Final Narrative Report

Experiences of Mexican Women When Accessing Sexual and Reproductive Health in California and Mexico

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INTRODUCTION

Our research project entitled Experiences of Mexican Women When Accessing Sexual and Reproductive Health (SRH) in Mexico and California: Effects of Globalization and Immigration Policies explores how Mexican women ages 18-45 in both sites learn about and procure services and supplies from formal (doctors and nurses at clinics) and informal (curanderas, parteras, yerberas, pharmacies, bodegas, or friends and family) sources of healthcare for sexually transmitted infections (STIs), family planning, and abortion. Drawing from existing literature in Mexico and the US, and based on in-depth interviews with Mexican women in states with high rates of migration to California, and migrants living in California, the study compares patterns and preferences for different types of care, and both the structural and cultural factors that influence how women meet their sexual and reproductive health (SRH) needs.

We hypothesize that many Mexican women use a mix of formal and informal sources of healthcare to meet their SRH needs, and women from these states who migrate continue

to creatively tap various resources once they arrive in California and face a new host of barriers that inhibit their access to formal systems of healthcare.

A multi-national, multi-disciplinary team of researchers has closely collaborated on this research. The results are important to healthcare providers, policy makers and advocates on both sides of the border who believe that immigrant women – regardless of their documentation status – have a right to quality, continuous, affordable reproductive healthcare.

PROPOSED RESEARCH

Our proposed research project is based on two working hypotheses. First, we hypothesize that Mexican women who live in rural areas, have low-incomes, less education and limited access to the formal healthcare system are more likely to utilize a mix of formal and informal sources of reproductive healthcare. Not coincidentally, some of these sites are major 'sending' communities. That is, they have high rates of migration to the US. Second, we hypothesize that when women from these areas migrate to the US and face a new set of structural and cultural barriers, these patterns and preferences are likely to continue, and may even sway more in the direction of informal sources for women who lack documentation. We proposed two primary research activities to examine these hypotheses.

Activity 1: Review and summarize the existent literature on the types and sources of reproductive health care that women in Mexico utilize, and the extent to which these patterns change when Mexican women migrate to California and encounter new systems, laws, and sources of healthcare. What are women's attitudes, practices, and preferences

surrounding sexual and reproductive healthcare, particularly in the areas of diagnosis and treatment of STIs, methods of family planning, and abortion? To what extent and under what circumstances do women seek care from formal medical providers, traditional healers, and/or informal sources such as bodegas? What factors influence their decisions to utilize different types of care? How does documentation status shape access to healthcare?

While the literature specific to this topic is limited, by piecing together research conducted in Mexico and California we can create a patchwork understanding of these trends and the context in which they are occurring. The literature review will also provide valuable questions and insights for our in-depth interviews. In addition to culling together existing studies, we will seek out other researchers examining similar issues to discuss our findings, identify gaps, and even identify data sets that have yet to be thoroughly analyzed.

Activity 2: Through in-depth, one-on-one interviews, we will explore how Mexican women and Mexican migrant women go about getting the reproductive health care they need and desire, and the factors that facilitate and inhibit their ability to do so, given the factors and circumstances they encounter in each location. What is their knowledge of and experience with the Mexican and Californian healthcare systems? How do they define their sexual and reproductive health rights? How do they understand current policy debates and actions regarding immigration, and how does this shape their ability to get care? What are their attitudes, practices, and preferences surrounding sexual and reproductive health care, especially surrounding diagnosis and treatment of STIs, family planning methods, and abortion? How do they identify and access different sources of

care? To what extent do they rely on family or friends to send herbs, drugs or other reproductive health related supplies from Mexico? What policy or systems-level changes would make reproductive healthcare services more reliable and desirable?

The in-depth interviews were designed and implemented according to grounded theory methods. Grounded theory emphasizes the collection of rich data that detail participants' views, feelings, intentions, and actions as well as the contexts and structures of their lives.[1] This approach also pushes the researcher to constantly re-visit the data in order to identify emerging patterns and identify new questions or people, places or documents to follow up with or investigate.

LITERATURE REVIEW

The general purpose of this literature review is to address how women born and raised in Mexico, U.S. immigrants from Mexico to California, and U.S. born women of Mexican ancestry living in California meet their reproductive health needs and navigate various health systems. .

WOMEN BORN AND LIVING IN MEXICO

Mexico's cultural and economic heterogeneity influences many areas of people's lives, including, family planning decisions. Miranda (2005) noted that Mexico's Indigenous population commonly resides in rural areas where agriculture is the predominant industry. Rural areas where many Indigenous Mexicans reside have a

[1] K. Charmaz. Constructing grounded theory: A practical guide through qualitative analysis. Sage, Thousand Oaks, California (2006).

scarcity of health and education services and resources. In fact, the Mexican Indigenous population has a lower average education level (approximately 5th grade) than the Mestizo (or biracial Native-Spanish) population (approximately 8th grade) (Miranda, 2005). Therefore, in light of education differences, it is not surprising that Indigenous language speaking women enter motherhood at younger ages than Spanish speaking women (Miranda, 2005). In fact, researchers found that having no schooling was a strong predictor of not using contraceptives (Nazar-Beutelspacher, Molina-Rosales, Salvatierra-Izaba, Zapata-Martelo & Halperin, 1999). Socioeconomic status (SES) also predicts Mexican women's contraceptive use. For example, in a study of low income women living in Chiapas, researchers found that women who lived in homes with floor covering were twice as likely to use contraceptives compared to those who lived in homes with no floor covering, that is, homes with mud floors (Nazar-Beutelspacher et al., 1999). Floor covering may be viewed as a proxy for household income

Researchers have identified attitudes and beliefs as barriers to reproductive health care in Mexico. Castañeda, Bilings, and Blanco (2003) interviewed 9 parteras or midwives in Mexico. They found that most parteras had negative attitudes and beliefs about miscarriages. Parteras blamed the woman for being unable to remain pregnant. Parteras believed that miscarriages were caused by everyday activities including lifting heavy objects and excessive movement. Authors explained that excessive movement is common among their participants because of the type of labor they do (e.g., planting, harvesting, and washing large loads). Parteras also believed that fright (susto), anger (coraje), malnutrition, domestic violence, and unfulfilled compulsive desires or food cravings (antojos) were causes of miscarriage. The nine midwives interviewed for this study all

had harsh labels for women who induced an abortion. They considered induced abortions "murder" or a "grave sin" (Castañeda et al., 2003). Castañeda and colleagues (2003) bring attention to the difficulties Mexican women can experience when seeking reproductive treatment for a miscarriage. Dealing with the pain and sorrow of the loss of a fetus is difficult for a woman; however, Mexican women who are treated by parteras may also deal with blame and perhaps guilt.

In Mexican society, attitudes and beliefs about contraception and gender dynamics may influence family planning. Castro (2001) studied Mexican men living in a small town (Ocuituco) in central Mexico; he focused on beliefs about sexuality and contraception. First, he noted that women in this small town of 3,200 in the Mexican state of Morelos live under male dominance. Castro (2001) interviewed 34 women, 24 men, and 16 key informants in Ocuituco. He found that participants endorsed a belief that sexuality is a natural drive in males but that in females it can be controlled. An accepted dynamic by both males and females was that males harass women and women's role is to resist this harassment. Being unable to resist the persistence and harassment of males is viewed as a woman's failure (Castro, 2001). This study found that men in Ocuituco have a strong say in women's reproductive decisions. They make decisions about pregnancy and labor. Men in Ocuituco ultimately decide where the labor will take place and who will attend it. In fact, men are the ones who speak to doctors. Last, an interesting belief held by participants in Ocuituco is that women accumulate semen in their system, semen that does not lead to the conception of a child is believed to decay and become worms. These worms are believed to cause an uncontrollable sexual desire in women. As a result, some men dislike contraceptives because of fear that their wives' uncontrollable sexual desire

caused by worms will lead to their wife's infidelity (Castro, 2001). This study shows that cultural beliefs may influence family planning practices in a society. Therefore, it is important for researchers to study cultural beliefs that may influence family planning decisions.

In Mexico, women and men who are in favor of contraceptive use often visit pharmacies. (Goel, Ross-Degnan, Berman & Soumerai, 1996). Women often seek reproductive health advice and sexually transmitted infection (STI) treatment at pharmacies in their area. Mexican women receive over-the-counter treatment from local pharmacists and other pharmacy staff. Some of the advantages include lower cost compared to seeking medical care at a clinic or hospital, confidentiality, convenient operating hours and proximity to homes and workplaces. Researchers who conducted a study in Mexico City found that the majority of participating pharmacy staff knew of drugs to interrupt a pregnancy (49 percent) and they recommended abortifacient (abortion-inducing) drugs to clients that requested them (74 percent) (Goel et al., 1996). In another study of pharmacies in Mexico City, researchers documented that the most frequently recommended drugs were hormonal injectables to induce abortion (Kroeger, Ochoa, Arana, Diaz, Rizzo & Flores, 2001). Researchers conducted a study of chain and independently owned pharmacies in the state of Morelos and found that, in general, pharmacy workers knew of misoprostol as an abortifacient. Researchers also found that pharmacists often recommended misoprostol when fictitious female clients requested something to terminate their pregnancies. Few, however, knew of safe and effective dosages (Lara, Abuabara, Grossman & Diaz-Olavarrieta, 2006).

