FAMILY PLANNING EXPERIENCES AND PERCEPTIONS OF ACCESS: LATINA IMMIGRANTS IN A NEW SETTLEMENT STATE

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ABSTRACT

M. GABRIELA ALCALDE: Family Planning Experiences and Perceptions of Access: Latina Immigrants in a New Settlement State
(Under the Direction of Suzanne Havala Hobbs, DrPH)

Background: Reproductive health is an integral part of women's self-determination and overall health and wellbeing. Public policies can strengthen or undermine reproductive health. As a health behavior, family planning affects many reproductive health outcomes, and is a key "gateway" health behavior to overall reproductive health and wellbeing.

Immigration and welfare policies have significant and often unexplored public health implications. Recent changes in immigration and other public policies affect the health of new Latin American immigrants in myriad ways. In Kentucky, as in other new immigrant settlement states, most adult Latinas are recent immigrants and foreign-born. As such they live in a post-welfare reform environment where immigrants are often barred from accessing public assistance that could mitigate poverty's negative impact on health. Immigrants in these states may also perceive that they are ineligible for services because of the lack of culturally- and linguistically-accessible services and the general attitude towards immigrants.

Objective: To explore foreign-born Latina immigrants' perceptions of access and experiences with family planning in an urban center in Kentucky and inform policy processes.

Methods: Twenty in-depth key informant interviews were conducted from June to August 2011. Nine foreign-born, Latina informal community leaders and 11 social and health service providers, and policy professionals were interviewed in Spanish and English, respectively. Qualitative analysis was conducted using qualitative analysis software.

Results: Findings were categorized as follows: social, political, and cultural context of Kentucky; scope and meaning of family planning; instrumental and perceived barriers; instrumental and perceived facilitators; role of policies in access to family planning; and potential impact of the Affordable Care Act on foreign-born Latinas' access to family planning. This study's findings suggest that Latina immigrants' perception of access is affected by immigration and transportation policies at the state and federal level, by local attitudes towards immigration, and language access practices at service agencies. Findings also support culturally- and linguistically-appropriate approaches to increase knowledge and understanding of family planning among foreign-born Latina immigrants.

Recommendations: This study indicates the need for changes at the policy, organizational, and programmatic level. Public health leadership is needed to bring about these changes. The need for culturally-and linguistically appropriate community outreach, peer-to-peer education, provider training, strong political messages regarding immigrants, advocacy to reverse policies that damage access to health, and enforcement of existing language access policies are among the recommendations in this study. More research is needed in this area, in particular using participatory methods.

A mis hijos, Matias Nicolas y Lucas Francisco

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I started this DrPH program the same week my oldest son started Kindergarten, and my youngest was 2 years old. As I finish this milestone, my oldest son is in third grade and my youngest in Kindergarten.

I am grateful to my parents, for setting an example of doing what you love in life. I am the last of their three children to complete a doctorate degree and I can only hope to instill a fraction of the love of learning into my children as they have in theirs.

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CHAPTER I
INTRODUCTION

Statement Of The Issue

Reproductive health is an integral part of women's self-determination and overall health and wellbeing. It is also highly sensitive to both social and physical environments. Public policies, and resulting programs, can both strengthen and undermine the reproductive health options and health outcomes of women. This policy impact is amplified for low-income women and communities of color. In the United States, African-American women and Latinas experience significant health disparities in the area of reproductive health. For foreign-born Latinas, immigration policies and attitudes that create further barriers to access and perceived access compound this situation.

By the year 2050, one in four women in the U.S. will be Latina. Although many Latinos are U.S.-born and have been in the U.S. for many generations, in 2006, about two-thirds of the Latino population in the U.S. was foreign-born. Over half of the foreign-born population in the U.S. originates from Latin America. Of all Latino foreign-born, the largest proportion comes from Mexico (64%).[1] In fact, according to the most recent Pew Hispanic Trust data, in 2008, there were 12.7 million foreign-born Mexican immigrants, accounting for about one-third of all immigrant

in the U.S.[2] These statistics, however, significantly under-represent the number of immigrants (Latinos in particular), as studies have noted that communities of color as well as documented and undocumented immigrants tend to have lower participation in the Census.[3]

