Final Narrative Report

Social Networks in the Access to Reproductive Health Services of Migrant Women to Chicago, Illinois: A Community Intervention

PROJECT # HNN09W PIMSA 2008-09

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I. Executive Summary

Objective

This study seeks to explore the role of social networks in the access to and use of reproductive health services among migrant Mexican women residing in the U.S.

Methods

All participants are women between the ages of 21-35 years, born in Mexico, with 15 years or less of residency in the United States and are or have been pregnant at least once regardless of delivery status. Sources of recruitment include two community health centers located in areas with high concentration of Mexican immigrants. The survey utilized consisted of 48 questions, took approximately 30 minutes to administer, and was provided in either English or Spanish. The survey was composed of a basic demographic section followed by general social network questions regarding support with various components of daily life and organized migrant organizations. Thereafter, the survey focused on sources of information and guidance associated with reproductive health services, sources of reproductive health care, satisfaction with RHS services received and barriers to access of care.

Results

A total of 175 women were included in this study, all born in Mexico, with a mean age of 28.7 years. Fifty-eight percent of the women had a 9^{th} grade education or less and 69.5% of the women had been living in the U.S. for 5-10 years. The three states of origin that were most represented amongst this sample were Guanajuato, Zacatecas and Michoacán. Since their arrival to the U.S., participants acknowledged having received general assistance and support from social service agencies provided by the city, state and/or federal government (60.0%) and churches or temples (35.4%).

Informal social networks of family and friends were the most commonly relied upon sources of support and information. Most participants reported physicians/nurses, family members, and friends/acquaintances as sources of information regarding where to go to receive care related to their reproductive health. When asked to rate their previous experiences with reproductive health services as good, regular or bad, at least two thirds of the women considered their previous experiences to have been “good” in the city of Chicago for any particular reproductive health services. The major barriers cited in the access of reproductive health services included lack of insurance (54.9%), language difficulties (47.7%), and cost of visit (38.9%).

Conclusion

Family, as a component of Mexican migrant women’s social networks, seems to facilitate the access to reproductive health services and represents a key element of social support. Additionally, healthcare staff, such as physicians and nurses, also play an important role as source of reproductive health information. Furthermore, participants are familiarized with the certain reproductive health services, especially those linked to prenatal care and pap smears, which are also the most frequently used services. Use of these reproductive health services occurs primarily through community health centers. Finally, the most important barriers Mexican immigrant women face when accessing reproductive health services include lack of health insurance, limited English proficiency, and high out-of-pocket cost for such services.

II. Study Proceedings

Phase I: General Investigator Meeting

Co-PIs and other members of the research team held a three day meeting in March 2009 hosted by the Universidad Autonoma de Zacatecas. At this time, each PI shared their work and intellectual relationship to the topic of this study. We honed our research objectives, designed our research methodology for both quantitative and qualitative components of the project and approximated our timeline. Each team member brought their skills and expertise to the table to craft an inter-disciplinary project.

Phase II: Focus Groups

We held three focus groups during the month of October 2009, each composed of three relevant subject groups. These subject groups consisted of Mexican Immigrant Women, Key Informants, and Reproductive Health Care Providers. Each focus group lasted 1-2 hours and was led by two research team members. Focus Group One (Immigrant Women) was made up of female Mexican immigrants who were 21-35 years of age. Investigators determined a subject's eligibility by asking a series of screening questions and documenting this prior to extending an invitation to participate in the focus group (See Attached Screening Questions - Interviews). Focus Group Two (Key Informants) included individuals with knowledge of the needs of Mexican immigrants. This group was composed of academicians, members of the Mexican Consulate, and leaders in community organizations or federations targeting their activities toward immigrants in Chicago. The members of this group were selected by a snowball sampling that targeted community leaders who have some relationship to access to healthcare of Mexican immigrant communities. Focus Group Three (Reproductive Health Care Providers) was comprised of individuals who work in health care services, clinics, or as social workers serving the Mexican immigrant community.

The results from this part of our study will be forthcoming from Dr. Miguel Montezuma, co-PI.

Phase III: Study Protocol and Institutional Review Board (IRB) Approval

During the initial phase of this research project, a study protocol delineating the following categories was developed.

Participant Sample. The selection criteria for the study participants were based on similar criteria used by other studies focusing on social networks and migration and reproductive health services. The first criterion required women to have been born in Mexico to ensure a more homogenous migration experience amongst the subjects. The age criterion of 21-35 was based on commonly studied ages in reproductive health studies. Less than 15 years within the U.S. was chosen to capture the effects of social networks in recent migrants. And finally, a prior or current pregnancy would most likely guarantee exposure to reproductive health services.

Survey Development. The survey was created through the collaboration of all study PIs. Based on the expertise of each PI and their literature reviews, questions were developed to reflect current themes in social networks, reproductive health services, and Mexican migrants into the U.S. Based on the selected themes, variables were defined and questions developed. Due to the exploratory nature of this study and lack of previous research in the field of social networks in the access to RHS in migrant women, the questions were self-designed.

Pilot Testing. Once the questions were developed and reviewed, the survey was pilot tested in Mexico on Mexican women who had migrated to the United States and had returned to Mexico. Appropriate adjustments were made to the survey. Survey was timed to facilitate data collection planning.

Data Collection Sites. Sites for data collection were selected after multiple and thorough discussions regarding the population attempted to be captured and risks of introducing biases to the data. Secondarily to the exploratory nature of the

study and limited resources, two sites were finally selected that would increase the odds of finding the appropriate population for the study. These two sites were two community health centers that have an established presence in the Latino community and serve a predominantly Latino population.

IRB Approval. Study protocol and required forms were submitted to the University of Illinois IRB for approval. After multiple revisions, study approval was granted. Study participant consent forms in English and Spanish were approved at this time as well as consent forms for collaborating agencies (i.e. participating community health centers). Additionally, both community health centers required internal IRB review of the study prior to allowing data collection at their facilities.

Phase IV: Data Collection, Entry and Analysis

Study Personnel. Bi-lingual, Latina Graduate Students were hired to assist with IRB submission, translation of study instruments, correspondence with data collection sites, and associated clerical activities. The graduate students had various academic backgrounds and research training. Additionally, four bi-lingual Latina undergraduate students participated as research assistants and assisted with data collection, data entry, and clerical activities. All research assistants participating in the data collection were extensively trained.

Data Collection. All interviews were conducted in the two community health centers, by trained, bi-lingual Latina research assistants. Interviews were conducted in private rooms. Study personnel worked closely with staff at the community health centers to minimize interruption in patient and/or client services. Data collection took six months to complete.

Data Entry. All data was entered in SPSS 16.0 by research assistants who had also participated in the data collection. All research assistants were trained in using SPSS and proper data entry technique. Data was tripled checked for accuracy.

Data Analysis. Data analysis was done using SPSS 16.0. Both quantitative and qualitative data was collected. Simple descriptive statistics were performed for the majority of the analysis reflecting the descriptive nature of this study.

QUANTITATIVE REPORT

Social Networks in the Access to Reproductive Health Services of Migrant Women to Chicago, Illinois: A Community Intervention

August, 2010

Introduction

The interplay between migration and health are complex. The health status of immigrants depends on the individual's antecedents prior to migration, the migration experience itself, and the circumstances encountered in their new destination. Worldwide more than 60% of immigrants in developed countries, such as the U.S., do not have access to medical care. Moreover, about half of these individuals are women (LA County, 2010). While certain facets of healthcare use amongst immigrants internationally have been explored, there is limited data available regarding reproductive health status and use. Thus, given the high percentage of migrant women who do not have readily available access to health care, it is imperative to understand the needs, use and availability of reproductive health services among immigrant populations.

