: a gravidez, o aborto voluntário e a saúde feminina para mulheres imigrantes em Portugal

Maternidad desplazada: el embarazo, el aborto voluntario y la salud femenina de mujeres inmigrantes en Portugal

Original Article

ABSTRACT

Objective: To identify issues related to topics such as maternity, pregnancy, voluntary abortion and women's health from the perspective of Brazilian and African immigrants living in Portugal. **Methods:** This is an exploratory and descriptive study with a qualitative approach, held in Portugal between May and June 2008, with 35 immigrant women (from Brazil and the Portuguese-speaking African countries - Lusophone Africa or PALOP). Information was collected through a sociodemographic questionnaire and focus group conduction. Data was analyzed according to the common procedure of content analysis. Two categories of analysis emerged: 1) Pregnancy and Maternity and 2) Voluntary Abortion. **Results:** The research included 15 Brazilians and 20 Africans, aged between 21 and 45 years. Brazilian participants refer to possess higher educational level compared to African women. In general, both women go through various difficulties regarding issues involving pregnancy, maternity and voluntary abortion, especially sociocultural differences faced by the country in which they live. **Conclusion:** It is necessary the adoption of a social model of positive health, focused on the individuals' and the population needs and, as far as possible, adapted to their specificities. In this sense, it is relevant that models are developed to promote the immigrant participation in the development of actions for health promotion in this area.

Descriptors: Emigration and Immigration; Women's Health; Abortion; Health Promotion.

RESUMO

Objetivo: Identificar questões ligadas a temas como maternidade, gravidez, aborto voluntário e saúde feminina a partir da perspectiva de imigrantes brasileiras e africanas que vivem em Portugal. **Métodos:** Trata-se de um estudo exploratório e descritivo, de abordagem qualitativa, realizado em Portugal, entre maio e junho de 2008, com 35 mulheres imigrantes (provenientes do Brasil e de Países Africanos de Língua Oficial Portuguesa – PALOP). As informações foram coletadas através de um questionário sociodemográfico e realização de grupo focal. Os dados foram analisados de acordo com o procedimento comum de análise de conteúdo. Emergiram disso duas categorias de análise: 1) Gravidez e Maternidade, e 2) Aborto Voluntário. **Resultados;** Participaram da pesquisa 15 brasileiras e 20 africanas, com idades entre 21 e 45 anos. As participantes brasileiras referem possuir maior nível de escolaridade em relação às mulheres africanas. Ambas, de maneira geral, passam por dificuldades diversas envolvendo gravidez, maternidade e aborto voluntário, principalmente pelas diferenças socioculturais enfrentadas nos países em que vivem. **Conclusão:** É necessária a adoção de um modelo social de saúde positiva, centrado nas demandas dos indivíduos e da população, e, na medida do possível, adaptado às suas especificidades. Nesse sentido, é relevante que sejam desenvolvidos modelos que promovam a participação dos imigrantes na elaboração de ações de promoção da saúde nessa área.

Descritores: Migração Internacional; Saúde da Mulher; Aborto; Promoção da Saúde.

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RESUMEN

Objetivo: Identificar cuestiones con relación a temas como maternidad, embarazo, aborto voluntario y salud femenina a partir de la perspectiva de inmigrantes brasileñas y africanas que viven en Portugal. **Métodos:** Se trata de un estudio exploratorio y descriptivo de abordaje cualitativo, realizado en Portugal entre mayo y junio de 2008 con 35 mujeres inmigrantes (procedentes de Brasil y países africanos con el portugués como idioma oficial). Las informaciones fueron recogidas a través de un cuestionario socio demográfico y realización de un grupo focal. Los datos fueron analizados según el procedimiento común de análisis de contenido. Surgieron dos categorías de análisis: 1) Embarazo y Maternidad, y 2) Aborto Voluntario. **Resultados:** Participaron de la investigación 15 brasileñas y 20 africanas, con edades entre los 21 y 45 años. Las participantes brasileñas refieren poseer mayor nivel de escolaridad que las mujeres africanas. En general, ambas tienen diversas dificultades acerca del embarazo, maternidad y aborto voluntario, principalmente por las diferencias socio-culturales afrontadas en sus países. **Conclusión:** Es necesaria la adopción de un modelo social de salud positiva centrado en las necesidades de los individuos y de la población y, siempre que posible, adaptado a sus especificidades. En ese sentido, es relevante que sean desarrollados modelos de promoción de la participación de los inmigrantes en la elaboración de acciones de promoción de salud en esa área.