Latinos face multiple socio-economic challenges and associated increased health risks, including the highest uninsured rate of any other group in the U.S. According to a Commonwealth Fund survey report, close to two-thirds of Latino adults state that they have been uninsured at some time in the past year, and 76% of low-income Latino adults have been uninsured in the past year.[4,5] A disproportionate number of Latinos is low-income; while Latinos represent 14 percent of the total U.S. population, they are 21.8 percent of the population living in poverty.[6,7] Additionally, twenty percent of Latina women, and close to half of female-headed Latina households with children live in poverty. Foreign-born Mexican immigrants face poverty at a higher rate (34%) than any other foreign-born immigrant group.[8]

Some of the factors that play a role in the health status of foreign-born Latina immigrants include disproportionate levels of poverty and low-income, high levels of lack of insurance, limited access to health care, language barriers, provider bias/discriminatory treatment, lack of awareness of health risks, eligibility status for public benefit programs, lack of understanding of the U.S. health care system, need for childcare, transportation, cultural barriers (including trust issues and gender roles), and immigration status.

Poverty is an important and defining factor in the lives of foreign-born Latina immigrants in the United States. Poverty is associated with a lack of resources, information, and knowledge; substandard living conditions; risk-promoting lifestyles; and diminished access to health insurance and health care. A 2003 literature review found that there is a strong relationship between various socio-economic status measures and health outcome measures.[9] This relationship between poverty or low socio-economic status and diminished health status holds true trans-nationally as well.[10]

Latinos in Kentucky

Over the past decade or so, Latin American immigrants have increasingly settled in states in the Midwest and Southeast of the United States, where Latino populations were very small prior to the early 1990s. This demographic shift has had significant impact in communities where the infrastructure, programs, and policies were not developed with new immigrants or persons with Limited English Proficiency in mind. In states where immigration waves are more recent, and where the majority of Latin American immigrants are foreign-born, immigrants may find themselves with less access to resources and information (particularly in a linguistically and culturally-accessible manner) and in less welcoming environments. Moreover, the current anti-immigrant/anti-immigration climate with the ensuing anti-immigrant policies at the state and local level, can feed into both decreased access to services and increased fear of accessing services and information from public entities.

Limited information is available about Latinos in Kentucky, and what is available is primarily based on the Census, which significantly undercounts the undocumented and mixed-immigration status families.[11] The literature available about Latinos in Kentucky beyond the Census is primarily focused on the role of the new immigrants in labor.

Kentucky experienced a significant growth (239%) in its Latino population in the decade between early 1990s and 2004.[12] This rapid growth put Kentucky in the eighth spot in terms of growth of Hispanic population during the 1990s.[13,14] To put this in context, this happened during a time when the state was experiencing significant exodus of its young population and this out-migration was not being replaced by native residents, but rather by international migrants.[15] In 2009, the Pew Hispanic Center produced a demographic profile of Hispanics in Kentucky based on 2007 data. According to the profile, Hispanics in Kentucky constitute only 2 percent of the state population.[16] The median age of Hispanics is 24 (compared to 38 for non-Hispanic whites and 30 for non-Hispanic African Americans) and had a poverty rate similar to African Americans in Kentucky, and significantly higher than white Kentuckians.[17] Latinas in Kentucky also have the highest rate of uninsured, 47.6%, compared to 17.1% White, and 25.8% for African American.[18] The total Hispanic population is estimated at 87,000 based on Census findings, which, as stated earlier, significantly undercounts the actual population.[19] Interestingly, close to half of the Hispanic population is considered U.S.-born, but the average age of the U.S.-born Latinos in Kentucky is 14, whereas the foreign-born Latinos average age is 30.[20] This speaks to the fact that majority of adult Latinos in Kentucky are foreign-

born and it is the U.S.-born children of these new immigrants who account for the vast majority of the U.S.-born Latinos in the state.

Latino, particularly Mexican, immigration was initially motivated by the availability of agricultural and horse-industry jobs throughout the state of Kentucky. Rich and Miranda, in a study about Latino immigrants in Lexington, (central) Kentucky, find that the surge in Latino population spiked in the 1990s in "response to labor needs in the region."[21] As the job opportunities expanded and shifted to more urban, service-oriented and manufacturing ones, more young women and families relocated to Kentucky.[22] While Kentucky is a rural state, more Latino migrants have settled in urban centers in Kentucky. As one of the larger urban areas in Kentucky, Lexington's Latino population grew by 500% in the decade of the 1990s.[23] However, Latinos in Kentucky are not concentrated in any one area, with population distribution in both rural and urban counties.[24] As Kentucky has been predominantly a white state (with African American population percentages in the single digits), the new Latino immigrants, although still relatively small in size, represent a dramatic change culturally.[25] According to Barcus (2006), Latino migrants living in rural areas face greater barriers in accessing needed services and have higher levels of poverty than those in urban areas. Barcus concludes that "Kentucky keeps a lot of its migrants" and that the trend of growing Latino migrant populations throughout the state will persist.[26] While initially the majority of the new Latino immigrants were adult males, more recently the proportion of women and children is growing, indicating "a degree of commitment to permanent residence" in Kentucky.[27]