In addition to pharmacies as primary sources of reproductive health care, Mexican

women also seek traditional healing or non-biomedical treatments. These health care practices are particularly true of poor women and women living in rural areas with limited access to formal healthcare services. Traditional practitioners may include healers (curanderas), herbalists (yerberas), bonesetters (hueseros) and midwives (parteras). Women often come to traditional healers when experiencing irregular or heavy menstruation, pre-menstrual syndrome, infertility, miscarriage, or when seeking an abortion. It has been documented that upon advice of traditional healers, women may induce abortions by carrying heavy things, self injecting, or ingesting a brew (Finkler et al., 2001). It is important to note that traditional healers also employ pharmaceutical medicines such as pitocin (for post-partum hemorrhage) and misoprostol (to induce abortion) in their practices (Castañeda et al., 2003). Thus, some Mexican women seem to be combining conventional and traditional sources of reproductive healthcare; this may be due to structural circumstances and cultural preferences, in a creative effort to meet their health needs (Galante et al., 1992; Hernandez et al., 1992; Rubel, Weller-Fahey, & Trosdal, 1975).

Abortion was not legal in most of Mexico until recently legalized in Mexico City. In the past, abortions were only legal in Mexico City if a woman had been raped; the pregnancy was a risk to the woman's life, or it was a spontaneous abortion (miscarriage) (Lamas & Bissel, 2000). The abortion laws reform in Mexico City has open women's access to abortion until 12 weeks of gestation; nevertheless, in the rest of Mexican States abortion laws are restricted and limited to the circumstances mentioned above. However, despite these exceptions to the abortion law, some women who were legally entitled to have an abortion were unable to have the procedure because medical personnel refused to perform

it (Lama & Bissel, 2000). Paulina del Carmen Ramirez, a 13-year-old female who was raped was refused an abortion in the State of Baja California even though her abortion was legal. She and her parents were lied to by medical personnel who exaggerated the risks of an abortion procedure; medical personnel told Paulina that if she had the abortion, she would become sterile and would die. These exaggerations scared Paulina's family and persuaded them against requesting an abortion (Lama & Bissel, 2000). Mexican legal restrictions against abortion procedures led women to seek clandestine abortions. Amuchástegui and Zivy (2002) interviewed 12 women who received clandestine abortions. Relationship conflict, fear of poor motherhood due to too many children, and a partner's history of child abuse were cited as reasons for seeking an abortion (Amuchástegui & Zivy, 2002). Researches noted a difference in the quality of medical care received between women of a higher socioeconomic status (SES) and those of a lower SES. Women with a higher SES were able to receive better medical care than their lower SES counterparts. Women with a higher SES did not experience any complications during their clandestine abortion or needed hospitalization after the procedure. In contrast, women with a lower SES had to resort to more affordable but lower quality care from midwives or self-induced abortions using surgical probes, teas and/or injections (Amuchástegui & Zivy, 2002). Clandestine abortions in Mexico are of concern because they can lead to health complications or even death. In fact, Amuchástegui Herrera and Zivy (2002) noted that clandestine abortions are the third leading cause of maternal mortality in Mexico. Effort to reduce these maternal mortality rates are needed perhaps through policy and societal attitudes towards abortions.

In addition to difficulties when seeking abortions, some Mexican women also

experience difficulties during child labor. Castro and Erviti (2003) found evidence of women's mistreatment by medical personnel during child labor. While working on a qualitative study with a different objective, they noticed that many women mentioned instances of mistreatment during labor. They decided conducted a study that incorporated these testimonies and direct observations of behavior during child labor. Researchers found that medical personnel sometimes had a dismissive attitude towards female patients undergoing labor. Doctors and nurses also invalidated women's suffering. For example, when women noted that they felt a great deal of pain, medical personnel responded by telling them that they were nervous and magnifying sensations. They noted that medical personnel considered women to be good patients when they cooperated with their orders. Doctors and nurses sometimes even blamed a patient when complications arose or mistakes were made. Another alarming finding was that women were sometimes coerced into using contraceptives after child birth. Doctors and nurses coerced women into using an intrauterine device (IUD) by giving them inaccurate information about other methods. For example, an interaction observed by researchers showed a doctor and nurse trying to persuade a patient to allow them to insert an IUD. The patient asked about other methods. The doctor told her that the IUD was the most effective method and the nurse told the patient that hormone methods would maker her "fat and ugly." The nurse also told the patient that the IUD is 90% effective while other methods are only 50% effective (Castro & Ervity, 2003).

MEXICAN-AMERICAN WOMEN AND MIGRANTS FROM MEXICO LIVING IN US

U.S. Immigration

The United States admitted 20.9 million immigrants between 1971 and 2000 peaking at 9.1 million in the last decade of the twentieth century. In contrast, the United States admitted 18.7 million immigrants between 1901 and 1930, peaking at 8.8 million in the first decade (Government Printing Office, 2000, Immigration and Naturalization Service, StatisticalYearbook of the Immigration and Naturalization Service). The rate of contemporary immigration relative to the total U.S. population is much lower than that of the earlier period. The rate of contemporary immigration is much lower because the U.S. population has more than tripled during the course of the twentieth century (James P. Smith and Barry Edmonston, eds.,1997, The New Americans: Economic, Demographic and Fiscal Effects of Immigration. National Academy Press). As of 2000, the foreign-born population represented 10.4 percent of the total U.S. population, compared with approximately 25 percent at the turn of the twentieth century. The immigration composition has also shifted, from predominantly European immigrants to predominantly immigrants of non-European origin (Government Printing Office, 2000, Immigration and Naturalization Service, StatisticalYearbook of the Immigration and Naturalization Service).

The U.S. admitted, between 1971 and 2000, 20.9 million legal immigrants, including 2.2 million formerly unauthorized aliens and 1.3 million special agricultural workers who were granted permanent resident status under the provisions of the Immigration Reform and Control Act (IRCA) of 1986 (Immigration Reform and Control Act, 1986, Pub. L.: 99-603). This influx has been characterized by an increase in the share of female immigrants. Since 1993, the share of women as a proportion of total immigration has varied from 53 percent to 55 percent, which is much higher than in the past. By 2000, close to 60 percent of immigrants from Mexico, China,

the Philippines and Vietnam were female (Government Printing Office, 2000, Immigration and Naturalization Service, Statistical Yearbook of the Immigration and Naturalization Service). This inflow is also much younger than the native population. As of 2000, 79 percent of the foreign-born were in the 18-64 age group, compared with 60 percent of the native population; and 44 percent of the foreign-born were in the 25-44 age group, compared with 29 percent of the native-born (Census Bureau, 2001, "The Foreign-Born Population in the United States: Population Characteristics," March 2000, P20-534). This young age structure suggests that these immigrants are in reproductive age.

U.S. Immigration from Mexico

It is estimated that 35.7 million people presently living in the US are foreign born and almost one in three (29 percent) came without authorization from the US government (Passell, 2005). Since the 1990's, more unauthorized than legal immigrants have arrived each year (Passell, 2005). Current US migration patterns from Mexico are influenced by a history of shifting borders, in which most of what is now the US southwest was Mexican territory until the end of the Spanish American War and the US and Mexico share the greatest contiguous border in the world (Rubel et al., 1975). It is not surprising that of the 10.3 million unauthorized immigrants residing in the US, more than half (57 percent) are from Mexico, with an additional 24 percent from other Latin American countries (Rubel et al., 1975). California has been and continues to be home to the largest and fastest growing population of legal and unauthorized Latin American immigrants. Mexican immigration is highly concentrated. There are approximately 63 percent of Mexican immigrants in the western US. Almost half (48.2 percent, or 3.8 million) of all

Mexican immigrants live in California. Texas accounts for another 18.5 percent or 1.5 million of all Mexican immigrants living in the United States. Together, Texas, California, Arizona, and New Mexico (all border states) account for 72.7 percent of Mexicans who have settled in the United States (Center for Immigration Studies, 2001).

Latinos and General Health

The poverty rate for Mexican immigrants is dramatically higher than that of US natives or non-Mexican immigrants in general. In 1999, approximately 1 in 4 (25.5%) Mexican-born immigrants while about one in ten US natives lived in poverty (Center for Immigration Studies, 2001). That is, Mexican-born immigrants are more than twice as likely to be poor as their US native counterparts. The Center for Immigration Studies (2001) estimated that of the three million unauthorized immigrants from Mexico, 2.1 million (71.4%) live in or near poverty. The Center for Immigration Studies (2001) reported that 56.5% of documented Mexican immigrants live in or near poverty. Unauthorized immigrants from Mexico have significantly higher rates of poverty and near poverty than do legal Mexican immigrants. However, poverty among legal Mexican immigrants is still estimated to be twice as high as that of US natives or non-Mexican immigrants (Center for Immigration Studies, 2001).