Health disparities are the result of specific vulnerabilities common to certain populations, as well as barriers present in the healthcare system that are more pronounced for specific subpopulations. The most recent annual National Healthcare Disparities Report (NHDR) indicates that although disparities in access to healthcare have decreased for all other minority groups in the U.S., disparities have increased among Hispanics (AHRQ, 2006). Latinas are also disproportionately poor and of low educational status, factors that contribute to their overall health and access to care. Yet despite the rapid population growth of Latinas in the U.S., data about their health and the quality of healthcare delivered to them are very limited.

Although considerable state variation on measures of access and utilization occur that often mask gaping disparities between women of different racial and/or ethnic groups (Bien-Aimé, 2006), for Latina women, access and utilization of healthcare are consistent problems. A greater share of Latinas, as compared to other minority groups in the U.S, lack health insurance, do not have a personal doctor/health care provider, and have delayed or went without care because of cost (James, 2009). Even though there is limited data on use of reproductive health services among Latinas in the US, the available data show disparity trends similar to other sectors of healthcare service utilization. For example, 16.3% of Hispanic

women have not had a Pap test in the past three years versus 13.2% of women in the general U.S. population. While all women are at risk for HIV, this epidemic has disproportionately affected Latinas (James, 2009).

Immigrants of Mexican origin in the U.S. encounter many obstacles when accessing the healthcare system. In 2008, there was an estimated 11.4 million Mexican immigrants in the U.S. of which an estimated 50% are undocumented (MPI 2010). Currently, 56% of the Mexican immigrant population lack any type of healthcare coverage. The proportion of uninsured among recent immigrants is even higher, estimated at 70%, as these individuals are more likely to be of low income, undocumented and consequently relegated to hold jobs that do not offer health benefits.

Disparities also exist in the types of health services received by Mexican immigrants in the U.S. Disparities in reproductive health are evidenced by the discrepancies observed in the use of preventative health services. In the U.S., Mexican immigrant women are less likely to receive Pap smears (74.4%) and mammograms (58.9%) versus U.S. born women, 79.9% and 78.2% respectively (Wallace, 2008; Capps, 2009). Furthermore, undocumented immigrants are less likely to receive prenatal care or any care before the third trimester of pregnancy as compared to legal immigrants (Bien-Aimé, 2006). A great proportion of Latina women immigrants in the U.S. do not qualify for publicly funded insurance programs like Medicaid even if in the U.S. legally due to other requirements and many have language barriers and low levels of health literacy that additionally challenge their access to the healthcare system (James, 2009).

In Illinois, Latinas represent approximately 13% of the total 6.5 million female population in 2005. Latinas accounted for about 49% of the 1.9 million Latinos in the state in 2005 with most women (74.8%) identifying as Mexican or Mexican American (Giachello, 2010). The 2008 estimate of Mexican immigrants residing in Illinois was of 720,106 or about 5.6% of the total state population. Of this figure, 44.2% were women. Moreover, Chicago and the surrounding area have the second largest percentage of Mexican immigrants in the country with an estimate of 691,113 (MPI 2010). Unfortunately, in Illinois, 1 out of every 6 women

is uninsured. Those who are younger and of low income are particularly at higher risk of being uninsured, as are women of color, of which Latinas are at greatest risk. Moreover, women in Chicago have the highest rates of uninsured compared to any other part of the state (HAD, 2007).

The scarcity of available research in reproductive health, in conjunction with the known health disparities of Mexican immigrant women, has prompted the undertaking of this study. This study will further the understanding of the complex interplay of social and structural factors that play an important role in determining the general well-being and reproductive health status of an important segment of the U.S. population. Additionally, this study will allow exploration into the needs and barriers encountered by Mexican immigrant women in relation to their reproductive health such that sound interventions may be developed to improve the reproductive health status of this vulnerable population (WHO, 2010).

Method

Sources of Recruitment

Two community health centers were chosen based on location and population served. Both centers were located in areas with a high concentration of Mexican immigrants.

Selection Criteria

All participants were women between the ages of 21-35 years, born in Mexico, with 15 years or less of residency in the United States and who had been pregnant at least once regardless of delivery status. Women were recruited from two different community health centers. In one community health center, women were either approached while they waited for their doctor's appointment or while they waited for another patient's appointment if accompanying that patient. Women were either recruited from the Obstetrics/Gynecology, Family Medicine, or Pediatric Clinics. At the second community health center, women who were currently participating in open support groups for better parenting skills were approached for recruitment.

Survey

Questions for the survey were developed based on common and relevant themes appearing in the literature for reproductive health services and social networks amongst U.S. Latino immigrants. The survey was comprised of 48 questions, took approximately 30 minutes to administer, and provided in either English or Spanish. The survey utilized was composed of a basic demographic section followed by general social network questions regarding support with various components of daily life and organized migrant organizations. Thereafter, the survey focused on sources of information and assistance associated with reproductive health services; sources of reproductive health care; satisfaction with reproductive health services received; barriers to reproductive health services; preference for reproductive health services between Mexico and the US; and finally how the participants became familiarized with their respective community health center.

Administration of Survey

Women were first provided with a brief synopsis of the study in a private room by trained bi-lingual, Latina women research assistants. If interested, the women were asked four screener questions to ensure study eligibility. If interested and eligible based on the selection criteria, the women underwent the process of informed consent in their language of choice. Once informed consent was completed and all questions answered, participants were given a verbal definition of reproductive health services along with a paper list of commonly used reproductive health services and a description of each of the services to orient the participants to the concept of reproductive health services. Women were then administered the paper survey in a face-to face format, in their language of choice by trained, bi-lingual Latina research assistants. The research assistants completed the survey based on the responses provided. Once the survey was completed, participants were thanked for their time, debriefed and given $10 for their participation.

Analysis

Data was collected on paper and transferred into an SPSS 16 database. Data was aggregated from both community health centers as no difference existed in their baseline characteristics. Information was entered, and triple checked for accuracy. Analysis was performed using SPSS and constituted of basic descriptives and frequencies.

Results

Demographics

A total of 175 women participated in the study, all born in Mexico, with a mean age of 28.7 years (range 21-35) and about 50% were older than 30 at the time of the study. About half of the women had been living in the US for 5-10 years with about equal distribution for women having been in the U.S. less than 5 years and greater than 10 (max of 15 years). All participants elected to complete the survey in Spanish. Seventy percent of the women are married or co-habiting, 16.6% are single with a partner, and 6.3% are single with no current partner. About 58% of the women had a 9^{th} grade education or less with a mean of 9 years of formal schooling (range 3-16years). The three states of origin most represented in this sample are Guanajuato, Zacatecas, and Michoacán, which correlate with the states of highest migration into the city of Chicago (Table 1).

Social Networks and General Support

Since their arrival to the U.S., participants acknowledged receiving general assistance and support from social service agencies provided by the city, state and/or federal government (60.0%); churches and/or temples (35.4%); and established migrant organizations with various aims (12.0%). In general, only 13.7% of the participants are familiar with any immigrant organization in the city and of these only a quarter have ever participated in any related activities provided by such organizations (Table 2).

