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Barriers Latin American Immigrant Women Face in Accessing Reproductive Health Services in The United States

Immigration and reproductive health care are two high profile topics in the politics of the United States. Both are constantly on the news, with ongoing debates about policies and reform. However, the link between the two topics gets very little media coverage. In this paper, I will address some of the overlap, looking at the question: what are the barriers for Latina immigrant women in accessing reproductive health care? Immigrant women in the United States face pronounced barriers in accessing reproductive health care, legally, socially, and culturally. These barriers stem from a history of political control of immigrant women's reproduction, legal immigration status, the process of acculturation and cultural differences between the US and Latin America, and the influence of traditional gender roles on attitudes towards sexual and reproductive health.

Interviews

For this study, I conducted three interviews with women who were all immigrants from Mexico. The first interview was with Celia¹, a 41-year-old woman who has been in the United States for 16 years. The second interview was with Maria, a 60-year-old woman who has been in the US for 14 years, and the third interview was with Rosa, a 50-year-old woman who has been in the US for five

¹ Names changed

years. All three interviews were conducted at the health clinic and community organization, Street Level Health Project, in Oakland, California. The interviews were done in Spanish. They each lasted between 15 and 30 minutes, and were tape recorded, and then transcribed and translated to English.

Control of immigrant reproduction

A multitude of stereotypes and prejudices has historically been used to rationalize to control immigrant fertility. In the United States, the history of eugenics which was used to control reproductive patterns of immigrant women, still has a visible impact. Eugenics, the practice of controlling reproduction in order to create a “superior” population, has historically been systematically applied to control immigrant populations through control of reproduction (Park, 47, 2011). In the early 20th century, the Immigrant Restriction League officially associated itself with eugenics, thus establishing the pattern of systematic control of what was deemed the “biological threat” of “inferior races” in the context of immigration (Park, 46, 2011).

Historically, non-Anglo Saxon women in the United States were commonly deemed “bad” mothers. Ideas about what constitutes a “good” or “bad” mother have also been used as a means of reproductive control, which is largely a form of cultural discrimination (Park, 47, 2011). Women have been judged on how many children they have and how well they can provide for their children financially, domestically, and emotionally. “Bad mothers” are unable to protect their children from harm (Park, 47, 2011). However, immigrant mothers who are unable to protect their

children from harm are often stuck in a cycle of discrimination. Immigrant mothers experience discrimination based on race, language, origin, family structure, etc. and their children are bound to experience this discrimination as well. Mothers who are unable to protect their children from this discrimination are then said to be bad mothers, and further discriminated against for that (Park, 3, 2011). On top of this, children who are born outside of the US, and are not US citizens, will have no sort of governmental social safety net, putting children at greater risk, and furthering the image of immigrant women as “bad” mothers for not being able to protect their children.

This concept of “bad” mothers exists in opposition to the ideal of “extraordinary” mothers. These are mothers who defy the odds, and are able to provide for their children in every way, despite any barriers. These are mothers who can miraculously fight against social obstacles, provide financially, and have enough time to raise their children in an exceptional manner (Park, 48, 2011). The “bad mother”/“extraordinary mother” dichotomy leaves no room for something in between. However, being an “extraordinary” mother is virtually impossible. An “extraordinary mother” must defy the odds by providing financially for her family while simultaneously fulfilling domestic and emotional responsibilities. Furthermore, her children should not experience the persistent discrimination that immigrants face (Park, 48, 2011).

Immigrant women, historically and presently, have been considered a public charge, meaning they are expected to be largely dependent on governmental resources, as will their children be. Moreover, immigrant women’s children who are

born in the US, and therefore US citizens, cannot be denied public services. This expectation of public dependence is used as a rationale for controlling women's fertility, so as to limit the immigrant population, and minimize public charges (Park, 3, 2011). This again relates to the history of eugenics, and the concept of immigrant women as a social burden. Eugenics was used to control women who were seen as having too many children, in order to avoid too many "welfare babies". These are children who would be dependent on social welfare, and therefore create a financial burden for taxpayers (Loue, 451, 1998). In the case of US citizen children of non-taxpaying immigrants, the need to avoid "welfare babies" is more emphasized because the family is seen as only taking from taxpayers without making a contribution.