As the ranks of the uninsured grow every year, there is greater focus on access to care, and its relationship to overall health status. Much of these data indicates that Latinos are one of the largest and fastest growing racial/ethnic groups to lack health insurance. In the US, between 40 and 50 percent of non-US citizens are uninsured (Kaiser Family Foundation, 2005) and Latinos constitute 32% of the uninsured (DeNavas-Walt 2004, cited in Marshall et al 2005). According to the Women's Health Survey, 37% of Latinas

between 19-64 years were uninsured (Kaiser Family Foundation, 2001 cited in Marshall et al 2005). These results show that Latinos often lack health insurance and this is of concern because lack of insurance may influence their health status.

More than half (52.6%) of Mexicans living in the United States have no health insurance, compared to 13.5% for US natives (Center for Immigration Studies, 2001). The Center for Immigration Studies (2001) estimated that more than two-thirds, 68.4%, of unauthorized immigrants do not have health insurance coverage. However, lack of insurance is common even among documented Mexican immigrants living in the United States. Many documented Mexican immigrants (41.4%) do not have health insurance, making them more than three times as likely as US natives to be uninsured (Center for Immigration Studies, 2001).

Differences between undocumented and documented immigrants in health treatment have been found. Undocumented immigrants obtain fewer ambulatory physician visits and lower rates of physician visits compared to other Latinas/os or the US population as a whole. However, hospitalizations for childbirth were higher among undocumented Latinas: 2.6 percent of Latinas had a childbirth-related hospitalization in 1994, compared to 3.4 - 6.4 percent of undocumented Latinas in this study (Berk, Schur, Chavez & Frankel, 2000). Berk and colleagues (2000) queried respondents about fear of seeking care because of their immigration status. Thirty three percent of undocumented persons in Houston, 36 percent in Los Angeles, 47 percent in Fresno and 50 percent in El Paso said that they were afraid they would be denied care because of their immigration status. Based on their findings, the authors conclude that excluding undocumented immigrants from health care services is very unlikely to affect immigration, but instead, denying a

vulnerable population these services may result in bigger and more expensive health problems.

Ortega, Fang, Perez, Rizzo, Carter-Pokras, Wallace and Gelberg (2007) analyzed data from the California Health Interview Survey (CHIS) to compare access to care, use of health services, and reports of health care experiences between US-born Latinas/os and undocumented Latina/o immigrants. Not surprisingly, they found that the use of health care services by Latina/o immigrants is lower than that of US-born Latinas/os. Patterns of increasing use appeared to follow the continuum of immigration status – that is, Latinas/os with greater legal authority used more services. Compared to US-born Mexicans, undocumented Mexican immigrants in California are less likely to have a usual source of health care, and had fewer routine physician visits, even after controlling for socio-demographic factors, insurance and need. Though undocumented Latina/o immigrants in this study were less likely than their US-born counterparts to have insurance and a usual source of care, they were less likely to have used the emergency departments in the last year (Ortega et al., 2007).

While undocumented immigrants in Ortega and collaborators' (2007) study reported their health status as fair or good, their US-born counterparts were more likely to report their health status as good or excellent. Counter to what we might expect, foreign-born Latinas/os report fewer problems accessing needed care and gave higher ratings of the care they received, compared to their US-born peers. The authors posit that foreign-born immigrants probably make fewer attempts to access care, and are more satisfied with the care they receive in the US compared to health care in their home countries. Foreign-born Latinos are also more likely than US-born Latinas/os to believe they would receive better

care if they were a different race or ethnicity. Likewise, they were more likely to report difficulty understanding their providers, demonstrating that communication barriers are a challenge to health care for this group. Ortega and colleagues (2007) conclude that strategies that and US citizens only, while restricting care for undocumented individuals, will only serve to exacerbate inequalities in health care in the US.

Nandi and colleagues (2008) examined access to and use of health services by undocumented Mexican immigrants living in New York City. They posit that characteristics of undocumented immigrants including age, gender, immigration status, year of entry, linguistic and social acculturation, economic resources influence the likelihood of health insurance coverage, access to a regular provider of care, and use of emergency departments. Of the 431 undocumented immigrants born in Mexico who participated in the study, one tenth said that poor physical or mental health impeded their usual activities for more than 5 of the last 30 days, just 10 percent reported having had health insurance in the last 6 months, and slightly more than a third (36 percent) reported having access to a regular health care provider. The investigators found that women were three times more likely than men to report having access to a regular provider, a difference that they attribute to women's use of obstetric and gynecologic care. They also hypothesize that men tend to migrate first, and are followed by their wives, once they have established social and economic resources, which their partners tap into (Nandi et al., 2008).

According to Ortega and colleagues (2007), immigrant respondents who arrived before 1997 were more likely to report access to a regular provider, probably because knowledge and utilization of services increases with time spent in the country. On the

other hand, it may reflect changes in legislation, such as the overhaul of the welfare system under the Clinton administration which restricted the provision of publicly funded services to undocumented immigrants. Respondents who completed some college were more likely to receive care in an emergency department than those with less than a high school education. The authors hypothesize that this may be because those with more education are more knowledgeable about how the healthcare system works. Not surprisingly, the investigators found a relationship between formal income earned in the last year, the likelihood of reporting health insurance coverage in the last 6 months, and the likelihood of having a regular source of health care. Confirming previous studies, the authors found that delays in seeking care are related to fears of discovery by government officials. They did not ask direct questions about this topic, but rather found a significant relationship between social support and access to health care services. Finally, respondents with more health needs were more likely to report health insurance coverage and emergency department care, but to lack a regular provider (Ortega et al., 2007).

Acculturation and Health

Lee, Goldstein, Brown, and Ballard-Barbash (2008) used CHIS to examine the relationship between acculturation and the use of non-Western medicine among Mexican and Asian-Americans. The authors define acculturation as an adjustment to a new culture. Individuals take on beliefs and values of the new mainstream culture while they may retain or reject traits of their original culture. They acknowledge that this definition of acculturation is somewhat narrow, and that recent theories take into account the reality of bicultural identities and the various ways to acculturate into US society. That is, US

culture is diverse and there is more than one way to acculturate into American society. Lee and colleagues (2008) stated that acculturation has been found to function as both a risk and protective factor for health. They use English proficiency and proportion of life spent in the US as proxy measures for acculturation. Eleven types of complementary and alternative medicine (CAM) are included: chiropractor, massage therapist, acupuncturist, traditional Chinese medicine practitioner, osteopath, curandero, naturopath, homeopath, Native American healer, Ayuervedic practitioner, Reiki practitioner. Lee and colleagues (2008) found that among Mexican Americans, 23 percent had used a chiropractor, 12 percent a massage therapist, 5 percent an acupuncturist and just 3 percent a curandero. Mexican Americans with low English proficiency were less likely to use a curandero, as well as a chiropractor or massage therapist. They posit that this may be due to a general lack of access to and utilization of health services. Mexican Americans who had been in the US longer were more likely to use a chiropractor or massage therapist. While their sample size of Mexican Americans was small (n = 1,561), and measures of acculturation limited, their findings of low use of curanderos by Latinas/os are consistent with national studies. They conclude that the findings from this study offer a cautionary message about using simplistic measures when examining the relationship of ethnicity, acculturation and health behavior. This study also shows the broad range of medical treatment categorized under CAM. This can be problematic because teasing apart the use of for example a chiropractor versus a curandero is difficult in studies that combine them under one category.

Reproductive Health

Contraceptive Use. Most public health models posit that knowledge and attitudes about particular health behaviors and their short and long term effects directly influence an individual's behavior. Such models tend to undervalue cultural and structural factors that help to create a context in which groups and individuals operate. Much of the literature on contraception follows the notion that a woman will choose a contraceptive method after a counseling or educational session and that she will use it effectively. Several articles, however, demonstrate that knowledge and attitudes are only part of the equation. Cultural norms and collective beliefs, income, healthcare access, and immigration status are among other crucial factors.

In a study of beneficiaries of a WIC program in Tennessee, Garcés-Palacio, Altarac, and Scarinci (2008) found that low-income Latinas have less knowledge about contraception than their non-Latina counterparts. They evaluated knowledge about contraceptive methods by a mean summary score based in a series of true/false questions. The mean summary score for Latinas was significantly lower (2.5) compared with the mean for non-Latinas (4.3).

Several studies have reported that Latinas use contraceptives at lower levels than women of other groups in the US (Darroch, Haas and Ranjit, 1999; Mosher and Jones, 2010; Abma et al, 1997) A study included in our review (Garcés –Palacio et al., 2008) supports that finding. The researchers found that low-income Latinas have lower contraceptive use (48 percent) compared with low-income non-Latinas (78 percent).

Harvey, Henderson, and Casillas (2006) reported that only 35.6 percent of Latinas 18 to 25 years old reported use of effective contraceptives. Being in a relationship of 1 to 2 years, being involved in the decision-making process about the use of contraceptives,

and having discussed contraception with a male partner prior to intercourse were significant predictors of use of effective contraception. Garcés -Palacio and colleagues (2008) reported that married Latinas were more likely to use contraceptives than single Latinas; and unmarried Latinas living with a partner were more likely to use contraceptives than single Latinas but less than married Latinas.