Descriptor: Migración Internacional; Salud de la Mujer; Aborto; Promoción de la Salud.

INTRODUCTION

International migration - considered a predominantly masculine phenomenon in the 1960s and 1970s - has been taking female contours from the later decades. Currently, about half of the migrant population in the world are females⁽¹⁾. International reports have emphasized that more and more, women migrate independently because of high demand for labor, the increasing social acceptance of their economic independence and their mobility conditions⁽²⁾. In that direction, adopting a gender approach towards migration recognizes the female migration as a source of resources and development alternatives for countries of origin and host countries, but also considers the existence of social and economic discrimination and in relation to this social group⁽²⁾.

Thus, it is important to mention that the feminization of migration arises simultaneously with other processes that affect women, such as the feminization of poverty and work⁽³⁾. In contexts with extreme levels of poverty and reduced access to education, health, financial resources and information networks on migration and employment, women may have low autonomy and less capacity to decide on their mobility⁽⁴⁾. They tend, therefore, to have less access to information regarding migration opportunities, many

times, ending up less prepared to deal with the inherent conditions of the migratory process⁽⁵⁾.

Considering these circumstances, major challenges arise for health area, as female migrations often represent greater risks and vulnerabilities, with an impact on their health. More specifically, the increasing female immigration has heightened the concern on issues of sexual and reproductive health in this population. The difference between social roles for genders, associated with socioeconomic and cultural variables, are often reflected on an unequal exposure of women to health risks, when compared with men⁽⁶⁾.

Given such issues, and trying to gather information and questionings that come to contribute with regard to knowledge involving the phenomenon of female international migration, this text explores the experiences, fears and expectations about motherhood in the context of immigrant women - living in Portugal - coming from Portuguese-speaking African countries (PALOP or Lusophone Africa) and Brazil.

The study has its relevance sustained by the need for information regarding the views of users of health systems, whether Brazilians, Africans or Portuguese. It is necessary that discussions of this nature serve to produce new practices aimed at promoting health broadly. The study guiding questions refer to understandings that Brazilian and African women have about pregnancy, motherhood and voluntary abortion. The objectives, therefore, are directed to identify issues related to topics such as maternity, pregnancy, induced abortion and women's health in immigrant communities, especially women's, from the perspective of Brazilian and African immigrants living in Portugal.

METHODS

It was developed an exploratory and descriptive study, with a qualitative approach, held in Portugal between May and June 2008, with 35 immigrant women (from Brazil and the Portuguese-speaking African countries - Lusophone Africa or PALOP).

In an initial phase, the study was presented to various non-governmental organizations, associations, social welfare institutions and social centers which develop work with immigrant communities in Portugal. Those institutions were asked to collaborate in signaling potential participants in the study, given the inclusion criteria: immigrant women (from Brazil and PALOPs, and whose parents were not born in Portugal), aged between 18 and 45 years (adult women of reproductive age)⁽⁷⁻⁹⁾, residing in Portugal for over 2 years, with availability and willingness to participate in the investigation. The indicated immigrant women were contacted by the research team, which succinctly presented

the study, confirmed the inclusion criteria and reported on the logistical issues regarding the groups conduction (location, time etc.). Participants were included in the study based on their availability and explicit interest in participating.

During contacts previously conducted, the participants were also asked to indicate other immigrant women to participate in the study. While organizing the focus groups, there was a concern in forming sufficiently heterogeneous groups with respect to sociodemographic characteristics, such as age, profession, income, number of children (and childless), diverse migratory experiences, among other differentiating aspects.