Table 1. Sociodemographic characteristics of participants in the project of their Social Networks in the Access to Reproductive Health Services (SNRHS) of Migrant Women in Chicago					
	n= 175	%		n= 175	%
Age			**Current partner is:**		
Mean in years = **28.7**			Mexican	143	81.7
< 25	32	18.3	Mexican born in USA	9	5.1
25-29	60	34.3	Latino	6	3.4
> 30	83	47.4	Other (Angloamericano)	3	1.7
Marital Status			**Years of residence in USA**		
Single without partner	11	6.3	< 5	29	16.6
Single with partner	29	16.6	5-10	86	49.1
Married/ Living together	125	71.4	> 10	60	34.3
Divorced/separated	7	4.0	**Years of residence in Chicago**		
Widowed	0	0	< 5	36	20.6
Years of school completed			5-10	85	48.6
< 6	11	6.3	> 10	54	30.9
6-9	102	58.3	**State of origin**		
> 9	59	33.7	High migration*	93	53.1
Current partner			Border states**	5	2.9
Yes	162	92.6	Other-low migration	76	43.4
No	11	6.3			
*States of historically high migration rate: Guanajuato, Zacatecas, Michoacán, Durango, Jalisco, San Luis Potosi, Nayarit, Colima, Aguascalientes. ** Baja California, Sonora, Chihuahua, Coahuila, Nuevo León, Tamaulipas					

Tabla 2. Organizations supporting of participants in the project SNRHS of Migrant Women in Chicago		
	n= 175	%
Organizations from which you have received information and/or support		
Temples/Churches	62	35.4
Migrant Organizations	21	12.0
Social services of City, State or Federal	105	60.0
Unions	5	2.9
Others	15	8.6
Do you know of any Mexican migrant organizations?		
Yes	24	13.7
No	151	86.3
Do you participate in any of these organizations?*		
Yes	6	25.0
No	18	75.0

Women in the study received various types of support and information through formal and informal social networks. Informal social networks of family and friends are more commonly relied upon as sources of support and information versus formal social networks such as social service agencies, schools, and government sponsored public health department clinics. Types of support elicited in this survey included assistance with activities of daily living, such as what bank to use or where to go grocery shopping; language assistance; transportation; support for health and legal issues; and job placement. Most frequently, family and friends are used as sources of support for transportation (53.2%, 31.6%), assistance with activities of daily living (53.1%, 30.3%), and job placement (46.3%, 44.0%) (Table 3).

Table 3. Social network support of participants in the project of their Social Networks in the Access to Reproductive Health Services of Migrant Women to Chicago by support type

	Associations and/or organizations		Government Agencies		Relatives		Friends/ acquaintances	
	n*	**%**	**n***	**%**	**n***	**%**	**n***	**%**
Employment	3	(1.7)	4	(2.3)	81	(46.3)	77	(44.0)
Language support	16	(9.1)	20	(11.4)	67	(38.3)	42	(24.0)
Help with daily activities	3	(1.7)	9	(5.2)	93	(53.1)	53	(30.3)
Transportation	4	(2.4)	11	(6.4)	94	(53.2)	55	(31.6)
Support with health issues	12	(6.9)	36	(20.6)	69	(39.4)	32	(18.3)
Support with legal issues*	11	(6.3)	8	(4.6)	21	(12.0)	9	(5.1)

*Numbers and percentages were determined independently for each support type. * *Number of women without missing values

Social Networks and Reproductive Health Services

Participants were asked about their sources of information pertaining to who has informed them of where to go to receive care regarding concerns related to their reproductive health. Most of the participants state they use physicians/nurses,

family members, and friends/acquaintances versus general social service agencies or government sponsored agencies as sources of information. For example, 48.6% of the participants asked a physician or nurse for prenatal care information, 49.1% asked their family members, and 26.9% turned to their friends or acquaintances. A similar trend occurs for all other inquired services including preventative care, contraceptive counseling, and STI information (Table 4).

Table 4. Sources of information regarding receipt of RHS of participants in the project SNRHS of Migrant Women in Chicago by RHS type*

	Associations and/or organizations **		Government Agencies**		Relatives**		Friend/ acquaintance **		Physician/ Nurse**	
	n[&]	%	n[&]	%	n[&]	%	n[&]	%	n[&]	%
Prenatal care	12	(6.9)	17	(9.7)	86	(49.1)	47	(26.9)	85	(48.6)
Partum and Postpartum care	5	(2.9)	10	(5.7)	39	(22.3)	23	(13.1)	133	(76.0)
Preventive Care (Pap Smear)	5	(2.9)	8	(4.6)	25	(14.3)	10	(5.7)	143	(81.7)
Counseling on Contraceptive use	7	(4.0)	9	(5.1)	15	(8.6)	8	(4.6)	135	(77.1)
STI information and/or services	10	(5.7)	9	(5.1)	15	(8.6)	4	(2.3)	100	(57.1)

*Participants were able to chose multiple sources of information for each RHS, **Number of women without missing information [&]Numbers and percentages were determined independently for each source of information

More specifically, in terms of receiving advice and guidance when in need of reproductive health services, most participants rely upon physicians and/or nurses (92%). Additionally, 88% of the women depend on family members or friends in the U.S. for advice versus 36% that still consult family or friends in Mexico. Associations and/or organizations (not specified) are also consulted for guidance in 38.9% of the sample (Data not presented in table).

Of the women interviewed, 86% are aware of institutions that offer reproductive health services in Chicago. 82.9% of the women found about these institutions through their family or friends and 11.4% through various media sources (TV/Radio/newspapers). With the exception of a few women, most women

(98.3%) affirmed that having knowledge of reproductive health services offered in Chicago facilitated their use of these services (Table 5).

Table 5. Utilization of Reproductive Health Services in Chicago of participants in the project SNRHS of Migrant Women in Chicago		
	n= 175	%
Are you familiar with the institutions that offer RHS in Chicago?		
Yes	150	86.0
No	25	14.0
By what means did you find out about these institutions?		
TV/Radio/ Periódico	20	11.4
Friends/Relatives/others	145	82.9
When in need of RHS which of the following institutions have you inquired upon:		
Clinics Health Center	160	91.4
Hospitals	54	18.3
Private Doctor and/or clinics	26	18.3
Other Institutions	9	5.1
Was it easier to make use of these services by having prior knowledge of them?		
Yes	172	98.3
No	3	1.7
In the last year have you needed one of the following RHS*:	Yes	No
Prenatal Care	80	45.7
Partum/Postpartum care	61	34.9
Sponataneous/Elective abortion	6	3.4
Preventive Care (Pap Smear)	136	77.7
Counseling on Contraceptive use	91	52.0
STI information and/or services	56	32.0
* Numbers and percentages were determined independently for each types services		

The majority of the women learned about the two community health centers in which the study took place mainly through family members (55.0%) or friends (47.3%) and only 7.7% found out through various media sources. The main reasons noted for choosing these particular community health centers included a comfortable clinic setting (94.9%), services offered in Spanish (92.6%), being an established patient (86.3%), and the clinic being situated in a convenient location (85.1%) (Table 6).

The majority of the participants (83%) are accompanied by someone else during their reproductive health service appointments although the companion may not be present during the whole appointment (i.e. in the exam room during the actual visit). Most of the women are accompanied by their partners (72%), mother/sister (28%), and/or daughter/son (20%) (Data not presented in table).

Prior Use and Knowledge of RHS in Mexico

Prior to migrating to the United States, 59.4% of the women had been aware of the existence of reproductive health services in Mexico, and of these participants about half had made use of them in Mexico. The services most commonly used in Mexico included pap smears (18.3%), contraceptive counseling (18.3%), prenatal care (14.3%), post natal care (14.9%), and STI information/services (10.3%) (Table 7).