Because of this long history of control of immigrant reproduction, and the effort to take away agency from these women in their own reproductive choices, immigrant women in the US remain a particularly vulnerable group. Socioeconomic status, class, race, culture, language, ethnicity, and gender all contribute to putting immigrant women in a particularly socially defenseless position. This history and the loss of agency in making reproductive choices creates apprehension and mistrust of the medical system and reproductive health care.

Immigration Status

An immigrants' legal and social status can be defining in their access to reproductive health care. Undocumented migrants are put at a serious disadvantage

in accessing health services due to their legal status, Just being an immigrant, even for those with documentation, can itself affect the accessibility of health services.

Individual attitudes towards healthcare quality and accessibility differ along lines of legal status. This was apparent in the series of interviews done for this project. Two of the women interviewed, Celia and Maria, indicated their high level of acculturation and comfort in the US. Both these women had been in the US for over 12 years, and much of what they described indicated a documented status, including mentions of healthcare coverage from the state. In contrast, the way Rosa spoke of her experiences in the US indicated an undocumented status. She described her migration as being trafficked by her previous employers in the US and she has no medical coverage not even MediCal.

Celia and Maria stood in stark contrast with the Rosa in overall views and experiences with the healthcare system. The first two women said that the health system in the US was in many ways better than in Mexico, and was otherwise comparable. The Celia commented on the overall higher quality of care she received in the US, and the Maria mentioned shorter waiting times and less corruption in the medical system. Rosa, however, saw the health system completely differently. She ended her interview by saying “What I have seen [of the healthcare system in the US] is ugly, very ugly.” This perspective was evident throughout her interview.

Rosa described discrimination she faced as an immigrant, the multitude of barriers she encountered, and her struggle to access any sort of high quality healthcare. She is only able to go to free health care clinics that cater to undocumented immigrants. Because she lives in a metropolitan area with a high

density of immigrants, there are a number of free health clinics available. However, Rosa has only recently found these clinics and in many ways they still don't meet her needs.

Celia and Maria said that their primary care providers are covered by MediCal. Rosa does not have access to any medical insurance because as an undocumented migrant, she is unable to register for governmental health coverage for non-emergency coverage, much less private insurance (Deeb-Sossa, 2013). Her legal status directly affects her medical coverage, the medical care she is able to receive, and her perception of the medical system.

Legal status in the United States comes with a governmental social safety net that is not available for undocumented immigrants. A critical part of this safety net is access to health services. As seen in the interviews, medical insurance is crucial to feeling that one has access to good health care. In California, the 1994 Proposition 187, prohibits the use of public services, including healthcare, for undocumented immigrants, essentially cutting off any governmental social safety net (Park, 47, 2011). Without Medicaid (or MediCal in California), it is essentially impossible for undocumented immigrants to have health coverage for primary and preventative care (Deeb-Sossa, 2013). This includes reproductive health services, apart from actual birth, which is covered in public hospitals (Deeb-Sossa, 2013). Preventative reproductive services, including pre and postnatal care, are therefore very difficult to access. Additionally, in the US, unlike in many developing countries, women need a prescription to receive oral contraception. Other forms of contraception, such as

the IUD, birth control shots, or hormonal implants, need to be provided by a medical professional (Park, 47, 2011).

Even in cases where they may be eligible for medical coverage, such as emergencies covered by Medicaid, the constant fear of deportation and fear of authorities may prevent undocumented immigrants from applying for coverage (Deeb-Sossa, 2013). Additionally, healthcare information is typically sensitive and personal, and for people who have to be constantly vigilant about being exposed, revealing sensitive personal healthcare information could be uncomfortable or feel unsafe. The fear of deportation commonly becomes greater than the fear of diseases (Deeb-Sossa, 2013). Non-emergency care, such as most reproductive health care, is typically not deemed worth the perceived risk of deportation (Deeb-Sossa, 2013).