For data collection, tools developed by the research team were used: an individual questionnaire (sociodemographic data) and a semi-structured script for the focus groups conduction.

Six focus groups (three with African immigrants and three with Brazilian immigrants) were conducted with a purposive sample of 35 immigrant women. The focus groups were conducted at the Institute of Hygiene of Tropical Medicine, Lisbon, Portugal.

The semi-structured script for the focus group was based on references⁽¹⁰⁻¹³⁾ and included the main topics to be explored in the discussion: knowledge, attitudes, practices and difficulties encountered in relation to various subjects of sexual and reproductive health, such as maternity, pregnancy, abortion and parturition. This script had no intention to impose a rigid structure, but to provide a way to contemplate the diversity of aspects intended to be focused on, give a referential framework to the development of the discussion, and organize the information collection. The individual questionnaire provided the sample characterization and included sociodemographic questions (age, education, country of origin, nationality, legal status, employment status and length of stay in Portugal).

All focus group sessions were conducted by a moderator and a co-moderator. Sessions lasted 1 hour and 30 minutes, in average. Each session was recorded on audio by the moderator, with the prior consent of the participants, in order to maximize data collection and allow full transcription of the discussions for further analysis. At the end of each session, observations considered relevant about the dynamics and interactions occurred between the participants were also recorded. The full transcription of the group discussions was subsequently proceeded.

Qualitative data was analyzed following the usual procedure for content analysis, as applied in qualitative methodology⁽¹⁰⁻¹²⁾. The different answers were grouped into two discursive categories, according to the regularity of appearance and repetition of some elements in the discussions, which were: 1) Pregnancy and Maternity and 2) Voluntary Abortion.

Data collection was performed after the participants' informed consent, who were given all ethical safeguards for the conduct of research, following the Declaration of Helsinki, in accordance with the recommendations in Portugal, where the research was held. The informed and voluntary consent was obtained from the participants with guaranteed anonymity and data confidentiality. The study was approved by the Ethics Committee of the Institute of Hygiene and Tropical Medicine. To preserve the interviewees' anonymity, they were called here the "African participant" and "Brazilian participant", and numbered "African participant" 1, 2, 3..., "Brazilian participant" 1, 2, 3..., and so on.

RESULTS AND DISCUSSION

Prior to presenting the testimonies related to the discussion, it is interesting to know the characteristics of the women who participated in the survey.

Characteristics of the women in the survey

Of the 35 female participants, 15 (43%) were Brazilian and 20 (57%) were African. Of the latter, nine were from Cape Verde, six from Angola, four from Sao Tome and Principe and one from Guinea. Effectively, the official data on immigration in Portugal in recent years indicate that most immigrant women come from these nationality groups⁽¹⁴⁾.

The participants' ages range from 21 to 45 years, but African participants were older than the Brazilians. This data is similar to the profile of immigrant women in Portugal described in several studies and national censuses. African immigrants residing in Portugal for a long period of time, given the immigration process these populations have started in the 1960s⁽¹⁵⁾, tend to have comparatively higher ages than Brazilian immigrants, who generally reside for less time in the country, as a result of the immigration process that has started later, in the 1980s⁽¹⁶⁾.

On schooling, all Brazilian participants reported owning a level equal to or greater than high school education, while African participants reported lower levels of education. Similarly, official data indicates that a greater proportion of Brazilian immigrants has secondary and higher education (31% and 19%, respectively) compared to women from PALOP (15% and 4%, respectively)⁽¹⁴⁾.

In the total group of participants, the majority - 26 women (74%) - live with their children or with their partner and children. Africans refer more often living alone with their children or with their partner and children, while Brazilians refer living with their parents and siblings.

Of the total, four participants were pregnant (one African and three Brazilians) and 25 (71%) had children.