Table 6. Medical attention Community Health Centers RHS of participants in the project SNRHS of Migrant Women in Chicago

	n	%
How did you hear about the clinic?*		
Husband/Partner	18	10.7
Family	93	55.0
Friends/Co-workers	80	47.3
Internet	4	2.4
Newpaper	2	1.2
TV/radio	7	4.1
Referred by another clinic/hospital	6	3.5
Other	11	6.5
Why did you decide to come to this clinic today?**		
I was already a patient of this clinic	151	86.3
It is in a convenient location	149	85.1
Offers services in Spanish	162	92.6
The location is comfortable	166	94.9
Referred by another clinic/agency	5	2.9
It was reccomended by Family/ Friends	104	59.4
I did not know where else to go	30	17.1

* Numbers and percentages were determined independently for each subcategories

Use, Need, and Satisfaction of Care of RHS in the U.S.

When asked about the general types of institutions in which the participants obtain any reproductive health service, most women stated receiving their care at

community health clinics (91.4%), public hospitals (18.3%) and private clinics/doctors (18.3%) (Table 5). Since living in the U.S., 59.5% have traveled back to Mexico however none of the women declared ever going to Mexico for the purpose of receiving reproductive health services (Table 7).

Table 7. Utilization of Reproductive Health Services in México of participants in the project SNRHS of Migrant Women in Chicago

	n*	%
Before migrating to the USA were you aware of the existance of RHS?		
Yes	104	59.4
No	71	40.6
At one point did you make use of them?		
Yes	41	23.4
No	134	76.6
Which of the following RHS have you made use of in Mexico*		
Prenatal Care	25	14.3
Partum and Postpartum care	26	14.9
Spontaneous/Elective Abortion	6	3.4
Preventive care (Pap Smear)	32	18.3
Counseling on Contraceptive use	32	18.3
STI information and/or services	18	10.3
Since living in the USA have you traveled to Mexico		
Yes	71	40.5
No	104	59.5
Since living in the USA have you traveled to Mexico in search of RHS		
Yes	0	0
No	71	100

*Numbers and percentages were determined independently for each RHS

Women were asked about their need for a selected number of commonly used reproductive health services within the last year. The most needed services included pap smears (77.7%), contraceptive counseling (52.0%), prenatal care (45.7%), partum/postpartum care (34.9%), and STI information/services (32.0%) (Table 5).

When asked to rate their previous experiences with reproductive health services as good, regular or bad, at least two thirds of the women consider their previous experiences to have been “good” in the city of Chicago for any particular

reproductive health service received. The services most favorably rated as “good” are prenatal care (92.9%), pap smears (93%), STI information/services (84.7%), and contraceptive counseling (84.1%). In proportion to their use, spontaneous and/or elective abortion services are more often (10%) rated as “bad” versus all other services (Table 8).

Table 8. Quality of care of RHS amongst participants in the project SNRHS of Migrant Women in Chicago

	Good		Regular		Bad		No applicable	
	n	%	n	%	n	%	n	%
Prenatal Care*	158	94.0	9	5.4	1	0.6	5	2.9
Partum and Postpartum care*	135	83.3	22	13.6	5	3.1	11	6.4
Spontaneous/Elective abortion*	20	69.0	6	20.7	3	10.3	144	83.2
Preventive Care (Pap Smear)*	161	94.2	8	4.7	2	1.2	2	1.2
Counseling on Contraceptive use*	127	85.2	21	14.1	1	0.7	24	13.8
STI information and/or services*	78	86.7	11	12.2	1	1.1	83	48.0

*Number of women without missing information

Socioeconomical and Cultural Barriers to Reproductive Health Services

Most participants stated lacking health insurance in the previous year (60.0%). Moreover, of those that did have health coverage, 82.4% had some type of public insurance, usually in contingency to their pregnancy status. Only 7.4% had private insurance either through their employment or their partner’s employment (Table 9).

Table 9. Health Insurance of participants in the project SNRHS of Migrant Women in Chicago		
	n= 175	%
In the last year did you have health insurance in Chicago?		
Yes	69	39.4
No	106	60.6
If you have insurance, what type?		
Private	12	17.6
Public	56	82.4
Your insurance provider is:		
Your husband/partners employer	10	5.7
Your employer	3	1.7
Other	55	31.4

Table 10 represents the major socioeconomical and cultural barriers in the access to reproductive health services. Socioeconomical barriers most frequently mentioned are lack of insurance (54.9%), language difficulties (47.7%), cost of visit (38.9%), transportation difficulties (26.95), and not knowing the city (25.7%). Overall, 31.5% of the women report being previously advised against using a reproductive health service in the past. Most commonly participants cite family members (62.2%), friends/acquaintances (41.8%), churches or social service agency (34.5%) and healthcare staff (16.4%) as persons or organizations having discouraged them from using any reproductive health services.

Table 10. Barriers in the access to the RHS of participants in the project SNRHS of Migrant Women in Chicago		
	n= 175*	%
Not able to communicate well in English	80	47.7
High consultation cost	68	38.9
Not having health insurance	96	54.9
Not knowing the city	45	25.7
Transportation difficulties	47	26.9
Other	10	5.7
*Numbers and percentages were determined independently for each barriers		

Discussion

Various investigations have documented the significance and importance of women comprising an increasingly larger proportion of Latino immigrants into the United States relative to the historically predominately male pattern of immigration (Oliveira, 1999; ONU, 2007; Woo, 2007). From the 1970s to the present, the rate of Mexican females immigrating into the U.S. has changed drastically. In the 1970s, there were an estimated 436,000 foreign-born Mexican women in the U.S. and by 2009 the estimated population was of 5.3 million. Since half of these women are within their productive and reproductive years (age 18-39), studying the impact of the "feminization" of immigration into this country, particularly in reference to their need of reproductive health services, is of high importance (Angoa, 2010).

The participants in this study have similar demographic characteristics to other studies focusing on migrant Latina women. The average age for participants in this study is of 28.7 years, similar to other studies documenting general demographics on immigrant Latina women to the U.S. (Gárces 2008, Wolff 2008). Stoops (2004) reports Latina women have the lowest educational attainments compared to other racial/ethnic groups in the U.S. Two thirds of this sample has a ninth grade education or less and only 29.6% has a high school degree or higher. These results are comparable to data presented by Galvan (2008) and Passel (2009). The minimal formal training marginalizes this population into certain job segments, not only leading to economical and social vulnerability, but consequently also to limited access of the healthcare system (CDSS, 2007; LA County, 2010). Similar to other studies (Garcés, 2008, Galván, 2008), the majority of the women in this study have a current sexual partner, highlighting the importance of the need of reproductive health services by this population.

Knowledge of Reproductive Health Services

There is a major deficit regarding reproductive health knowledge among U.S. Latinos regardless of age or sexual experience. Arroyo (2006) and Foulkes (2005) found this deficit to be attributable to low educational attainment and lack of reproductive and sex education. In an exploratory study of reproductive health

among Latina immigrant women of predominantly Mexican origin, Talmi (2006) found that most women first came into contact with reproductive health services when seeking prenatal care or pregnancy testing. Due to this general lack of understanding of what is encompassed by reproductive health and its corresponding services, it was necessary to create a list of commonly used reproductive health services and their definitions to be used as reference throughout the interview in order for the participants to complete the survey. Often times the participants would comment that they had been unaware of what services were for (i.e. pap smears), even though they had been recipients of such services in the past.