Racial and cultural discrimination towards immigrants can also act as a barrier in access to healthcare services. Immigrants may have experiences in hospitals or healthcare clinics where discrimination by healthcare professionals affects the quality or efficiency of care. Stereotypes of immigrants coming to the US to use up social services and take these services away from taxpayers create a discriminatory stigma (Moss, 1996). This can have a negative affect on immigrants' experiences and further inhibit their ability to access healthcare.

For undocumented immigrants who are unable to receive any medical insurance coverage, free health clinics offer one of the only viable options to receive medical attention. In the interviews, Rosa, the likely undocumented immigrant, reported relying heavily on a few different free health clinics. She discussed seeing

different doctors throughout the city in the variety of clinics where neither documentation, nor payment, is needed. Rosa has been able to access these clinics largely because of her location. She lives in a metropolitan area with a large immigrant population. Various free clinics that cater to immigrants exist in the area, such as the clinic where the interviews were conducted. For Rosa, these clinics are her only source of primary health care attention. This is the case for many undocumented immigrants.

Multiple factors affect the viability of free clinic services for immigrants. First and foremost, if immigrants are asked to provide information about their documentation status, they may be unwilling to use a clinic. Second, if health care services are not free or at least subsidized, immigrants may not be able to afford to use a clinic. Without health insurance medical services can be astronomically expensive. This is especially true for undocumented immigrants whose incomes are almost always limited by documentation status (Deeb-Sosa, 2013). Third, if a clinic's environment does not cater to immigrants, they may not feel comfortable or welcome. While comfort is important for anyone, for undocumented people this is of great significance, because of their constant vulnerability. By reducing language and cultural barriers, clinics can also contribute to communication about the privacy of health information (McDonald, 2009). For example, at Street Level Health Project, where the interviews were held, identification is never needed to access services, medical professionals speak Spanish, and effort is put into diminishing any cultural barriers. All of these measures are intended to create a safe environment where undocumented immigrants feel comfortable enough to utilize health services.

Despite many good qualities, free clinics are also viewed as having disadvantages. In the third interview, Rosa mentioned how she felt the care she was receiving through the free clinics was of a lower quality than at larger medical institutions. This is a perception that may or may not be true, but is pervasive in both immigrant and non-immigrant communities (Deeb-Sossa, 2013). Another concern Rosa mentioned, one echoed throughout the literature on free clinics, is long waits. Due to the large number of people who want to access this service, and the limited availability of doctors, waits can be very long, often between 2 and 4 hours (McDonald, 2009). Doctors commonly volunteer at these clinics without pay. Most have other jobs and do not spend as much time at these clinics as at their own practices or hospitals (McDonald, 2009). Additionally, due to the constant fear of deportation, undocumented immigrants may feel uncomfortable providing their name or information in order to make an appointment. For this reason, some clinics require patients to come into the office to make same-day appointments. This results in less efficient scheduling and greater delays.

Factors outside of the medical system, that influence immigrants' lives, can also play a part in their ability to access healthcare services. For undocumented immigrants, external factors are often amplified. These include a lack of childcare, transportation, location, and scheduling (Loue, 454, 1998).

A lack of childcare can make attending medical appointments difficult for women in general. For immigrant women, this problem is often exacerbated because much of their extended family is still in their home country. Thus they often have smaller, or non-existent, family networks in the area. Paying for childcare is

often not feasible for undocumented workers, who generally earn smaller salaries than documented people, and are most likely also sending a portion of their earnings back home (Loue, 455, 1998). Transportation can also act as a barrier in seeking healthcare. Driving is risky for undocumented immigrants, because they are unable to acquire driver's licenses, and a traffic violation could result in deportation (Loue, 454, 1998). Public transportation can also be a risk due to its nature as an enclosed, public space, where government authorities can easily enter (Loue, 455, 1998). Location, particularly location in more rural or remote areas, may mean less access to free clinics and health services. Fewer local clinics—and thus longer travel distances—may discourage immigrants from seeking preventative reproductive health care. Lastly, scheduling is an important external factor. Undocumented immigrants are more likely to have a lack of autonomy in their work schedules, and may work long or unusual hours. This can make scheduling medical appointments difficult (Deeb-Sossa, 2013).