Most African women had children, unlike the Brazilian participants, most of whom reported not having. Still regarding the number of children, 16 (80%) African participants had three or more children, while only two Brazilian females (13%) reported having 3 e 4 children. It is important to draw attention to the fact that Africans reported having a greater number of children compared to the Brazilians, which can in part be explained by differences in age and length of residence in Portugal between the two groups.

Large proportion of discussions held during the focus groups was related to issues such as maternity, pregnancy, abortion, and experiments related to childbirth and women's health.

1. Pregnancy and maternity

In the following section, some issues that emerged during the meetings, on the themes of pregnancy and motherhood, will be addressed.

African women reported greater difficulties related to motherhood in their countries of origin, compared to the difficulties encountered in Portugal:

It is totally diferente, here and there. It is different in the treatments. (...) The appliances they have here, didn't exist there. (...) These were devices they should have for a normal delivery, for everything to work out fine. (African participant 1)

On the other hand, Brazilian participants reported a greater number of negative experiences related to care during pregnancy in Portugal:

I was very ill in pregnancy in relation to milk. I had a fever and I got to give. I asked the nurse if he had any milk bank here in Portugal. She did not know and I was a little frightened about it. (Brazilian participant 1)

In Brazil, I don't know if it is a question of love, of solidarity, but here it lacks a bit of attention (...). Of my friends, all who gave birth (...), they were like that, almost in agony (...). (Brazilian participant 2)

Earlier experiences related to healthcare in the country of origin may explain these differences. Although this study has not explored the experiences of African and Brazilian participants in their countries, it has been documented that preceding experiences influence perceptions and expectations that individuals have regarding healthcare, as well as their satisfaction with the host country's health services⁽¹⁷⁻²⁰⁾.

Indeed, in previous studies conducted with immigrants in Portugal, the perception of quality and satisfaction with healthcare appeared to be related to the development level of health systems in the countries of origin^(19,20), which may help understand the differences in the experiences related to maternity observed in this study.

From the testimonies presented, it can be observed that the issue of pregnancy is also associated to the need for greater access to information in the context of the host country. Furthermore, issues related to prevention in this area are also demanded. Such situations of conflicting perceptions, which can be observed in the testimonies of women from different countries of origin, are often enhanced, especially by what many authors and official documents have pointed out as cultural differences, involving a number of elements that act in an articulated manner, such as economic indicators affecting the living conditions in different regions of the world, socio-spatial relations and valuation related to different genres, profiles of family relationships, among others. These are the questions that invariably lead to different qualifications concerning the host countries^(1,2,21).

Still in the same direction, some algumas Brazilian women point out the negative consequences caused by the lack of information, among them, the early and/or unintended pregnancy:

I think that happens a lot here in Portugal, like in Brazil. Many young girls who end up pregnant. (Brazilian participant 4)

I got pregnant with my son at the age of fifteen. Sheer lack of information. Because I did not know how it was. (Brazilian participant 2)

Such situations are in line with studies that indicate that women with unintended pregnancy tend to show a lack of adequate knowledge about the various methods of contraception⁽⁸⁾.

This fact is further aggravated by the disruption of social and family relationships along the migratory process (especially when the immigrant moves alone). Separation from family and support systems, as the isolation, may be potential factors of lack of support and information in these populations⁽⁹⁾. In this context, the absence of mechanisms for social and emotional support can perpetuate the exposure to risk factors and encourage practices harmful to health^(13,22-24).

In almost all cases, the issue of unplanned pregnancy was considered a very relevant subject. One of the African participants reported certain situation she experienced, due to an unplanned pregnancy:

There in my work, they discovered that I was pregnant and sent me away. I wanted to go home [to my parents'], but [I] couldn't. How will I get a living? I went to get a hotel and stayed in that hotel to live. (African participant 2)

However, an interesting topic, emerged from the speeches of many African women, is the idea that pregnancy is not under their control:

I caught this child, that I did not expect. (African participant 3)

However, other Africans emphasized the need to take precautions to avoid unwanted pregnancy:

If it comes, it comes. There's nothing more for me to do. But if I can help it, I will avoid this. (African participant 4)

I think there are ways to avoid. The health center gives the pills for free. (African participant 5)