Prior Use of Reproductive Health Services in Mexico

About 50% of the women in this study had some knowledge of available reproductive health services in Mexico prior to immigrating to the U.S. Of these women, only half had made use of them in Mexico, which mostly included pap smears and contraceptive counseling. However, this percentage may be a reflection of the age at which the individuals migrated into the U.S. versus any other potential contributing factor leading to underuse of reproductive health services such as living in a rural versus urban locations or lack of knowledge regarding available reproductive health services (Kaplan 2002). Immigrating to the U.S. exposes women to a new cultural setting that may influence their reproductive health practices as well as increasing the probability of acquiring new information and accessing more reproductive health services (Maternowska, 2010).

Sources of General Social Support

Currently there are institutions and organizations including community health centers, health promoters, and churches promoting and providing health education and the use of health care services in the Latino population, inclusive of those that due to their legal status are not eligible to participate in certain need-based programs (Wallace, 2008, Bada, 2010, Livingston, 2008). The role of some institutions, such as churches, has changed over the years to provide services not traditionally associated with their organizations, such as providing health education

and facilitating health fairs in order to meet the needs of the changing U.S. population. In this study, the participants acknowledge social service agencies and churches as important sources of social support although specifics regarding type of support received were not elicited in this study.

Social Networks in the Access to Reproductive Health Services

Previous studies have documented the importance of social networks amongst immigrants the U.S. (Lynam, 1982, Martínez, 1999). Ample data exists supporting the protective effects of social networks in terms of general well being and health (Vera, 2005; Cattell, 2001; Sluzki, 1996). Studies show that both formal and informal sources of social support, such as family, friends, and organizations, have profound effects on the mental and physical well being of individuals. The mediating and moderating effects of social support are numerous and occur through various pathways. For example, social support is an important mitigator of significant life stressors such as the process of immigration (Leigh, 1992, Rubio, 2001). The benefits conferred through social support are both tangible and intangible. Such tangible benefits include the promotion of healthy behaviors (Albrecht, 2003, Knowlton, 2005) and sources of information (Livingston, 2008, Valle 1986), as is the case for the women in this study, in which family and friends with longer residency in the U.S. served as important providers of information regarding various activities of daily living, language support, and health information.

Very limited data exists regarding the role of social networks among Mexican immigrant women, particularly in association with their reproductive health and their use of associated services. In this study, the major sources of information regarding reproductive health services for the women are health care providers (doctors/nurses), family and friends. This is particularly true for preventative services, such as pap smears and prenatal care, with similar results reported by Livingston (2008). Women were least likely to have received any type of information regarding sexually transmitted infections, spontaneous abortions, and elective abortions. Quality of information received and comprehension of such information are two key variables that need to be further investigated.

Use and Need of Reproductive Health Services

In this study, 69.5% of the women have been living in the U.S. for 10 years or less. No differences in use of reproductive health services were detected when comparing women with greater than 10 years of residency in the U.S versus those with less than 10 years. This may be the result of the study selection criteria which required women to have been or currently be pregnant (irrespective of their delivery status), which may have brought them into contact with reproductive health services and thus linked them to additional services. Additionally, when questioned about their need for reproductive health services within the last year, there was no difference in type of reproductive health service endorsed when comparing women with more or less than 10 years in the U.S.

Access and Barriers to Reproductive Health Services

Access to healthcare services amongst Mexican immigrants is limited in the U.S. as more than half (55%) do not have medical insurance. Amongst Mexican immigrants with less than 10 years of residency in the U.S., the percentage of uninsured is even higher, estimated at about 70%. This may be secondarily to the possibility that many recent immigrants may be undocumented and have limited formal education thus precluding them from jobs conferring health benefits and/or eligibility to social services for which they would otherwise be eligible to receive. Moreover, numerous studies report inequalities and inequities in the access to reproductive health services amongst migrant women (Blewett, 2003; Arroyo, 2006; Sable, 2009; Ghosh, 2009).

Access to the U.S. healthcare services is primarily through the use of private medical insurance coverage or public medical insurance programs such as Medicaid or Medicare. Most individuals acquire private medical coverage through their employment and Medicaid and Medicare have specific eligibility criteria, including age, poverty status, duration of time in U.S., and legal status requirements (James 2007). Sixty percent of the participants in this study reported no health insurance within in the past year; a similar figure was reported by Wallace (2008) and Leite (2009). Of the women who stated having medical insurance, more than 80% were covered by a state funded public insurance

program which provides limited coverage and is contingent on their pregnancy status.

Mexican immigrants face structural, socioeconomic and cultural barriers when accessing health care. Difficulty navigating the fragmented and complex healthcare system is an important structural barrier to the use of health services, especially in lieu of limited access due to the legal status of many Mexican immigrants. High out-of-pocket prices for services, inaccessible private insurance, lack of stable jobs, poverty and marginalization all contribute to socioeconomical barriers to care (Blewett, 2003; Arroyo, 2006; Sable, 2009; Ghosh, 2009). Cultural barriers associated with different reproductive health norms and language limitations are important barriers to care, especially when concerning use of reproductive health services (Cristancho, 2008; Cheng, 2007; Asamoa, 2004; Arroyo, 2006; Becker, 2008; DHHS, 2008). Participants within this sample cite lack of insurance, limited English skills, and the high cost of medical services as previously encountered barriers to care when accessing reproductive health services. Based on this data, it is evident that this sample of Mexican immigrant women face multiple and simultaneous barriers when accessing reproductive health services.

Satisfaction of Care

The literature shows inconsistencies regarding satisfaction with the use of health care services amongst U.S. Latinos. In a study by Livingston (2008), 76% of U.S. Latinos rated their current care as excellent or very good. On the contrary, several other studies have found that minorities, particularly non-English speakers, report lower levels of satisfaction with health care and worse health care experiences than whites (Becker 2008). In this study very high rates of satisfaction are reported amongst the women regarding their previous experiences with reproductive health services in the U.S., particularly for prenatal care and preventative services like pap smears and contraceptive counseling. However, these results may be highly dependent on the community health centers from which the participants were recruited as both locations catered to servicing the

poor and underserved with a multitude of services in Spanish, in relatively easily accessible locations, and used sliding scale pricing along with payment options.

Study Limitations

Some of the limitations of the study include use of a convenience sample that may not be representative of all Mexican female immigrants into the U.S. Due to the selection of participants from two urban community health centers in which health services are targeted for minorities, especially Latinos, and the underserved, biases in terms of participants' demographics and experiences may not be representative of other Mexican immigrant women in the U.S. for which such centers many not exist in their communities. However, this exploratory study provides a glimpse into the reproductive health of Mexican immigrants by studying the role of social networks as sources of information; use of reproductive health services; barriers to care; and satisfaction of care.

Conclusion

This exploratory study focused on role of social networks in the access to and use of reproductive health services in a sample of Mexican immigrant women from two urban community health centers. The following are the major conclusions obtained from this study. Family, as a component of migrant women's social networks, seems to facilitate the access to reproductive health services and represents a key element in the social support of these women. In addition, healthcare staff, such as physicians and nurses also played an important role as source of reproductive health information. Furthermore, participants are familiarized with the certain reproductive health services, especially those linked to prenatal care and pap smears, which are the most frequently used by this sample. Use of these services occurs primarily through community health centers. Finally, the most important barriers Mexican immigrant women face when accessing reproductive health services include lack of health insurance, limited English proficiency, and high out-of-pocket cost for such services.

This study, although exploratory in nature, provided insight into the importance of social networks in the access to and use of reproductive health services in Mexican migrant women and warrants further investigation into the topic to better understand possible mitigating pathways in which social networks may be used to overcome barriers to care.