Acculturation and Contraceptive Use

Nativity.

Minnis and Padian (2001) conducted a study about contraceptive use with young women 15 to 24 years old comparing foreign-born Latinas, US-born Latinas, and US-born non-Latinas. They found that US-born Latinas were most likely to have vaginal intercourse without using contraception (33 percent) than the other two groups of women (54 percent). Additionally, they found that there is lower use of oral pills, emergency contraception (4 percent vs. 18 percent), and condoms (75 percent vs. 88 percent) in foreign-born Latinas (20 percent) compared with US-born Latinas (40 percent).

Unger and Molina (2000) found that women 15 to 50 years who reported various levels of language acculturation used contraception at equal levels. In contrast, Romo, Berenson, and Segars (2004) found that Latinas 18 to 44 years old who have more years living in the US have 1.7 more probability of being a consistent user of contraception compared with women who have been in the US for a shorter period of time. Perhaps, findings differ because the measure of acculturation differs. Unger and Molina (2000) used language acculturation while Romo and collaborators (2004) used length of US residence. More studies are needed to understand the role various types of acculturation

play in contraceptive use for women of Mexican descent.

Abortions. There is limited information about abortion and access to these services among the Latina population or specifically Mexican women in the US. The rates of abortion among Latinas in the US are lower compared with other groups. Kaplan, Erickson, Stewart, and Crane (2001) found that 7.5 percent of women 14 to 24 years old reported they had ever hand an abortion. The underreporting of induced abortion among this population might contribute to the difference between Latinas and non-Latinas.

Even though abortion is less frequent among Latinas, there is evidence that abortion is more frequent among Latinas born in the US compared with foreign-born Latinas (Minnis and Padian, 2001). A study conducted among 15 to 24 years old women in the San Francisco area reported that a history of abortion is significantly lower in foreign-born Latinas (28 percent) compare with US-born Latinas (80 percent) (Minnis & Padian, 2001).

Kaplan and collaborators (2001) investigated predictors to having had an abortion in a sample of 14-24 year-old women. They found that women who have less traditional beliefs regarding women's roles were significantly more likely to report an abortion than women who were more traditional. Acculturation and familism were not associated with reporting an abortion. They found that a higher number of pregnancies and a higher number of sexual partners were positively related to having an abortion. The length of a sexually active life was negatively associated with reporting an abortion (Kaplan et al., 2001).

A study conducted by Angulo and Guendelman (2002) explored the

characteristics of women who obtained an abortion in San Diego. The researchers reviewed the medical records of women attending the clinic and classified them in four groups: Tijuana residents (20 percent), US non-Latinas (48 percent), US predominantly English speaking Latinas (13 percent) and US predominantly Spanish-speaking Latinas (19 percent). Researchers also conducted in-depth interviews with four Spanish-speaking medical staff. Mexican residents were less likely to be younger than 20 compared with non-Latinas. Mexican residents and Spanish speaking Latinas were less likely to have a second trimester's abortion compared with non-Latinas. Also Mexican residents and Spanish-speaking Latinas have a lower probability of having a repeat abortion than non-Latinas. As expected, almost every Mexican resident paid for her procedure with cash (97.7 percent); in contrast, less than two-thirds of the other groups did so ($p < 0.01$). Latinas with high levels of acculturation were far more likely to pay for this procedure through private insurance coverage. Almost 22 percent of the non-Latinas used private insurance compared to 11 percent of English speaking Latinas, 2 percent of Spanish speaking Latinas, and 0.7 percent of crossborder users. Results of the in-depth interviews reported that Mexican women attending the clinic had a middle class background, were employed, and had high literacy levels. They also consistently referred to crossborder patients as resolute, intelligent, resourceful, and leaving nothing to chance (Angulo & Guendelman, 2002).

In addition to accessing traditional sources of abortion care, evidence is beginning to mount that Latina immigrant women in the US also self-medicate, specifically to induce abortion. Researchers studying a predominantly Latina sample in New York City clinics found that 37 percent of respondents knew of a method to self-induce an abortion and 5

percent had used it themselves (Rosing & Archbald, 2000). In this study, Misoprostol use was significantly associated with recency of immigration and better knowledge about the drug. When asked why women might use misoprostol, respondents most commonly said because it is "easier" than abortion and because "abortion is too expensive." Researchers have also documented attempted self-induction of abortion among Mexican women seeking abortion in San Diego (Grossman, Kingston, Schweikert, Tronscoso, Falquier & Billings, 2005). In a survey of 1,516 abortion clients at four clinics in San Diego, 87 (5.7 percent) Mexican residents participated. Of the Mexican women, sixteen reported taking something during the current pregnancy to self-induce an abortion. Seven women reported using misoprostol, and the remainder said they used hormonal injections or herbal preparations (Grossman et al., 2005). These researchers did not examine self-medication among non-Mexican clients.

Informal Care. Deeb-Sossa and Moreno (unpublished) has documented the use of traditional, informal sources of health care by Mexican immigrant women in North Carolina and California to meet their sexual and reproductive health needs. She used ethnographic and case methods, as well as focus group and semi-structured interviews, with Latinas of various ages, medical practitioners and curanderas. Interviews were done with 13 key informants in California and North Carolina that included two midwives, a Latina Health Project Coordinator at a major teaching hospital, the Director of the Migrant Program from a community clinic, and eight traditional healers. The analysis focused on how institutions shape the health practices of marginalized women in society. In North Carolina, Latina minors, who wanted to get an abortion, encountered

institutional barriers such as having to acquire judicial bypasses or permission from a judge if they could not get or did not want to get parental consent. Teenage and adult Latinas were often referred to "Pregnancy Support Services," one of the many crisis pregnancy centers run by anti-choice activists, that provide biased information, limited options for women, and in some ways dissuaded women from exercising their right to choose. Many Latinas had no choice but to have an abortion at privately owned clinics because it was least expensive; however, in these clinics they felt humiliated by the discourse and practices of doctors. Thus, clandestine abortions occurred as Latinas attempted to address their reproductive-health needs through informal care and self-medication. The traditional healers observed and interviewed indicated that women come to them for help with reproductive needs, diagnosis and treatment of STIs, advice on how to deal with male partners, prenatal and postnatal advice and care, and abortion. From the perspective of the traditional healers, their services are sought by women who feel that they cannot go to a formal healthcare provider because they are not documented, cannot pay, they do not like the treatment they receive, their rights are not respected, for confidentiality, and because they desire more clandestine approaches to family planning and abortion that their male partners will not know about. In terms of contraception and abortion, several curanderas claimed that their clients preferred using herbs, roots and teas brewed from plant leaves to control their fertility, as they had misgivings about hormonal methods and in cases where unwanted pregnancy occurred, to induce abortion (Deeb-Sossa and Moreno, unpublished).

California has taken relatively bold steps to create and maintain a safety net for the immigrant population. In the face of increasingly restrictive federal policies that sought to

severely limit or altogether do away with public funding for health, education and social services for undocumented immigrants, in 1996 California initiated a program that provides free reproductive health services to low-income women, men and adolescents residing in the state, regardless of their documentation status. The Family PACT program has grown exponentially since its inception by expanding the number of participating clinics and providers, easing eligibility rules and enrollment, and offering a wider range of services (UCSF Bixby Center for Reproductive Health, 2006). The program now serves more than 1.5 million patients a year, approximately 18 percent of whom are undocumented immigrants (Foster et al, 2006). Though the Family PACT program has made tremendous strides in providing reproductive healthcare to low-income women (and men) throughout California, including undocumented women, there is still a high level of unmet need for contraception, and perhaps as a result, for abortion services.

Conclusions

Together, these studies raise many important questions about health and immigration policies, and how they influence the reproductive healthcare trends and decisions of Mexican migrant women living in California. Many are quantitative in nature, examining broad trends. A qualitative approach may help reveal some of the factors and experiences underlying such patterns.

The study by Castañeda and colleagues (2003) bring attention to the difficulties Mexican women can experience when seeking reproductive treatment for a miscarriage. It is important for reproductive health care providers in Mexico, both formal and informal, to

receive more training and education in the area of attitudes and beliefs about miscarriages.

Abortion, recently legalized in Mexico City, has open women's access to abortion until 12 weeks of gestation. In other states, abortion is legal only if a woman had been raped; the pregnancy was a risk to the woman's life, or it was a spontaneous abortion (miscarriage). Despite these exceptions to the abortion law, as noted above, some women who were legally entitled to have an abortion were unable to have the procedure because medical personnel refused to perform it (Lama & Bissel, 2000). These findings illustrate that even in cases where an abortion may be legal, there are other challenges related to Mexican medical personnel's attitudes towards and willingness to perform abortions.