Despite protests about unwanted pregnancies, some immigrants revealed desires related to having children (or more children) and their speeches (mostly Africans') have shown how the large number of children is valued in the cultural context of their countries of origin:

If you have no more children, the husband will leave you. (African participant 1)

In fact, the social and cultural value attached to reproduction and motherhood, reinforced by the traditional gender roles culturally assigned within families and associated to the women's status, influences the expectation and the desire to have many children⁽²⁵⁾. However, in the case of these participants, the fact that they live in Portugal (and not in their countries of origin) makes implementation of this desire:

Even if you want, here you can not. Because you have to pay the nanny, almost the salary that you earn (...). If you already have, we have to bear this. But for me, these four are more than sufficient, it's plenty enough. (African participant 3)

In this sense, for the African participants, pregnancy and taking decision related to having children are strongly associated with difficulties encountered in the host country:

I am a single mother, so I do not want to have more children. Because, here, I thought I would find help to arrange my children's lives. Didn't find help, [instead of that], only got more children. And I did not want that. (African participant 3)

Unwanted pregnancy is a such a big worry, because, nowadays, to support so many children, it's a serious case. (African participant 6)

Factors such as the stress associated with pregnancy and the difficulties inherent to the immigrant status have been identified in several studies as determinants of problems that often, immigrant women face in host countries during the gestation period⁽²³⁾. In some studies⁽²¹⁻²³⁾, other factors affecting pregnancy of migrant women are pointed out, such as the stress associated with poor living and employment conditions, heavy work during pregnancy and living situations of racism and discrimination. Some women, for the reasons identified, may be particularly vulnerable during the period of pregnancy and postpartum, with implications for the health of mother and baby⁽²⁰⁾. Moreover, such issues often guide decisions of immigrant women toward abortion, because, according to data from other investigations, there is a higher prevalence of this situation in the context of immigrant populations⁽²⁴⁻²⁶⁾.

2. Voluntary Abortion

Following, the participants' points of view with regard to voluntary abortion are presented.

Despite the difficulties reported, the theme was not spontaneously addressed by participants in any of the focus groups conducted. However, after being introduced in the discussions, this topic has become one of the most debated. Along the speeches, it was observed that most participants do not agree with the practice of induced abortion. Examples of this can be illustrated by the following statements:

Abortion, I don't like it. If I get a child, I want him to be healthy, and me, also healthy. (African participant 1)

I also think that abortion is very ugly. (African participant 3)

I think it is murder, because it's a life that's in risk. (Brazilian participant 4)

As a way to endorse the unfavorable statements on abortion, the participants, mainly the Brazilians, also pointed arguments associated with religiosity:

When you talk of life, abortion, sexuality, we encompass the religious issue (...) and the person think twice before

having the abortion because she knows that there's something beyond, that she would be charged for that in the future. (Brazilian participant 4)

Me, with my religious background, I'm not sure I would be able to do it. But I'm not against it. (Brazilian participant 1)

Im my opinion, it's a great sin. (Brazilian participant 5)

However, one group of participants, also Brazilians, was favorable to abortion:

I do not know what is worse, if it is the abortion or letting the child be born (...). When the child is born, begins their mother's suffering, who rejects the child, sometimes being rude, spanking, beating them up. There are some children that die, so beated up by both the father and the mother. (Brazilian participant 3)

In this same group, it was considered that it is not appropriate to judge other women from personal values:

I am not against those who do it, because each one knows own reasons. Because it is very easy to say: 'you should not have an abortion'. But it's up to you to decide that. (Brazilian participant 6)

I'm not against (...), because the person has free will. She has the right to decide whether she wants to have a child, if she wants to see her son go through all this, if she wants to go through all this. (Brazilian participant 7)

I also don't think it's right to bring a child into the world to suffer; therefore, be for or against is relative. We can not judge and say that person had an abortion and is a horrible thing. We must ask what what was the situation in which things happened. (Brazilian participant 8)