References

Agency for Healthcare Research and Quality (AHRQ). National healthcare disparities report. 2006 En: http://www.ahrq.gov/qual/nhdr06/nhdr06.htm.

Albrecht, T.L., & Goldsmith, D.J. Social support, social networks, and health. In T. L. Thompson, A.M. Dorsey, K. I. Miller & R. Parrott (Eds.), Handbook of health communication. NJ, US Lawrence E. Associates Publishers, 2003:263-284.

Angoa M. Mexicanas en Estados Unidos. Consejo Nacional de Población, 2010. En: http://www.conapo.gob.mx/publicaciones/migracion/politicaspublicas/05.pdf

Arroyo L, Pinzón A. National Council of La Raza. Entre Parejas: An Exploration of Latino Perspectives Regarding Family Planning and Contraception. Conference Edition. National Council of La Raza 2006. http://www.nclr.org/content/publications/detail/40994/.

Asamoa K, Rodriguez M, Ginés V, Varela R, Dominguez K, Mills CG, Sotomayor G, Beck-Sagué CM. Report from the CDC. Use of preventive health services by Hispanic/Latino women in two urban communities: Atlanta, Georgia and Miami, Florida. J Womens Health 2004;13(6):654-61.

Bada X, Donnelly R, Fox J, Selee A. *La importancia del contexto; el compromiso cívico de los inmigrantes latinos en nueve ciudades de los Estados Unidos*. Washington, DC: Centro Internacional Woodrow Wilson para Académicos, Instituto México, mayo 2010.

Becker D, Tsui A. Reproductive health service preferences and perceptions of quality among low-income women: racial, ethnic and language group differences. Perspectives on Sexual & Reproductive Health, 2008; 40(4): 202-11.

Bien-Aimé F, Rosales C. Women's Sexual and Reproductive Health in the Arizona-Sonora Region. 2006 En: http://www.azdhs.gov/phs/borderhealth/pdf/women_health.pdf.

Blewett L, Smaida S, Fuentes C, Zuehlke U. Health Care Needs of the Growing Latino Population in Rural America: Focus Group Findings in One Midwestern State. The Journal of Rural Health 2003;19(1):33-41.

Capps R, Rosenblum M, Fix M. Inmigrants and Health care Reform. What's Really at Stake? Washintong, DC, Migration Policy Institute 2009.

Cattell V. Poor people, poor places, and poor health: the mediating role of social networks and social capital. Soc Sci Med. 2001; (10):1501-16.

Characteristics of Young Women Who Gave Birth in the US-Mexico Border Region, 2005: The Brownsville-Matamoros Sister City Project for Women's Health.Prev Chronic Dis 2008;5(4):112-21.

Cheng EM, Chen A, Cunningham W. Primary language and receipt of recommended health care among Hispanics in the United States. J Gen Intern Med. 2007;22 Suppl 2:283-8.

Comisión sobre Determinantes Sociales de la Salud (CDSS). Subsanar las desigualdades en una generación: alcanzar la equidad sanitaria actuando sobre los determinantes sociales de la salud. Informe final de la Comisión sobre Determinantes Sociales de la Salud. Ginebra, Organización Mundial de la Salud, 2008. http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-sp.pdf.

Consejo Nacional de Población. Migración México-Estados Unidos, Temas de Salud. México D.F 2005. En: http://www.conapo.gob.mx/publicaciones/salud_migrantes.pdf

Cristancho S, Garces M, Peters K, Mueller B. Listening to Rural Hispanic Immigrants in the Midwest: A Community-Based Participatory Assessment of Major Barriers to Health Care Access and Use. *Qual Health Res* 2008; 18; 633-39

Department of Health and Human Services (DHHS), Montgomery County, The Latino Health Steering Committee. Blueprint for Latino Health in Montgomery County, Maryland, 2008-2012. 2008. En: www.lhiinfo.org

Foulkes R, Donoso R, Fredrick B. Opportunities for Action: Addressing Latina Sexual and Reproductive Health. Perspectives on Sexual and Reproductive Health. 2005; 37(1):1-13

Galván F, Mirchandani G, McDonald J, Ruiz M, Echegollen A, Castrucci B, Gossman G, Lewis, K. Garcés-Palacio I, Altarac M, Scarinci I. Contraceptive knowledge and use among low-income Hispanic immigrant women and non-Hispanic women. Contraception. 2008; 77:270–275.

Ghosh J. Migration and gender empowerment: Recent trends and emerging issues. United Nations Development Programme. Human Development Reports. Research Paper 2009/4.

Giachello A, Estrella M. Health Disparities of Hispanic/Latina Women in the Chicago area. 2010 En: http://www.mujereslatinasenaccion.org/resources/HealthDisparities.pdf

Health & Disability Advocates (HDA). A Study of Uninsured Women in Illinois. 2007. Chicago Foundation for Women En: http://www.cfw.org/Document.Doc?&id=115.

James C, Salganicoff A, Thomas M, Ranji U, Blanton M, Wyn R. Putting Women's Health Care Disparities on the map: Examining Racial and Ethnic Disparities at State Lavel. The Kaiser Family Foundation. 2009. www.kff.org.

Kaplan AM. Salud reproductiva de las mujeres migrantes africanas en España: retos e implicaciones para las actuaciones públicas socio-sanitarias. Centre d'Estudis Demogràfics Universitat Autònoma de Barcelona. 2002. http://mgf.uab.es/doc/2d.pdf

Klugman J. Informe sobre Desarrollo Humano 2009. Superando barreras: Movilidad y desarrollo humanos. Programa de las Naciones Unidas para el Desarrollo, NY 2009.

Knowlton A, Hua W, Latkin C. Social support networks and medical service use among HIV-positive injection drug users: implications to intervention. AIDS Care, 2005; 17(4): 479- 492.

Leigh AL. The Role of Informal Support Networks in the Adjustment of Central American Immigrant Families. Journal of Community Psychology 1992;20(3):247-256.

Leite P. Mexicanos en Estados Unidos. Acceso a la Salud. Ponencia presentada en el 4° Curso Internacional sobre Migración y Salud, Puebla, México, Junio 2009.

Livingston G, Minushkin S, Cohn D. Hispanics and Health Care in the United States: Access, Information and Knowledge A Joint Pew Hispanic Center and Robert Wood Johnson Foundation Research Report. 2008 http://pewhispanic.org/reports/report.php?ReportID=91.

Los Angeles County Department of Public Health, Office of Women's Health. Health Indicators for Women in Los Angeles County: Highlighting Disparities by Ethnicity and Poverty Level, February 2010. http://www.lapublichealth.org/owh/docs/final%20data%20report%20pdf.pdf.

Lynam, MJ. Support networks developed by immigrant women. Social Science & Medicine 1982;21(3): 327-332

Martinez M, García M, Maya M. El papel de los recursos sociales naturales en el proceso migratorio. Intervención Psicosocial 1999;8(12):221-232

Maternowska C, Estrada F, Campero L, Herrera C, Brindis C, Vostrejs M. Gender, Culture and reproductive decisión-making among recent Mexican migrants in California. Culture, Health & Sexuality 2010;12(1):29-43.

Organización de las Naciones Unidas, *Encuesta Mundial acerca del Papel de las Mujeres en el Desarrollo: Mujeres y Migración Internacional*, consultado en: http://www.senado.gob.mx/internacionales/assets/docs/relaciones_parlamentarias/america/foros/parla_latino/ derechos1_2.pdf.