In addition to difficulties when seeking abortions, some Mexican women also experience difficulties during child labor. Women are mistreated by medical personnel during child labor (Castro and Erviti 2003). Castro and Erviti (2003) also found that doctors and nurses invalidated women's suffering and sometimes even blamed a patient when complications arose or mistakes were made. Castro and Erviti (2003) also found that women were sometimes coerced into using the intrauterine device (IUD) as a contraceptive method by giving them inaccurate information about other methods. This study shows that improvements are needed in the area of reproductive care and rights for Mexican women.

In conclusion, Mexico is a heterogeneous country with a myriad of cultural values and views in the area of family planning. Cultural values and gender role views influence beliefs regarding contraceptive use. Researchers who study Latino/a family planning beliefs, attitudes and behaviors in Mexico and in the US must consider these

views in order to fully understand their source of these beliefs. These beliefs influence the family planning choices Mexican and Mexican American women make both in Mexico and the US. We noted that some women seek reproductive advice from pharmacies and their staff; some are interested in non-biomedical treatments, while others combine biomedical and non-biomedical or traditional sources of reproductive care. Some issues of concern in the area of female reproductive health justice are clandestine and legal (but denied) abortions and maltreatment by medical personnel during delivery. More studies and policies or controls are needed to minimize these injustices to Mexican women.

In conclusion, Mexican women in the U.S., in particular undocumented women, still have high level of unmet needs for contraception and abortion services. Latinas use contraceptives at lower levels than women of other groups in the US (Darroch, Haas and Ranjit, 1999; Mosher and Jones, 2010; Abma et al, 1997) As noted above, researchers have found that low-income Latinas have lower contraceptive use (48 percent) compared with low-income non-Latinas (78 percent).

Despite the limited information about abortion and access to these services among the Latina population or specifically Mexican women in the US, researchers have found that the rates of abortion among Latinas in the US are lower compared with other groups (Kaplan, Erickson, Stewart, and Crane 2001). Even though abortion is less frequent among Latinas, there is evidence that abortion is more frequent among Latinas born in the US compared with foreign-born Latinas (Minnis and Padian, 2001). A study conducted among 15 to 24 years old women in the San Francisco area reported that a history of abortion is significantly lower in foreign-born Latinas (28 percent) compare

with US-born Latinas (80 percent) (Minnis & Padian, 2001).

Latina immigrant women, researchers have found, access traditional sources of abortion care. Latina immigrant women self-medicate, specifically to induce abortion (Grossman, Kingston, Schweikert, Tronscoso, Falquier & Billings, 2005; Rosing & Archbald, 2000). Deeb-Sossa and Moreno (unpublished) have also documented the use of traditional, informal sources of health care by Mexican immigrant women in North Carolina and California to meet their sexual and reproductive health needs.

PIMSA RESEARCH OBJECTIVES

The purpose of this study is to explore how Mexican women ages 18-45 in Mexico and California learn about and procure services and supplies from formal (doctors and nurses at clinics) and informal (curanderas, parteras, yerberas, pharmacies, bodegas, or friends and family) sources of healthcare. The project is based on two working hypotheses. First, we posit that Mexican women who live in rural areas, have low-incomes, less education and limited access to the formal healthcare system are more likely to use a mix of formal and informal sources of reproductive healthcare. Second, we contend that when women from these areas migrate to the US and face a new set of structural and cultural barriers, these patterns and preferences are likely to continue, and may even sway more in the direction of informal sources for women who lack documentation.

METHODS

A total of nine interviews were conducted in California with women who were

migrants from Mexico and have had experience accessing formal or informal reproductive health services in the US, Mexico, or both countries.

Women were recruited in Yolo County by posting flyers at the following clinics and community centers: Planned Parenthood in Sacramento and Woodland, the Davis Community Clinic, and the Yolo Family Resource Center in Woodland. The interviews took place at the Woodland Mall, at UC Davis, at participants' homes, and at the Yolo Family Resource Center. The semi-structured interviews were conducted from March to May 2010 by a researcher (Dr. Natalia Deeb-Sossa) with extensive qualitative study experience.

ANALYSIS

Data were analyzed inductively using the qualitative data analysis software ATLAS.ti 5.5 (Scientific Software Development, Berlin, Germany). To identify key themes, we began by reading through all interview transcripts and creating codes based on the in-depth interview guide, study goals, and interview findings. The transcripts were then coded, and clusters of related codes were organized into themes. We explored the rich variation in each theme by quantitatively and qualitatively identifying key concepts and exploring the perspectives of different subgroups of participants. We then conducted a data reduction by building matrixes to make the most essential concepts and relations visible, and to identify how the themes relate to each other and to their context. Additionally, we created summaries of each participant, along with tables with the most relevant socio-demographic information (see appendix).

RESULTS

Characteristics of the participants

Participants' ages ranged from 20 to 45 years old. Six participants were married, two were single, and one separated. Two participants had not completed elementary school; five participants completed or had some level of high school or had completed a vocational training program; and two had undergraduate education. The year of migration to the US ranged from 1988 to 2004. Two participants had lived in the US for 20 years or more, four participants had lived in US between 10 to 19 years, and two had been in the US for less than 10 years. One participant was born in Texas, but her family returned to Mexico until she was seven years old, after which time her family moved back to Texas and California. Almost all participants migrated from states located in the north of Mexico—Jalisco, Michoacan, and Guanajuato; one participant was from Oaxaca (a poor state with a high proportion of indigenous people located in the southeast of the country); and another was from Morelos, a state located in the center of the country. Seven participants had at least one child, and two participants had never been pregnant. One participant was pregnant at the time of the interview. (See table 1 for more information about participants' characteristics)

Use of and experience with informal reproductive health services

Four of the nine women reported that they had visited an informal health provider in the US or Mexico in order to obtain reproductive health services. We defined an informal provider as the following: healers (curanderas), herbalists (yerberas),

bonesetters (hueseros), sobadoras (hands-on healers), traditional midwives (parteras), and pharmacy vendors. We considered trained midwives in the US as formal providers since they have formal education in universities and they conduct their professional practice within the health care system. Two participants reported that they had visited informal providers but not for reproductive health conditions.

Three of the women who visited informal providers said that they had visited "parteras" (traditional midwives)—one in the US and two in Mexico. Only one woman said that she visited a "curandera" (healer) in Mexico. The two women who reported visiting traditional midwives in Mexico stated that they went because their relatives or neighbors brought them there. A young woman who was living in Los Angeles during her first pregnancy said, "When I was pregnant my mother and my mother-in-law brought me to get hands-on work on my abdomen" (Participant C04). (Cuando yo estaba embarazada mi mama y mi suegra me llevaba para que me sobaran).

The reasons why women visited these informal providers were in almost all cases related to prenatal care and childbirth. Three women visited traditional midwives for "hands-on" work—a procedure to place the baby in the right position for childbirth. One woman who visited a midwife in Mexico said: "you have to go to have a massage every month, every two months during your pregnancy, you have to go to move the baby in the right position" (C03). (Tienes que ir para que te soben que cada mes, cada dos meses de embarazada tienes que ir para que te acomoden el niño). Another woman mentioned that in addition to positioning the baby, the midwife also determined that her baby would be a boy: "she knew… she said that she knew that he would be a boy" (C04). (ella sabia… dice que sabia que iba hacer hombre).

Only one woman visited a healer in Mexico because she had a menstrual disorder (possibly a miscarriage):

Interviewer: "Have you visited a healer or do you know what a healer is?" Participant: "Yes, I know. In Mexico I went because I had a hemorrhage. I had my period and I started bleeding a lot, I was bleeding for 15 days. Then, she said that my hip was broken and that was the only time that I went. I had hands-on work but she did not give me anything to drink..." (C06).

I: ¿Usted ha ido alguna vez a una curandera o sabe que es una curandera?
P: Si, si se. En México si y este fui pro que este tenía una hemorragia, me vino mi regla y empecé a reglar mucho, tarde como quince días sangrando. Entonces dijo que era como la ruptura de cadera y fue la única vez que fui. Me sobo me—este pero no me dio nada de beber…

Two women did not express opinions about their interactions with the traditional midwives in Mexico (the interviewer did probe for this information); however, one woman mentioned that she had a negative experience that contributed to her decision to continue her prenatal care with a formal provider: "I went to one [midwife] and she stated to do hands-on work, but it was so painful that I told her you know it's better that you stop… So, that was a very bad experience, and I was scared that instead of helping my baby it would kill him/her. So, I said no, no more midwives and then thank god I had the possibility of health insurance and so I chose the hospital" (C03). (Yo fui con una [partera] y me empezó a sobar pero era tan doloroso que le dije sabes que mejor ahí no

mas… Así que esa también fue una experiencia muy mala entonces dije no, me dio miedo en vez de ayudarme a mi criatura me la matan. Así que ya de allí dije no, no mas parteras y pues ya gracias a dios tenía la posibilidad de la aseguranza y pues fue por eso que escogí el hospital. The participant who visited a healer did not express any opinions about her interaction with her.

Opinion about informal health care providers

Six women expressed opinions about informal health care providers. Two of them had negative opinions about them (C02, C06), and the rest had neutral or positive opinions (C03, C05, C07, C08).