This shift from primarily young, male adults perceived as transient to more permanent family units and women immigrants, changes both the overall community perception and awareness of the newcomers and the newcomers' social, educational, housing, and health needs. As children enter the public school systems, the broader community becomes aware of the permanence of the new immigrants in their communities. Further, because of the overall racial/ethnic heterogeneity in Kentucky communities, Latino immigrants are highly visible. Kentucky has limited recent experience with languages other than English, thereby making the language barriers immigrants experience more marked with a dearth of infrastructure available to address the needs of persons with limited English proficiency.

In terms of economic realities of Latino immigrants, Rich and Miranda state, "Mexican immigrants in Kentucky form the newest and poorest segment of the working class."[28] These economic realities in tandem with the social, linguistic, and cultural isolation that many immigrants experience, can represent significant impediments to basic social and health services and information.[29]

With more of the Latino population becoming family units, and as a result of more stringent immigration policies, families and individuals are less likely to risk returning to their country, thereby increasing the chance that the new immigrants will have a long, if not permanent, residence in Kentucky. As these newcomers adapt to a new home and its complex systems and culture, the community and its systems' reaction has been what Rich and Miranda have described as a transition

from a non-response to perceived invisibility to one of combined and "tense…xenophobia and paternalism."[30]

On April 2010, the Kentucky State Police signed a Memorandum of Agreement with the Immigration and Customs Enforcement (ICE) to carry out the "Secure Communities" initiative. This creates a link between law enforcement and immigration normally outside the purview of local and state law enforcement. While it is not known what the impact of such partnerships may be, the potential fear created by the knowledge of such linkage between immigration and law enforcement can create barriers to crime-reporting in immigrant communities, including domestic violence cases. Immigrants who commit three levels of crimes are targeted by this initiative. The first two levels are primarily felonies, serious crimes such as homicide, national security crimes, rape, kidnapping, burglary, larceny, fraud and money laundering.[31] The third level states "other offenses" and includes general categories of "immigration…damage property…gambling…family offenses…liquor…health and safety…public order…" and others that may open the door for broad application of the initiative, thereby lending itself to profiling.[32]

This MOA in Kentucky comes in the heels of a controversial Arizona immigration law, considered by many as the "broadest and strictest immigration measure in generations".[33] The law allows law enforcement (local and state police) to demand documentation that proves a person's right to be in the United States. In effect, police can ask for documentation from persons that appear to be undocumented, thereby raising significant concerns of racial and ethnic/linguistic

profiling. The law makes it a misdemeanor state crime not to carry immigration papers.[34] It also allows individuals to sue the local government for failure to enforce federal or state immigration law.[35] Shortly after the Arizona Governor signed the immigration law, a law banning the teaching of "ethnic studies" at public schools was also passed in Arizona.[36]

In early 2011, Kentucky's Senate proposed a bill that imitates and goes further than the Arizona law. The Kentucky bill passed the Senate but failed to pass the House and provoked widespread and intense reaction from both community advocates and some providers and small business owners. The Kentucky bill added to the Arizona provisions by holding anyone who aids undocumented immigrants to be in violation of the legislation. This could potentially have put teachers, social workers, health providers, even bus drivers, at risk of committing a felony.

These measures contribute to an atmosphere of fear, confusion, and increased barriers to public services and resources for both documented and undocumented immigrants, and indeed for persons of color whom the police may believe "look like" an undocumented immigrant.