Passel J, Cohn V. A Portrait of Unauthorized Immigrants in the United States. Pew Hispanic Center 2009. http://pewresearch.org/pubs/1190/portrait-unauthorized-immigrants-states.

Peckham E and Wyn R. *Health Disparities Among California's Nearly Four Million Low-Income Nonelderly Adult Women*. Los Angeles, CA: UCLA. Center for Health Policy Research, 2009.

Rubio R. Redes sociales y mecanismos de apoyo en la migración de mexicanos a estados unidos: datos de una encuesta de flujos. Centre d'Estudis Demogràfics, UAB. Ponencia presentada en el VI Congreso de la ADEH, 2001. http://www.ced.uab.es/publicacions/PapersPDF/Text198.pdf

Sable M, Havig K, Schwartz L, Shaw A. Hispanic Immigrant Women Talk About Family Planning. Journal of Women and Social Work. 2009;24(2):137-151.

Sluzki C. Presencia y ausencia de redes sociales. En la red social: Frontera de la práctica sistémica. Barcelona, España: Gedisa; 1996: 143-159.

Stoops N. Educational attainment in the United States: 2003: US Census Bureau. Curr Popul Rep 2004:20–550.

Talmi D, Robyn S, Billings D, Gordon R. La salud sexual y reproductiva de las mujeres latinas en Carolina del Norte: Una evaluación de necesidades en cinco condados. Chapel Hill, Carolina del Norte, Ipas, 2006.

Valle R. Hispanic social networks and prevention. In Psychiatric epidemiology and prevention;the possibilities; papers resulting from research planning workshop held through the Neuropsychiatric Ins. 1986:131-157.

Vera JA, Sotelo T y Domínguez M. Bienestar subjetivo, enfrentamiento y redes de apoyo en adultos mayores. Revista Intercontinental de Psicología y Educación, 2005; 7(2): 57-78.

Wallace, Steven P. and Xóchitl Castañeda. Migration and Health: Latinos in the United States. Mexico City. CONAPO. 2008. http://hia.berkeley.edu/documents/conapo_rpt.pdf.

Wolff H, Epiney E, Lourenco A, Costanza M, Delieutraz-Marchand J, Andreoli N, Dubuisson J, Gaspoz J, Irion O. Undocumented migrants lack access to pregnancy care and Prevention. *BMC Public Health* 2008, 8:93-99.

Woo, Ofelia, "Panorama general sobre la migración de las mujeres en México", ponencia presentada en la Segunda Reunión Regional: *Red para la atención de mujeres afectadas por el fenómeno migratorio*, Zona centro, Guadalajara, Jalisco, 24 y 25 de mayo, Guadalajara, Jal., México, 2007: http://www.inmujeres.gob.mx/dgpe/migracion/ res/Anexo_41_03.pdf.

World Health Organization. Social determinants of sexual and reproductive health: informing future research and programme implementation.WHO, 2010 En: http://whqlibdoc.who.int/publications/2010/9789241599528_eng.pdf

IV. POLICY PAPER

Background and Significance

It has been well documented that nationwide Latinos receive the lowest levels of health care delivery due to financial, institutional and cultural barriers. While Latinos in general are less likely to have health insurance than Whites or African Americans, Latinas nationwide and in Chicago have the highest rate of uninsurance for women of any racial/ethnic group. In 2006, 36 percent of Latinos, 13 percent of whites, and 22 percent of African American were uninsured across the nation. Among women and men in Illinois who were uninsured in 2005-2006, 30 percent were Hispanic (Health and Disability Advocates, 2007; Kaiser Family Foundation, 2007). In addition to lack of medical insurance other structural factors contribute to the lack of access to health care Latinas face. In relation to sexual and reproductive health care Latinas are more likely than African American or white women to report that they delay health care appointments because of lack of transportation or childcare services (Kaiser Family Foundation, 2004) and they often report being dissatisfied with their visits to sexual and reproductive health care providers (Forrest, 1996).

For migrant women, who face exacerbating reproductive health disparities, lack of access to health care is even more severe. Recent research has shown that approximately 55 percent of low-income Latina immigrants of reproductive age do not currently have health insurance. As a consequence, they are even less likely to receive reproductive health care than their Latina counterparts. With the circulation of increasingly popular anti-immigrant sentiment, fears of deportation

may keep many migrants, some of whom may have an undocumented legal status, from seeking needed services. Since 1995 the number of Latinas receiving health care has fallen from 29 percent to 12 percent, leaving an increasing number of immigrant Latinas without any options to receive reproductive and general health care (NLIRH, 2005). Additionally, immigrant women may not be aware of their right to receive publicly funded reproductive health services or are afraid to apply because of their migrant status. Although Medicaid provides reproductive health services to low income migrants, for those who may have an undocumented legal status, access to these services is negligible in practice (Romero, 2003).

Objectives

From this perspective, the specific objectives of this research project were 1) To identify the needs and barriers of access to reproductive health services for Mexican immigrant women in the Chicago, Illinois area; 2) To characterize the offering of reproductive health services and social support networks to Mexican immigrant women in the Chicago, Illinois area; 3) To describe and assess the formal and informal social support networks of immigrant women and how they impact an individual's knowledge of and access to reproductive health services in the Chicago, Illinois area.

Methods

All participants are Mexican-born women between the ages of 21-35 years, with 15 years or less of residency in the United States and are or have been pregnant at least once regardless of delivery status. Sources of recruitment include

two community health centers located in areas of Chicago with high concentration of Mexican immigrants. The survey utilized consisted of 48 questions, took approximately 30 minutes to administer, and was provided in either English or Spanish. The survey was composed of a basic demographic section followed by general social network questions regarding support with various components of daily life and organized migrant organizations. Thereafter, the survey focused on sources of information and guidance associated with reproductive health services, sources of reproductive health care, satisfaction with RHS services received and barriers to access.

Results

A total of 175 women were included in this study, all born in Mexico, with a mean age of 28.7 years. Fifty-eight percent of the women had a 9th grade education or less and 69.5% of the women had been living in the U.S. for 5-10 years. Since their arrival to the U.S., participants acknowledged having received general assistance and support from social service agencies provided by the city, state and/or federal government (60.0%) and churches or temples (35.4%). Informal social networks of family and friends were more commonly relied upon as sources of support and information. Most participants reported physicians/nurses, family members, and friends/acquaintances as sources of information regarding where to go to receive care related to their reproductive health. When asked to rate their previous experiences with reproductive health services as good, regular or bad, at least two thirds of the women considered their previous experiences to have been “good” in the city of Chicago for any particular reproductive health

services. The major barriers cited in the access of reproductive health services included lack of insurance (54.9%), language difficulties (47.7%), and cost of visit (38.9%).

Findings and Policy Implications

Replicating the findings of other social scientific research, the Mexican immigrant women in our sample face structural, socioeconomic and cultural barriers when accessing health care. Difficulty navigating the fragmented and complex healthcare system is an important structural barrier to the use of health services, especially in lieu of limited access due to the legal status of many Mexican immigrants. High out-of-pocket prices for services, inaccessible private insurance, lack of stable jobs, poverty and marginalization all contribute to socioeconomical barriers to care (Blewett, 2003, Arroyo, 2006, Sable 2009, Ghosh, 2009). Cultural barriers associated with different reproductive health norms and language limitations are important barriers to care, especially when concerning use of reproductive health services (Cristancho, 2008, Cheng, 2007, Asamoa 2004, Arroyo, 2006, Becker, 2008, DHHS, 2008). Participants within our sample cite lack of insurance, limited English skills, and the high cost of medical services as previously encountered barriers to care when accessing reproductive health services. Based on this data, it is evident that this sample of Mexican immigrant women face multiple and simultaneous barriers when accessing reproductive health services.