Women who expressed negative opinions mentioned a lack of trust in informal health providers, which is related to the fact that the providers' knowledge is not based on formal training. Women cited fears that these providers may cause harm or health complications as a result of their practices. One woman who finished vocation training in Mexico said: "but they don't really know what bone you have here, and they don't know if they are touching a vertebra or something, because their knowledge is empirical… but sometimes I think they don't know, they can leave you with a disability, I am scared" (C02). (…pero ya realmente no saben que hueso tienes aquí o no saben que si tocan la vértebra o algo…por eso porque ese es su conocimiento – empírico… Pero a veces yo no creo que ellos sepan te pueden dejar invalido, a mi me da miedo).

A participant mentioned that she would have gone to a traditional midwife for her pregnancy, but she was too far along and felt it would have been so risky to go with her: "Because my mother told me, you are 8 months along, it is too big. If they turn [the

baby], they might strangle it" (C08). (No porque me dijo mi mama, ella dice no dice ya son ocho meses, ya está muy grande. Donde le dan vuelta la puedan horcar.)

Other women talked about how they think it is better to go to a formal health provider, but that sometimes people go to informal health providers because the services are cheaper and are therefore more accessible for those who have to pay out-of-pocket or who do not have access to health insurance.

Two participants talked about how some people visit informal health providers for overall health improvement, or to treat an illness linked with bad luck or superstition. One woman (C03) talked about how her neighbors visit hands-on healers when they have fertility problems and they want to get pregnant. Two participants (C07, C03) mentioned that women go to informal providers to treat problems such as indigestion (empacho), "the evil eye" (mal de ojo), or to "be cleansed" (hacerse limpias).

Use of formal reproductive health services

All women interviewed reported that they had visited a formal provider to obtain reproductive health services. Six of them reported that they had attended these services only in US and three of them said they had attended these services in both the US and Mexico.

Three women said that they went to trained midwives for their prenatal care and childbirth. One woman that had prenatal care and childbirth assistance with a trained midwife in the US explained that she went to her because her husband did not want her to be seen by a male physician: "No, my husband did not want me to attend a male doctor,

therefore the midwife was ideal for us." (C04). (No se mi esposo también no quería que fuera con un doctor hombre y eso entonces la partera fue algo muy ideal para nosotros.)

Five women reported that they had obtained care with physicians (general practitioners or OB/GYNs). Three women visited physicians to obtain prenatal care and childbirth assistance, while three obtained care for the following reasons: ectopic pregnancy, miscarriage, and abortion.

The three women who had prenatal care and childbirth with physicians were living in Mexico at that time. One woman talked about how her pregnancy was very complicated because she had malnutrition and had to be hospitalized in a public hospital in Mexico: "And they told me they have to take my baby because he/she wouldn't be able to be born, he/she was in a bad position. I had malnutrition, I couldn't eat because of the pregnancy, I was not strong enough, and I could not have my baby. They told me it was a threatened miscarriage, they put me on vitamins and fluids, and I stayed 15 days in the General Hospital of Oaxaca" (C01). (Y me dijeron que me iba a sacar mi bebe por que era posible que no naciera estaba mal acomodada igual. Pero como estaba muy malnutrida, muy desnutrida, mas bien no comía bien por el mismo embarazo era muy y luego la comida pues no todo se apetecía en ese estado, no tenía suficientes fuerzas y no podía tener a mi bebe. Me dijeron que era un principio de un aborto lo que tenia y me pusieron vitaminas en el suero y me mantuvieron quince días dentro del hospital general en Oaxaca.)

One participant (C03) said that she obtained prenatal care while living in the state of Jalisco in an Instituto Mexicano del Seguro Social (IMSS) hospital, and another participant who required a C-section went to a private physician and an OB/GYN in the

state of Guanajuato: “Yes, I was seeing a physician, she just took my measures and weight, and that’s it. After that, we changed to another physician who did an ultrasound, and said that the girl was breech, that was when I was at seven and a half months, and is the reason that I had a C-section” (C08). (Si ósea iba con una doctora primero y ella nada más me media y me pesaba y era todo. Ya después que cambiamos de doctor ya fue el que me hizo el ultrasonido y fue cuando dijo que la niña estaba sentaba fue como a los siete meses y medio y por eso me hicieron cesárea.)

The three participants who obtained reproductive health services with physicians in the US reported that they did so for an abortion, miscarriage, or ectopic pregnancy. A woman who had four children (C01) had the following conversation with the interviewer:

Interviewer: “Tell me about the abortion that you had.”

Participant: “Well, it was something that I never… I wanted to have it because I decided I cannot have any more children, it was something that I wasn’t looking for.”

Interviewer: “And it was in United States?”

Participant: “Yes, it was here.”

Interviewer: Cuentame si no te importa de el aborto que tuviste

Participante: Pues, pues fue algo que nunca a – manejar y preferí hacérmelo porque yo decía yo pues sean los niños no puedo asistir a otros mas y fue algo que yo misma pues no lo busque

Interviewer: Y fue aquí en Estados Unidos

Participant: Si fue aquí en Estados Unidos

A 34-year-old participant who wanted to get pregnant was cared for by an OB/GYN for a miscarriage and an ectopic pregnancy: "But it didn't work, last year I had an ectopic pregnancy and one month ago a miscarriage, so it didn't work for me to wait… it is about being lucky, I am normal but I had back luck" (C02). (Pero no, no me ha, no me funciono el año pasado tuve un embarazo ectópico y hace un mes tuve un aborto entonces ya no me funciono esperarme… Nada pues que ya son como suertes que parece que estoy en todo bien pero que ya tuve mala suerte). Another participant who was pregnant at the time of the interview reported that she had obtained services at Davis Community Clinic for a previous miscarriage: "When I went to the emergency room at Davis it was because I had another miscarriage." (C08). (Ya cuando después fui a Davis de emergencia ya fue cuando ya había tenido el aborto repetido.)

Six of the nine participants said that they had obtained other reproductive health services, such as Pap smears, breast exams, STI evaluation, or contraception from health providers in the US (this question was asked in some of the interviews but not consistently). The majority of the women obtained their services in free clinics. Three women said that they obtained these services at Davis Community Clinic and two at Peterson Clinic.[2] Two women also mentioned the Planned Parenthood Clinic in Woodland.

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[2] Davis Community Clinic and Peterson Clinic in Woodland belong to CommuniCare Health Centers. They provide primary medical and dental services. CommuniCare also provides substance abuse treatment services, and health education and outreach throughout Yolo County at seven community clinic sites and in the community.

Only one woman mentioned that she obtained reproductive health services through Family PACT, however, she stopped using it once her husband got health insurance: “One year I did not have health insurance, and I took the green card [for Family PACT] that they give in a health care center, and they give you free services. But once my husband got health insurance, I was ashamed of using a free service, because there a lot of people who use them” (C02). (Ahí pero un año me quedé sin aseguranza y agarré la tarjeta que verde que dan en hay un centro por -- y ahí te daban los servicios eso gratis. Pero nada más cuando mi esposo tuvo ya la aseguranza, pues a mí como que me dio pena valerme de un servicio gratis y yo tenía mi aseguranza porque pues hay mucha gente que los están también ocupando.)

Only one participant mentioned that she had private health insurance and that she regularly obtained reproductive health services at Sutter Clinic. This participant was born in Texas and migrated back to Mexico with her family because her father wanted to return to Mexico. When she was seven years old, the family moved back to the US. She finished undergraduate education in the US.

Experience with formal reproductive health services

Six women considered their experience in formal reproductive health services very good or good, while three women considered it very bad. Three women either did not express opinions about their experience with the services or were not asked the question directly in the interview. The majority of the participants talked about more than one experience obtaining reproductive health services. All the experiences that a participant qualified as good or very good took place in the US, while two experiences in

Mexico and one in the US were considered very bad. The experiences that were classified as good were the ones for which women had positive statements such as: “they treated me very well” (me trató muy bien), “I really like it” (me gustó mucho), and “everybody had a a good time there” (no ahi bien, todos pasamos un ratito bonito). In the cases that were classified as very bad, women expressed the following: “terrible attention” (atencion pésima) or “very bad” (muy mal).

Three women who had good experiences with reproductive health services talked about how the providers were willing to communicate with them in Spanish or overcome language barriers. A participant who had prenatal care and childbirth assistance during her first pregnancy reported liking the experience because: “she tried to speak Spanish with us, and she gave us information about a lot of things, and she was there during my childbirth” (C04). (Porque ella pues no se ella trataba de hablar español con nosotros y no se ella nos informó muchas cosas y ella estuvo también ahí en mi parto.) A 29-year-old woman who did not complete elementary school said that she appreciated the effort that the midwife made to communicate with her even though there were some language limitations: “She did not speak Spanish all the time; I did not converse with her only in Spanish or English. Sometimes I forgot what I wanted to say in Spanish and I told her in English, likewise I forgot what I wanted to say in English and I told her in Spanish, and I told her I don’t know the word, and she would say ‘tell me the word maybe I know the meaning.’ She was always supportive” (C01). (Y ella no habla totalmente español ni total como se llama no era totalmente mi dialogo con ella ni en español ni en ingles a veces se me olvidaba lo que quería decir en español y se lo decía en ingles de igual manera se me olvidaba de lo que quería decir en ingles y se lo decía en español y le decía es que no se

la palabra dice dímela a la mejor yo si la sé y le digo siempre es muy compresiva siempre me daba mucho apoyo.)