Background

Latinas represent a unique population in the U.S. in many ways. In 2000, Latinas were 14% of reproductive-aged women (15-44 years) and 20% of all live births, although the birth rate has been dropping. The socio-economic and political context in which Latinas live contribute to reproductive health challenges facing Latinas, including a high uninsured rate (over half of low-income Latinas), low

prenatal care rate (more than 23% of Latinas don't receive prenatal care during the first trimester), high and rising HIV/AIDS rates (Latinas account for more than 20% of the AIDS cases among women and the HIV infection rate among Latinas is almost seven times higher than for non-Hispanic white women), maternal mortality rate 1.7 times higher than white women, and high unintended pregnancy rate (the unintended pregnancy rate for Latinas is nearly two times the rate for non-Hispanic white women and teen pregnancy is highest for Latinas, with some notable country of origin variance-- Mexican-highest; Cuban-lowest).[37,38,39,40,41] This high rate of unintended pregnancy also contributes to an abortion rate that is higher than that for white women, and among poor women, Latinas have the highest rate of abortions.[42] Latinas also face health risks in terms of reproductive cancers, with the cervical cancer rate for Latinas more than twice as high as the rate for non-Hispanic White women.[43]

Latinas have a lower contraceptive use rate than other women in the U.S., and have a higher contraceptive failure rate than other groups of women in the U.S.[44] Access to family planning is to a great degree determined by access to information and affordable, culturally-relevant services, as well as by multiple economic and social realities influencing health behaviors and the perception of access. As a reproductive health behavior, family planning affects many of the aforementioned reproductive health outcomes. As such, it is a key "gateway" health behavior to overall reproductive health and wellbeing.

Welfare Reform and Immigrants

Immigration and welfare policies have significant and often unexplored public health implications. Although the United States has a long history of immigration, and of Hispanic/Latino presence, recent changes in immigration and other public policies and resulting cultural attitudes towards immigrants, affect the health and lives of new Latin American immigrants in myriad ways.

In 1996, the United States passed welfare reform legislation (Personal Responsibility and Work Opportunity Reconciliation Act of 1996--PRWORA), which, among other things, changed eligibility criteria of immigrants for public benefits and devolved the responsibility for coverage of public benefits for certain groups of immigrants to the states. Specifically, Title IV of the PRWORA implemented new conditions of eligibility to both documented and undocumented immigrants. The legislation provided that persons entering the U.S. after August 22, 1996, would be barred from receiving non-emergency, means-tested, federally-funded public benefits for the first five years in the U.S. This bar included benefits such as Food Stamps, Medicaid, Supplemental Security Income (SSI), and Temporary Assistance for Needy Families (TANF). This lack of access to basic services may exacerbate the socio-economic conditions of Latina immigrants and therefore put them at greater health risks. As a significant proportion of Latina immigrants are low-income, eliminating access to public benefit assistance has the potential of increasing negative health outcomes associated with poverty and low socio-economic status to a significant, growing, and particularly vulnerable segment of the U.S. population.

The 1996 welfare reform represented a substantial deviation from the philosophical underpinning of welfare policies in the United States heretofore. It shifted from a presumption of government responsibility for provision and assurance of basic needs for its people, to a more punitive approach that laid increased responsibility for meeting all basic needs upon individuals and families. Further, by singling out recent immigrants as a group that was not "deserving" of the government's assistance except in cases of emergency, the policy also served to reinforce and push along an increasingly negative and antagonistic attitude towards immigration and immigrants.

PRWORA gave states the option of providing public benefits to unqualified immigrants through state-funded programs during the five-year period and it also gave states the option of not extending eligibility to these public benefits for legal immigrants even after the five-year period was over. Therefore, the impact of PRWORA differs depending on the state where immigrants reside, potentially creating 51 different versions of welfare reform. Further, because of a provision that would factor both an individual immigrant's income and that individual's sponsor's income, many immigrants were ineligible for Medicaid benefits even after the five-year waiting period.[45]

As intended, usage of public benefits by immigrants dropped dramatically after PRWORA. For example, according to research conducted by the Urban Institute, permanent resident immigrants usage decreased by 60% in TANF; 48% in Food Stamps; 32% in SSI; and 15% in Medicaid.[46] Due to the significant proportion

of low-income families and individuals within the immigrant population (particularly single-female headed households with children), such a decline could have dramatic consequences on the general wellbeing and access to needed services for foreign-born Latina immigrants.