All of these external factors, which could apply to anyone regardless of immigration status, are amplified by the vulnerability that comes with being undocumented. Reproductive healthcare, which is generally not an emergency, may then seem unimportant and not worth the risk and difficulty that comes with simply attending a medical appointment.

Cultural Barriers

Cultural barriers prevent access to reproductive health services for immigrant women. Differences between cultural standards in the United States and

Latin America regarding sexuality and reproduction are often pronounced. The process of acculturation affects the social acceptance of reproductive health services.

Latin America and the United States typically have differing standards on views and expression of female sexuality. This is particularly true when it comes to contraception and the age at which women have their first sexual encounter (Minnis, 2001). A series of studies looks at the differences between first generation Latin American women and second and third generation Latina women and non-Latina women, examining differences between the generations in the use of contraception and the age of first sexual encounters. The studies show that first generation Latin American youths are less likely to use contraception, and typically have their first sexual encounter at a later age than second and third generation Latinas and non-Latina youths in the United States (Minnis, 2001). Attitudes around sexuality and the use of contraception that differ in Latin America and the US may affect the way in which women approach reproductive health, the importance they place on certain aspects of reproductive health, and the level of comfort they feel seeing medical professionals about issues surrounding sexuality and sexual health (Minnis, 2001).

Changes in sexual practices or attitudes towards sexuality may be an indication of a woman's acculturation to the United States. In the interviews, Rosa said that she has never used contraception. She appeared uncomfortable when this subject came up. The other two women, however, discussed using contraception in their pasts, and both appeared comfortable talking about this openly. Throughout

the interviews, the level of comfort with the US that Celia and Maria had in comparison to the Rosa was evident. This suggests that Celia and Maria have adopted cultural values of the U.S. to a greater extent than Maria.

In a study of women in the Dominican Republic and the United States, women from the DR who had moved the US felt a greater sense of freedom of sexuality, and this increased with their time in the United States. The use of contraception by young Dominican women in the US was an adoption of the cultural values of the US (Breitbart, 2010). This suggests that reproductive health practices may have a cultural significance for immigrant women in addition to health considerations (Breitbart, 2010).

Language can act as a cultural barrier in accessing healthcare. Typically comfort with English and comfort with American culture are closely correlated. For immigrants who do not speak English, access to healthcare can be difficult on many levels. From scheduling appointments, to understanding diagnoses and treatments, language barriers are immense. Immigrants may feel fear and apprehension when accessing services where they can't communicate. In the interviews, language barriers came up as an issue that all three women had experienced in some capacity (Maternowska, 2010). They all said that translators are now generally available at clinics but that this is a recent development. Learning English can be an indication of the level of comfort, or sometimes the level of acculturation, of an immigrant. An inability to communicate through language acts as a serious cultural barrier in accessing health care services.

Communicating with healthcare providers can be difficult not only due to language barriers, but also because of broader cultural barriers. Understandings of healthcare issues may differ culturally, and communication between patients and healthcare professionals may not be effective due to a gap in cultural understandings of health and sickness (Roncancio, 2011). The anticipation that one won't understand one's healthcare provider's view of health and medicine or that one's own view won't be understood creates an additional barrier in the willingness of an immigrant to seek out healthcare.