This same participant expressed that her experience with her first pregnancy, which she also had with a midwife in the US, was not as pleasant as the second one because she had more difficulties expressing her symptoms and needs in English and she needed a translator.

In contrast, a 34-year-old single woman expressed concerns about the quality of the services because of the limitations of the provider in understanding her symptoms: "There are some physicians that speak Spanish and there are some physicians that understand a little bit of Spanish but are not fluent in Spanish… sometimes they ask you to repeat one, two, or three times, and you can tell that they don't understand what you are saying… I don't consider that to be OK, because if it is not clear what you are saying, they cannot give you what is appropriate or what you need" (C05). (…si hay doctores que hablan español o hay en veces doctores que en medio lo entienden el español que no lo hablan exactamente todo…porque a veces quieren que lo repita una, dos, tres veces, o tu vez que no están entendiendo muy claro lo que tu les dices. … Pienso que no está muy bien porque si no está muy claro lo que uno le dice, no pueden darte lo adecuado, lo que uno necesita.)

Two women liked the services because they received information and health education in the clinics. One woman who migrated 20 years ago to the US and gave birth twice there said: "WIC helps a lot, they teach you how to breastfeed and about nutrition… it is very, very important" (C03). (…ayuda mucho eso de el WIC y ya luego luego le dan a uno el WIC con unas clases tanto de que amantar y te van orientando como

amantar y de nutrición… y si muy muy importante.) In contrast, this same woman talked about her first childbirth experience in a hospital in Jalisco, Mexico and qualified it as very traumatic because the provider did not have compassion, the baby did not stay with her after the birth, and her husband was not allowed to be with her during the birth: "Although I had my baby in a hospital the care was very bad…because my baby was born at 8:45 pm, and I heard that he cried, but they took him away. They brought him to me the next day to breastfeed him, it was terrible. I look at how different it is here, very beautiful, you have the baby and he/she is with you, there is a connection between the mother and the child. That was very traumatic for me, because they do not allow that a relative, your mother or husband, accompany you. My husband was outside, they did not allow him to be with me, he never knew what was happening to me inside the clinic" (C03). (pero a pesar de que tuve mi niño en un hospital de verdad que fue una atención pésima… porque mi niño nació a las 8:45 de la noche y yo no mas oí que lloro y se lo llevaron. No me le trajeron hasta el siguiente día este para tratar de que lo amamantara, entonces eso digo que horror ya cuando mire el cambio acá yo digo que bonito aquí que tienes el niño y está contigo ósea desde ya hay una conexión entre el niño y la mama y todo eso. Para mí eso fue muy traumático, muy traumático porque no te dejan que pase como aquí que pase el familiar o el esposo la mama o alguien. Allá no podía, estaba mi esposo afuera pero nunca lo dejaron entrar para con migo así es que él nunca se enteró de que me estaba pasando dentro la clínica.)

Three participants expressed how the competency and accuracy of the diagnosis and treatment are important for them in their evaluation of their experiences with the reproductive health services. One participant (C02) said that she trusts an OB/GYN who

has a lot of experience and has been assertive in her diagnosis, and she does not trust two providers that were inaccurate.

Another woman who saw a trained midwife in the US talked about her experience with her as negative based on what she considered a lack of competency. This woman, who is the mother of two children with mental disabilities, said that she had a premature rupture of membranes and that the midwife told her to wait one week in her home. During that week she was exhausted and could not sleep. After one week, the midwife induced the labor, but it was long and painful. She said that the midwife had to call an OB/GYN who helped her to deliver the baby. She associates her long labor with the frequent seizures that her son has had since birth. She said: "That first childbirth was very painful for me, I did not have any water [amniotic fluid], the childbirth was dry. They didn't call the doctor until 5 pm. The nurse called the OB/GYN on call. He helped me to deliver the baby. The baby had a cone in his head, as babies are usually born with that, but the cone that my baby had was very big, like an egg. So, they think that might have triggered his seizures" (C06). (Entonces fue muy doloroso para mi ese primer…parto fue muy doloroso porque pues ya no tenía nada de agua, ya era parto seco. Y no llamaban a la doctora, no llamaban a ningún doctor. Ya fue hasta las cinco que veo la enfermera que no, que pues que no podía aliviar este mandaron a llamar el doctor al ginecólogo turno y ya fue él. Con él fue cuando ya mi niño salió. Pero mi hijo nació con el cono… ya ve que nacen los niños con un cono pequeñito verdad…Pero mi hijo lo tenía demasiado su cabecita estaba así como un huevo. Entonces piensan que eso fue también lo que le provocó las convulsiones a él.)

Another participant complained about the lack of attention to her symptoms and

problems when she visits the doctor, and how they force her to focus on only one symptom to be treated during each appointment: “Sometimes you have multiple complications, and they just want to treat you for one thing, [they tell you] ‘no, you have to make another appointment,’ and meanwhile they just look at the most urgent problem, and that’s it. You have to make another appointment for the other things” (C05). (Pues como que a veces lleva uno varios complicaciones o algo y cuando va uno así no mas quieren que se trate como una sola cosa. No es que para eso tienes que hacer otra cita y ahorita por el momento cual es lo mas mas que traes y ya. Y ya as una siguiente cita para lo demás.)

Four participants talked about the time that they have to wait to get an appointment or the time they spent during the appointment. Only one of the four participants talked favorably about it: “Sometimes there are a lot of people, but if you have an appointment it is very fast” (C04). (A veces hay mucha gente pero si vas por cita es muy rápido.) The other three participants had negative opinions. A single woman who completed middle school in Mexico and migrated to US 6 years ago said: “I consider the service very bad because when you have your appointment, they have you there inside the room for one hour, waiting, and I do not like that. Because sometimes you come for an emergency or you have very strong pain, and the waiting time is too long… sometimes you think that they have forgotten that you are there, and then you go out looking for the doctor. This is very common and lots of people complain about this” (C05). (Pues el servicio me parece muy mal porque bueno cuando vas a consulta y eso a veces te tienen ahí adentro en el cuarto hasta una hora en espera y este pues eso no me parece. Porque a veces vas pues de emergencia o puedes ir de un dolor fuerte o algo no sé el tiempo de

espera se me hace muy largo y muy exagerado… que ya uno dice ya se les olvido que estoy aquí pues sale uno a buscar a ver si donde está el doctor o que onda. Pero si muchas veces pasa eso y veo que coincide eso con mucha gente.)

CONCLUSIONS

The use of informal health providers in the US among the Mexican migrants interviewed in our study was infrequent. Only one of the nine women reported visiting a traditional midwife in the US for prenatal care. Three other women visited informal providers in Mexico, two of whom visited traditional midwives for prenatal care and one of whom a healer for a menstrual disorder. In contrast, all of our participants mentioned that they have obtained reproductive health services in Mexico or the US from formal providers. The use of professional midwives for prenatal care and birthing is popular among Mexican migrant women in the US, and one-third of the participants mentioned that they visited them.

The use of informal health providers might be underestimated in our study, since our sample is small and convenient. Additionally, some of our participants were recruited at clinics, and these women may tend to prefer formal health providers over informal providers.

In Mexico and the US, visiting traditional midwives might be influenced by relatives and socio-cultural factors. It might also be related to young age and with a first pregnancy. The three participants who visited traditional midwives were under 20 years old at the time, and all of them were having their first pregnancy. Due to their comparative inexperience, these women may have been influenced by relatives and

friends in the decision of the type of health care provider they should access. Gender issues may also influence women's decisions to use midwives, as illustrated by the case of the woman whose husband did not want her to see a male provider.

From our analysis, it seems that one of the reasons why women attend informal providers in Mexico and the US is a lack of health insurance and access to formal health providers. In Mexico, one woman who did not have access to the workers' health insurance (IMSS) started to see a traditional midwife but changed to a formal provider as soon as she had access to health insurance. Some Mexican women in the US also talked about how people visit informal health providers because their services are affordable for those who lack health insurance or cannot afford to pay out-of-pocket for formal health services.

Even though the majority of the participants have a positive opinion about healers and traditional midwives a couple of women expressed concerns about visiting them because they think they do not have enough knowledge or that they may harm women with their practices.

The use of trained midwives for prenatal care and birthing in the US was popular among our participants. The majority of the women were pleased with the attention they received, and they liked the professional midwives because they are women, they are supportive, they are willing to communicate in Spanish with them or are able to overcome language barriers, and they provide information. In contrast, none of the women who gave birth in the US visited a physician. Women instead reported visited OB/GYNs in the US for more specialized treatments.