Research addressing the question of the impact of welfare reform on reproductive health of immigrants is limited. Studies that have looked at this issue have often failed to distinguish between foreign-born and U.S.-born immigrants; generally focused on states with long-history of Latino immigrant presence (Texas, Florida, California, New York);[47] and had almost an exclusive focus on pregnancy and birth outcomes. Most studies relied exclusively upon Vital Statistics for data, and this reliance on Census Bureau data lends itself to undercounting immigrants and limits the richness of analysis possible. Further, the literature lacks a social determinants analysis that could further elucidate the reproductive health implications of access to public benefits other than Medicaid. There is a strong tendency towards using Medicaid as a proxy for all public benefits when the discussion is addressing health outcomes, seemingly ignoring the strong link between socio-economic context and wellbeing and health outcomes. Although the reviewed literature provided valuable and utilitarian policy analysis, it failed to connect the policy to the specific case and the lived experiences of immigrant Latinas.

Some findings that are relevant to the current study of experiences and perceptions of access to family planning for foreign-born Latina immigrants in Kentucky include:

- Fear of negatively affecting their immigration status, or that of their family members, lead some eligible immigrants to not apply for public benefits.[48]

- Welfare reform paralleled and was followed by a significant number of anti-immigrant legislation at the state level limiting access to "public education, health care or other public benefits" for immigrants.[49]

- Welfare reform restrictions on immigrant access to public benefits undermine the public health, and place undue burdens on safety net providers, who can and do provide often unreimbursed reproductive health services for immigrants made ineligible for means-tested public benefits by welfare reform.[50]

- All categories of immigrants experienced a drop in Medicaid enrollment following welfare reform, whether the group had Medicaid eligibility or not.[51]

- Some studies found a decrease in immigrant access to reproductive health services following welfare reform.[52,53]

PRWORA attempted to change, through programmatic incentives and disincentives, the reproductive and sexual behavior of low-income women. First, because women and children are the primary recipients of public benefits, it is implicit that reproductive and maternal and child health are a large component and potential impact of PRWORA. Low-income populations, especially foreign-born

immigrants, have barriers to access for health services. Therefore, establishing more barriers (ineligibility for Medicaid) to health services access could be expected to have reproductive health effects. Further, as stated by Wise et al, PRWORA "permitted states to tie assistance to compliance with specified maternal behaviors, including reproductive and marital decisions."[54]

The importance and health-relevance of access to public benefits and programs is underscored by its potential impact on mitigating poverty. According to the Center on Budget and Policy Priorities, public benefits in the U.S. "cut[s] the number of Americans living in poverty almost in half" as well as mitigating the effects of poverty for those still living in poverty. Through public benefit programs, some low-income individuals and families who would otherwise be uninsured also gain access to health care coverage and consequently to preventive and curative health services.[55] By providing for some of the basic needs of families, it allows families not to have to make tough decisions between providing for one basic need over another and possibly alleviates some of the psychosocial stress of living in poverty.

Welfare reform reauthorization took place at the end of 2010, giving Congress and President Obama an opportunity to change the elements most harmful to women, families, and immigrants. Such changes could have had a profound impact on the health and social well being of immigrant families. With Democrats in control of the "House, Senate, and Presidency", they "might want to repeal- or at least modify- some of the reforms."[56] However, with the current immigration policy

trends and political climate (Arizona anti-immigrant law, and a copy of that law, SB6 in Kentucky, for example), it seems to have been too politically difficult to change existing restrictions on immigrants' access. Immigrants continue facing the same restrictions and states have been following the suit in attempting to legislate further immigration restrictions (a federal power) through punitive measures that seek to bar immigrants from all social and health services.

Importance And Rationale

Foreign-born Latin American immigrants in the U.S. represent a large and rapidly growing population. Latin American immigrants are a significant part of the U.S. economy and due to their comparatively younger age, represent a sizeable proportion of both the working and reproductive age population in the U.S. Foreign-born Latina immigrants are also more likely to be low-income and to be uninsured, thereby putting them at a higher risk for negative health outcomes and diminished health status. Most adult Latina immigrants in Kentucky are recent immigrants and foreign-born. As such they live in a post-welfare reform environment where immigrants are often barred from accessing public assistance that could mitigate the effects of poverty and poverty's negative impact on health behaviors and outcomes. Immigrants in these states may also perceive that they are ineligible for services as a result of the lack of culturally- and linguistically-accessible services and the general attitude towards immigrants and immigration.