Many participants reported experiences related to abortion experienced by other women (usually young women) in Portugal:

I knew a girl when I lived in Sacavém, there was a woman who made abortions and adolescents aged 14, 15, 16 (...) went there to do it. (African participant 1)

Honestly, here in this neighborhood, it's common. Not only here in this neighborhood, it's worldwide. (Brazilian participant 4)

But it still happens a lot that friends of mine, one of them gets pregnant, she doesn't want it, nor her boyfriend, not

wanting to tell her mother, and they abort. (Brazilian participant 2)

African immigrants stated that the practice of voluntary interruption of pregnancy is also quite common in their countries of origin:

There, many people do it. They do it hidden. (African participant 6)

There, they do it, but without anesthesia. (African participant 4)

On the other hand, in the opinion of the Brazilian immigrants, the practice of induced abortion is most often accepted by Portuguese women. Such fact can be directly related to the decriminalization of this practice in Portugal, approved in 2007:

I think the Brazilian, there, don't do it so much. (Brazilian participant 1)

Now, with this abortion law, the doors were opened here in Portugal. For now, you can do it without any prevention. Get pregnant, go to the clinic, abort and it's ready. (Brazilian participant 6)

Some people do not bother to prevent: 'later, I go there and do it'. (Brazilian participant 10)

I know a Portuguese who has already made it (...). I am even amazed, because she already had two abortions and she talks about it like she was going to buy a candy. I think here it became too easy (...). (African participant 7)

The consequences of abortion were strongly highlighted:

The other day, I saw a television presenter, [which] when she was eighteen, she had an abortion. And today, she has financial condition, she can not have children. (...) This is the result of an abortion she did in the past, badly done. (...) Because an abortion also has consequences (...). Sometimes a woman gets sterile for the rest of her life. (African participant 8)

The use of the day-after pill has been referred to as common practice, having been considered by some participants as a form of abortion:

If you take the day-after pill, it is also a form of abortion. (Brazilian participant 11)

Furthermore, during the speeches, the participants described different practices that can be adopted when there is the intention to terminate a pregnancy. Such practices can be divided into two groups. In the first place, those that are made from the use of drugs:

It is a medication (...) to make illegal abortions (...). There was a woman there who used to sell this drug. (African participant 12)

They only sell to men (...). But now that it was discovered, they no longer sell it. (African participant 11)

Secondly, the home methods:

At my mother's times, there's one thing they do with the wine and this also causes abortion. (African participant 12)

Here there's that thing for the cough. (...) Eucalyptus (...). With the tree, he leaves. (African participant 13)

Coffee with beer also ends pregnancy. (African participant 14).

In the focus groups, participants emphasized that, sometimes, in the face of difficulties inherent to having children in the host country, abortion comes as the only alternative:

Here in Portugal, life is very difficult (...). We must also conscientiously, take the child, have an abortion. (African participant 12)

It's up to the person to decide. The life that you have, the plans you have. Automatically, it's not that a child brings trouble, but makes it more difficult. (Brazilian participant 12)

I know a girl who went there to the hospital. The doctor put her to hear the little heart, and the girl was crying saying she could not have [the child], because she could not afford it. (African participant 15)

Some women highlighted that, sometimes, upon becoming aware that they are pregnant, they feel they don't have any support from family and/or partners, and report that, frequently, those are the ones who push them for termination of pregnancy:

When I got pregnant, I told the father. He didn't want to accept it and wanted me to end it. I said I would not do it. He never spoke to me again. (African participant 1)

In this context, women describe that, when they decide to have a child, they need to take, by themselves, the parental responsibility:

Sometimes men do not want to assume the responsibilities (...). Suddenly, one day, pregnancy appears. Obviously, he will say: 'Ah, now, here, we have to separate because I will not be able to take that.', and the girl is left alone, without the boyfriend's responsibility. (African participant 1)

I had the opportunity to have an abortion, I didn't (...). I've been through a lot of things. I've already raised my children, but without man's help. (African participant 16)

In respect to the issue of abortion, it was found the existence of unfavorable attitudes towards this practice by the majority of focus group participants. Many participants said it was a common practice in Portugal and reported being aware of several experiences of abortion. Data from other studies that seek to examine the same subject have pointed to a higher prevalence of this situation in the immigrant population, because, as pointed out earlier, the social conditions in which it lives, with bonds shortage and poor access to health systems, place it in a position of vulnerability⁽²⁷⁻²⁹⁾.