The majority of participants said they have obtained other reproductive health

services, such as Pap smears, breast exams, STI diagnoses, or family planning services, from health care providers in the US, for the most part from free clinics. The majority of the participants reported that they had a good experience with the formal health services in the US and Mexico. Some of the problems that women faced in the US included: language barriers, lack of trust in the providers, single-issue health care appointments, and long waiting times. Women who were treated in Mexico complained about a lack of compassion from physicians, childbirth practices that do not foster the relation between the mother and the child, as well as lack of provider competency.

Table 1. Socio-demographic characteristics of participants.

	Age	Number of children	Abortion	Marital status	Country of origin	Year of migration to US	Education
C01	29	4 1 born in Mexico 3 US	1	Married	Oaxaca, Mexico	1997	Has not completed elementary school
C02	34	1 Born in US	1 miscarriage 1 ectopic pregnancy	Married	Jalisco, Mexico	2000	High school; vocational training as secretary in Mexico
C03	45	4 1 Mexico 3 US	NA	Married	Jalisco, Mexico	1988	Teacher in Mexico

C04	20	1 Born in US	0	Married	Michoacan, Mexico	2000	Elementary school in Mexico; middle school in US
C05	34	0	0	Single	Jalisco, Mexico	2004	Middle school in Mexico
C06	37	2 Born in US Both with disabilities	0	Married	Morelos, Mexico	1998	High school; started studies to be a nurse in Mexico
C07	32	0	N/A*	Single	Born in Texas, US		Bachelor in US; currently in graduate program at USF
C08	32	2 children, first born in Mexico, the second in US She is pregnant	1 miscarriage	Married	Guanajuato, Mexico	2002	First year of high school in Mexico
C11	42	4 children	N/A	Separated	Michoacan, Mexico	1989	Studying at a college

*information not available

Summaries of each participant

C01

Woman from Oaxaca. She is 29 years old and was interviewed with her 44-year-old Mexican husband. They talked a lot about the discrimination they have suffered in the US. She migrated to the US in 2007 because all of her family was already there. When she was a child she worked in the fields with her family. She had 4 pregnancies. She had her first birth when she was 15 years old and was living in Mexico. She visited a partera to "acomodar el bebe" when she was 3 months pregnant. When she was six months pregnant she started to have symptoms of a premature delivery and was hospitalized at the General Hospital in Oaxaca. In the US, she had 3 children at the Peterson Community Clinic. She complained about long waiting times during the prenatal care visits of the second pregnancy (her first in US). The births were attended by a nurse and trained midwife. She liked the care she received. She briefly and superficially mentioned that she had an abortion in a clinic in US.

C02

Woman from Mexico who migrated to the US 10 years ago. She finished high school and a vocational program to be a secretary in Mexico. She migrated because all her family was already in the US. Since she moved to the US, she has worked in warehouses packing products. She married a Mexican in the US, and has a 7-year old daughter that was born in the US. She had a good experience during the delivery. She had an ectopic pregnancy and a miscarriage in the US after her first childbirth. She has been trying to get pregnant again. She has never visited informal health providers. She said that she is afraid about the consequences of using informal health care services, since their knowledge is empiric. She mentioned that even her sisters that live in Mexico usually go to trained doctors and not with informal providers for their healthcare. She said that maybe her mother went to some midwives or curanderos. But her generation does not go with these providers anymore.

C03

Woman from Jalisco, Mexico, that migrated to the US in 1988. She studied to be a teacher in Mexico. She came to the US with her husband with the plan to stay there for one year. Then, her husband was murdered and she decided to stay. She first lived in Oakland and then moved to Woodland with her four children. The first child was born in Mexico at the IMSS clinic. She said that she had a very bad experience because the doctors did not have good training. During this first pregnancy she visited a midwife in Mexico because her neighbors told her that she has to go every 2 months “para que le acomoden el nino” but it was too painful and she told the “sobadora” to stop and she

never went back. The other 2 pregnancies (she had twins) happened in the US. She compared the health systems of the two countries, and said that prenatal care and childbirth services are much better in the US than in Mexico because women receive more information, and the health staff has more training and are friendlier.

C04

20-year-old woman who migrated from Michoacan in 2000. She moved to LA with her family. She met her husband there and they moved to Sacramento. She has one child born in the US. While she was pregnant in LA, she visited a "sobadora" because her mother and step-grandmother recommended her to do so. She said that the "sobadora" "acomodo el bebe" and predicted the baby would be a boy. Then when she moved to Sacramento she continued her prenatal care at Davis Community Clinic. A trained midwife attended the childbirth. She said that her husband did not want that a male doctor to attend the birth and that is the reason that she decided to have her prenatal care and childbirth with a midwife. She liked the care she received from her. She said that now in the US it is more common for women seeking an abortion to go to an abortion clinic than to take herbs or do other things. She was not aware of misoprostol.

C05

A 34-year-old woman from Jalisco, Mexico. She migrated to US in 2004 because all her family migrated there. She is single and lives with another sister that is single. She is

learning English and is not working. She sometimes feels discriminated. She has not become pregnant. She obtains RH services at Peterson or Davis Community Clinic. She does not like the services because she has to wait a long time and they usually do not treat all the problems she had, and they focus only on one symptom. She also mentioned that the Spanish proficiency of the doctor varies, since she sometimes realized that he does not understand what she has said. She doubts about the quality of the treatment she receives because of the language barriers. She has heard about women having abortions in clinics in the US and has heard that some women use ruda to interrupt their pregnancies. She has never used informal providers, but she said that sometimes you have to use informal providers (curanderos, sobadores) if you lack health insurance.

C06

A 37-year-old woman from Morelos, Mexico with low economic resources. She grew up in a very hostile environment. She had an alcoholic father and wanted to escape from that situation. She was offered to migrate to the US with a family to be a domestic worker and nanny. She migrated 12 years ago. After that she married and had 2 children with mental retardation and seizures. She is not working and has difficulties learning English. She reported that she has faced a lot of discrimination for being Latino and have children with disabilities. She went to a “sobadora” when she was living in Mexico because she had a heavy menstrual period. She said that the treatment was effective even though she does not talk about the quality of care. Her first birth was attended by a trained midwife and she said that she had a very bad experience. She had a long labor and the baby had problems going through the birth canal. After many hours of painful labor, they finally

called an OB/GYN and she delivered the baby. She said that maybe her baby has seizures as a consequence of the long labor since the head of the baby was deformed when he was born. She said that she receives reproductive health care, such as Pap smears and breast exams, at Peterson Clinic but she stopped going to that clinic because of poor quality of the service and discrimination from the clinic staff. She now goes to Davis Community Clinic and likes the services there. She did not have any knowledge of abortion services in the US or Mexico or of the use of misoprostol.

C07

32-year-old woman that was born in Texas. Her mother migrated to the US 35 years ago. She was the only one of her nine relatives that was born in US. The family returned to Mexico and she spent the first 6 years of her life in Mexico. Then they moved back to Texas and then to California. She said that she had problems understanding and speaking English and adapting to the school system in the US. She also suffered racial discrimination. She is now studying in a graduate program in Family-Marriage Counseling at USF. She is single and has never been pregnant. She has never received RH services with informal providers. She has heard about people attending curanderos "para hacerse limpias." Her mother "se hizo una limpia" because she had an illness and she did not recuperate after taking medicines. Her mother was attended by a midwife in her first three pregnancies in Mexico. She has heard about people going to informal providers "sobadores" because they have "mal de ojo" or "empacho" or they want to be pregnant, but not for abortion. She thinks that people attend informal providers because of lack of health insurance, lower cost, and better cultural relations with the provider. She

has not heard about misoprostol.

C08

A 32-year-old woman. She finished the first year of high school in Guanajuato. She married in Guanajuato and then migrated with her husband to Woodland 8 years ago. Her first daughter was born in Mexico and her son was born in the US. She had a miscarriage in 2007 and she was pregnant at the time of the interview. During her first pregnancy she had prenatal care with a physician. When she was 8 months pregnant the physician told her that the baby was not in cephalic position. Neighbors told her to go with a "sobadora" but she refused because at that time she was 8 months pregnant and she was concerned that her baby would be injured. She had a C-section in a clinic in Mexico. During her second pregnancy she had her prenatal care at Peterson clinic in the US. She had preeclampsia and had a C-section. After that she had a miscarriage that was treated at Peterson clinic and at this time is receiving prenatal care in the same facility. She likes the care she has received in the clinic. She considers that health services in the US to be better than in Mexico. There was no information about abortion or misoprostol in this interview.

C11

A 42-year-old woman from Michoacán. She migrated with her husband 21 years ago. She said that the process of integration to life in the US was terrible for her. She was depressed and suffered domestic violence. She separated from her husband in 2007. She now lives in Davis. She said that she feels inhibited to speak in English. She mentioned

that when she was living in Mexico her mother used to bring her to a curandera that would give her teas when she had “empacho” stomachache. She said that she does not like to go to community clinics because of the waiting time. She said that she heard that a sister of a friend who became pregnant by accident took ruda with chocolate and had an abortion. That is the way that she learned that ruda with chocolate was used to have abortions. She has not heard any information about misoprostol.

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