In addition to gaps in cultural understandings of health, differences in healthcare practices between an immigrant's home country and the US may affect an immigrant's willingness to use healthcare services, her trust in the healthcare system, and the effectiveness of the care she receives. More acculturation and comfort with US health customs diminishes this barrier (Roncancio, 2011). One example is customs around birth. In the US, most births occur in hospitals under the care of a doctor. However, in many developing countries the use of a midwife is more common. A midwife's care may be more comfortable for a woman, especially if this is what she is used to or expects (Roncancio, 2011). Additionally, immigrant women in the US sometimes fear hospital births, or even prenatal care, because of the high rate of cesarean sections, and the fear that if they give birth in a medicalized environment they will be forced to have a cesarean section (Park, 90, 2011). Differences in medical practices may also affect pre and postnatal care practices, contraception, and preventative reproductive healthcare (Roncancio, 2011). Comfort with healthcare practices, communication with medical

professionals, and differences in perspectives on reproductive health and sexuality can all influence the way that immigrant women approach reproductive healthcare, and their ability to receive high quality care.

Gender Roles

Much of Latin America traditionally has had a patriarchal social structure, and concepts of traditional gender roles are brought with immigrants when they migrate to the United States. Traditional gender roles have an impact on ideas of sexuality and reproduction, and can act as a barrier in immigrant women's ability to access reproductive health care. The role of reproduction can be an expression of traditional gender roles. Reproduction is typically key to a traditional female role. Aspects of reproductive healthcare that are emphasized in parts of the US, such as contraception, may not be emphasized in an immigrant's home country and may make a woman more skeptical of reproductive health services in general (Gonzalez, 2010).

Contraception can be used as a means of control and power. In a traditionally patriarchal dynamic men try to control women's fertility. Some believe that if a woman is using contraception it is a sign of infidelity (Deeb-Sossa, 2013). Children confer social status. Reproduction is not only seen as a reflection of a women's femininity, but also of a man's masculinity. It may reflect negatively on a man if his partner does not give birth. Therefore male partners may also discourage women from using reproductive health services in the US, for fear that contraception will be pushed or that women may be discouraged from reproducing (Gonzalez, 2010).

Distrust of reproductive health services may be intensified by the history of state and medical control of immigrant (Park, 98, 2011).

The role of male partners can be critical in women's ability to access reproductive health services. Male partners who try to maintain traditional gender roles, and as an expression of a patriarchal relationship may be barriers to such access. Female economic dependence, as a result of traditional gender roles in which men earn money and women work domestically, can mean women lack of autonomy in making reproductive health decisions. This dependence can also affect the use of contraception (Gonzalez, 2010). Patriarchal power structures and economic dependence diminish agency in women's reproductive and sexual health decisions.

For undocumented immigrant women, this dependence on a male partner can be exacerbated. This is particularly so when females are undocumented and males are documented, which is not uncommon due to programs that existed to bring male workers to the United States from Mexico. The vulnerability that comes with an undocumented status means a diminished lack of agency, and the potential increased control by a male partner (Gonzalez, 2010).

Modes of modesty and the gender dynamics between a healthcare provider and a patient can act as a barrier in effective reproductive health care. Most Latina immigrants are accustomed to female reproductive healthcare providers and may be uncomfortable with male doctors for reproductive healthcare (Maternowska, 2010). This can diminish the effectiveness of healthcare and the willingness of patients to seek out care. In all three interviews, the women indicated that they

would not feel comfortable with a male reproductive healthcare provider. They said that they would not feel a high level of trust or understanding with a male doctor when discussing topics viewed as sensitive and personal.

Conclusion

Access to reproductive healthcare is extremely important in maintaining the health of women. However, there are a series of significant obstacles for immigrant women in accessing reproductive health services in the United States, including the historical political control of immigrant women's reproduction, legal status, the process of acculturation in the US, language barriers, and the significance of traditional gender roles. With an influx of immigrant women into the United States, access to reproductive health care will only become more relevant. It is critical that the issues of reproductive health and immigration rights are not exclusively addressed individually, so that everyone, regardless of gender, race, origin, or legal status, has access to comprehensive health care.

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