As it could be observed in the statements presented, the possible consequences of the practice of abortion, at the level of physical and mental health, were also highlighted, indicating a kind of empowerment with regard to the risks⁽²⁹⁾. In this sense, the participants described a number of practices, potentially risky to health, often adopted when women intend to terminate the pregnancy, and that serve as resources to medication and traditional practices ('home recipes').

In the focus groups conducted with African women, many situations have been described in which the partners and/or parents push for pregnancy termination and, very often, when they do not accept to interrupt it, end up assuming alone the responsibilities inherent to the option of having the son. Thus, the context of 'difficult life and difficulties that underlie having more children', sometimes appears as a justification for abortion^(24,30,31). It is noteworthy, in this context, that abortion is not considered a positive practice and, as in similar studies with other groups of women, they tend to point it as the last alternative they would take and/or took in the face of any difficulties⁽³²⁾.

As observed in the speeches related to pregnancy and maternity, also on the topic of voluntary abortion there were differences of perception and opinion between African and Brazilian participants. Among the Brazilians, the religious question stands out. While to Africans, according to

speeches, the highlights are the traditional practices and homemade recipes.

FINAL CONSIDERATIONS

In this work, the intention was to discuss issues related to topics such as pregnancy, motherhood, voluntary abortion and female health of immigrant communities, especially women's, from the perspective of Brazilian and African immigrants living in Portugal. The statements brought here indicate some of the difficulties reported regarding the issues surrounding motherhood and their sexual and reproductive health. From what was shown, it is possible to reflect on the quality of services offered to these women, as well as to question on the required information which they should have access to.

Based on the results presented, it becomes evident the need to adopt a social model of positive health, focusing on the needs of individuals and population, and, as far as possible, adapted to their specificities. The fact that differences were observed in perceptions and experiences related to pregnancy, maternity, and voluntary abortion among African and Brazilian participants reinforces that the population of immigrant women is a heterogeneous group and their sociocultural context of origin plays an important role in knowledge, attitudes and practices in reproductive health.

Adopting a social model of positive health therefore implies an openness to the community, allowing their involvement in relation to the health-disease process. The communities, subject to socio-sanitary interventions, should be recognized as collaborative elements, essential throughout the process of planning, developing and implementing such interventions. In this sense, it is necessary that strategies are developed allowing and promoting the involvement, participation and empowerment of immigrants, and their communities' as well, so that they can thus contribute with alternatives to health promotion in this area.

Valuing the immigrant communities' opinion on the planning of activities and programs in the area of women's health, particularly with regard to maternity and pregnancy termination (whether voluntary or not), should give opportunity to the use of their own resources as well as to encourage the creation of prevention, information and skills development programs. These are some of the strategies that can enable these women to be protagonists in their own health's improvement. On the other hand, innovative approaches, such as the development of peer education programs, could provide effective strategies, especially when related to topics such as pregnancy and motherhood in the context of the realities of immigrant women.

Many issues certainly remain unresolved and may be better and more accurately developed in future studies. The qualitative methodology, to the extent that it values the women's perspective on the issue of sexual and reproductive health, can contribute to the planning of strategies and actions in this area. It would be interesting to include, in the development of new studies, broader and more diverse samples in relation to the participants, controlling variables such as socioeconomic status, legal status, educational level, among others. It would also be pertinent to conduct research in the area of sexual and reproductive health that included samples with immigrant men.

In closing this text, it is reiterated the relevance of promoting mechanisms for monitoring and evaluation of policies and programs in the area of sexual and reproductive health, so that they include the perspective of immigrant communities.

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