Somewhat paradoxically, in this study very high rates of satisfaction are

reported among the women regarding their previous experiences with reproductive health services in the U.S., particularly for prenatal care and preventative services like pap smears and contraceptive counseling. However, these results may be highly dependent on the community health centers from which the participants were recruited as both locations catered to servicing the poor and underserved with a multitude of services in Spanish, in relatively easily accessible locations, and used sliding scale pricing along with payment options. The participants are familiarized with the reproductive health services in Chicago and use them primarily through Community Health Centers; services most frequently used are those of preventative care, like pap smears, and prenatal care.

Family, as a component of Mexican migrant women's social networks, seems to facilitate the access to reproductive health services and represents a key element of social support. Additionally, healthcare staff, such as physicians and nurses, also played an important role as source of reproductive health information. Use of these reproductive health services occurs primarily through community health centers. Finally, the most important barriers Mexican immigrant women face when accessing reproductive health services include lack of health insurance, limited English proficiency, and high out-of-pocket cost for such services.

Improving Health Service Delivery

Much more funding must be allocated to health and social service providers who can provide accessible and culturally proficient care for Chicago's diverse Latino communities that respect their needs. While the results of this study must

be tempered by the fact that the community health centers from which the participants were recruited, specifically catering to a Latino immigrant target population, the positive experiences reported are notable and provide a successful model.

Eliminating Barriers to Access

Increased state funding for comprehensive health care coverage for all Illinois residents, regardless of economic and citizenship status must be established. Latina immigrants must have access to insurance and health care so that they are not forced to delay or forgo their health care. Preventative care is essential to detecting disease at an early stage. Because Latina immigrants face exacerbated challenges to receiving health care, federal funding for Medicaid for lawful immigrants must be reinstated. Additionally, health care services must be located in Latina/o communities so that transportation barriers are reduced.

Reference

National Latina Institute for Reproductive Health. A National Latina Institute for Reproductive Health. National Latina Institute for Reproductive Health, New York, 2005. 22.

Arroyo L, Pinzón A. National Council of La Raza. Entre Parejas: An Exploration of Latino Perspectives Regarding Family Planning and Contraception. Conference Edition. National Council of La Raza 2006. http://www.nclr.org/content/publications/detail/40994/.

Asamoa K, Rodriguez M, Ginés V, Varela R, Dominguez K, Mills CG, Sotomayor G, Beck-Sagué CM. Report from the CDC. Use of preventive health services by Hispanic/Latino women in two urban communities: Atlanta, Georgia and Miami, Florida. J Womens Health 2004;13(6):654-61.

Becker D, Tsui A. Reproductive health service preferences and perceptions of quality among low-income women: racial, ethnic and language group differences. Perspectives on Sexual & Reproductive Health, 2008; 40(4): 202-11.
Blewett L, Smaida S, Fuentes C, Zuehlke U. Health Care Needs of the Growing Latino Population in Rural America: Focus Group Findings in One Midwestern State. The Journal of Rural Health 2003;19(1):33-41.

Cheng EM, Chen A, Cunningham W. Primary language and receipt of recommended health care among Hispanics in the United States. J Gen Intern Med. 2007;22 Suppl 2:283-8.

Cristancho S, Garces M, Peters K, Mueller B. Listening to Rural Hispanic Immigrants in the Midwest: A Community-Based Participatory Assessment of Major Barriers to Health Care Access and Use. *Qual Health Res* 2008; 18; 633-39
Department of Health and Human Services (DHHS), Montgomery County, The Latino Health Steering Committee. Blueprint for Latino Health in Montgomery County, Maryland, 2008-2012. 2008. En: www.lhiinfo.org.

Forrest J, Frost J. "The Family Planning Attitudes and Experiences of Low-Income Women." Family Planning Perspectives 28 (1996): 246-255 & 277.

Ghosh J. Migration and gender empowerment: Recent trends and emerging issues. United Nations Development Programme. Human Development Reports. Research Paper 2009/4.

Health & Disability Advocates (HDA). A Study of Uninsured Women in Illinois. 2007. Chicago Foundation for Women En: http://www.cfw.org/Document.Doc?&id=115.

Sable M, Havig K, Schwartz L, Shaw A. Hispanic Immigrant Women Talk About Family Planning. Journal of Women and Social Work. 2009;24(2):137-151.

The Henry J Kaiser Family Foundation. Health Insurance Status, by Race/Ethnicity: Total Nonelderly Population. Urban Institute and Kaiser Commission on Medicaid and the Uninsured. The Henry J Kaiser Family Foundation, 2006.

V. Student Support

Graduate and Undergraduate Students Supported

Elizabeth Mora Perez, MD/MPH Candidate
Ms. Perez assisted as a Graduate Research Assistant and Project Coordinator. She was involved with recruitment of data collection sites; securing grant extension; finalizing study protocol; training and supervising RAs completing data collection; data collection; data management; data analysis; mentoring and training of undergraduate research assistants; and manuscript writing and translating.

Laura De Los Santos, MA (Latino Studies)
Ms. De Los Santos assisted as a Graduate Research Assistant and Project Coordinator. She assisted with translation of documents, literature reviews, recruitment of data collection sites, and data collection.

Juanita del Toro, PhD Candidate in Sociology
Ms. Del Toro assisted in this project as a Graduate Research Assistant. She provided general clerical assistance; completion of IRB forms and submission; and performed literature reviews.

Luisa Rollins, PhD Candidate in Sociology
Ms. Rollins assisted in this project as a Graduate Research Assistant. She was involved with the study during the initial phases in which she assisted with IRB forms and submission; survey translation and layout; and data collection.

Alejandra Villanueva, BA (Psychology)
Ms. Villanueva assisted in this project as a recent undergrad graduate and then as recipient of Summer Research Scholarship Training Program. She completed her program through this study and during her time assisted with data collection; data entry and cleaning; literature reviews; and independently developing an abstract.

Cristina Grijalva, BA (Sociology)
Ms. Grijalva assisted in the initial phases of this project with general clerical assistance, literature reviews, and data entry.

Laura Alvelar, Undergraduate Student
Ms. Alvelar assisted in this project as an undergraduate research assistant and is currently completing her degree in Kinesthesiology. She is a recipient of the HCOE Summer Research Scholarship Training Program. She completed her summer research program through this study and during her time assisted with data

collection; data entry and cleaning; literature reviews; and independently developing an abstract.

Alexandrina Almazan, Undergraduate Student
Ms. Almazan assisted in this project as an undergraduate research assistant and is currently completing her degree in Sociology. She is a recipient of the HCOE Summer Research Scholarship Training Program. She completed her summer research program through this study and during her time assisted with data collection; data entry and cleaning; literature reviews; and independently developing an abstract.

VI. Papers in progress

Portrait of the Mexican Immigrant's Use of Reproductive Health Services in the Chicago area, 2010

Characterization of Reproductive Health Services in Selected Community Health Centers in Chicago Neighborhoods with a Large Mexican Immigrant Population.

Literature Review on the Inequities in Access to Reproductive Health Services among Immigrant Populations.

Characteristics Associated with Perceived Good Care for Reproductive Health Services Among Mexican Immigrants in Chicago.

Cultural Barriers Affecting the Access to Reproductive Health Services among Recent Mexican Immigrants.

Literature Review of the Conceptualization of Reproductive Health among Mexican Immigrants in the U.S.