Family planning (contraception) is "one of the most widely used services among women."[57] Family planning directly affects several health outcomes in which

Latinas fare significantly worse than average: unintended pregnancy, abortion, cervical cancer (in many cases resulting from the sexually transmitted disease Human Papilloma Virus --HPV), and HIV/AIDS. Family planning has a multi-generational impact on Latino families and the ability and resources necessary to effectuate plans on if and how closely to have children intersect with numerous social determinants of health. States like Kentucky have limited experience and existing infrastructure with foreign-born Latin American immigrants and limited or non-existent data on the experiences of Latinas in Kentucky in terms of reproductive health, and health in general. New settlement states are at a juncture where the status, participation, and role of Latino immigrants are being played out and decided.

Due to the multi-generational aspect of reproductive health consequences, the mediating role of family planning in relation to other reproductive health outcomes, and the general preventability of many negative reproductive health outcomes, focusing on the experiences, knowledge, and perceptions of accessibility of family planning of foreign-born Latina immigrants in post-welfare reform Kentucky is of particular relevance and importance in terms of public health and within the context of the social determinants of health.

In making informed and salient policy decisions, it is important to engage the community in policy and programmatic decisions. This research project explores the family planning experiences, knowledge, and perceptions of family planning access of low-income foreign-born Latinas in post-welfare reform era Kentucky

through conversations with foreign-born Latina community leaders and professional providers serving this community. The Latina informal community leaders belong to a local grassroots collection of Latina women's groups in Louisville—the Latina Women's Movement.

Using the social determinants of reproductive health framework (a concept in development that integrates the concepts of social determinants of health and reproductive justice frameworks), this study applied qualitative methods to give voice to and analyze the lived family planning experiences and perceptions of access of foreign-born Latinas in Kentucky to inform policy development and implementation. This project also examined the knowledge, perception, and experiences of providers Kentucky's largest urban area as well as of policy professionals working at the state level. Such an understanding can further inform public health's role in public policy development and implementation. This project is particularly relevant to policy-development around women's health issues in new, non-traditional immigrant settlement states. Specifically, the researcher posed the question of how family planning experiences and perceptions of access to family planning of Latina immigrants in an urban center in Kentucky can be used to inform community-based policy initiatives to improve the reproductive health of Latinas? This question is explored through several related sub-questions:

1. How do professional service providers and policy professionals differ and align with foreign-born Latina immigrants in terms of their understanding and expression of:

a. The social, political, and cultural context of Louisville, Kentucky

b. The scope and meaning of family planning

c. The (structural and perceived) barriers to family planning use by low-income foreign-born Latina immigrants in Kentucky

d. The facilitators to family planning accessibility (perceived and instrumental) by low-income foreign-born Latina immigrants in Kentucky

e. The role of policies in access to family planning services and information

f. The potential impact of the Affordable Care Act on foreign-born Latina immigrants' access and perception of access to family planning services and information

g. What is necessary to improve access to family planning services and information by Latina immigrants in Kentucky?

2. How can public health advocates more effectively use community-based approaches to influence reproductive health policy initiatives targeting Latina immigrants in Kentucky?

(The terms "cultural, socio-economic, and political context", "structural barriers", and "instrumental and perceived access" are defined in the Methods section.)

The growing importance and relevance of the Latino population in Kentucky-- and other new-immigrant-settlement states-- and the dearth of existing literature on new, foreign-born immigrant groups in such states, create a need for more and

richer information about the experiences, perceptions, and attitudes of the individuals who make up these new communities. Such information can serve as a tool for more grounded policy-development, more culturally- and linguistically-relevant programmatic development and implementation, and a more participatory and community-based approach to health education and outreach. Particularly given the current political climate surrounding immigration and reproductive health, the investigator believes a rethinking of reproductive health is necessary to place it not just as an integral and essential public health component for women and communities, but as both a product and determinant of general health and socio-economic well being.

CHAPTER II
LITERATURE REVIEW

The current literature available on the family planning experiences, knowledge, and perceptions of Latinas is limited, particularly when excluding U.S.-born Latinas. The current study focused on foreign-born Latinas in Kentucky, as a state that has experienced a recent and significant growth in Latino population over the past two decades. Only a very small number of studies address Latinos in these new Latino settlement states, and most of these focus on the new Latino labor force.

Findings

Themes

The following themes were identified in the literature review in terms of Latinas and reproductive health and family planning.

Contraceptive Use

Latinas are less likely to use contraception than white or African American women.[58] They are more likely to experience inconsistent use of contraception and contraceptive failure.[59,60] For those who use a contraceptive method, they are more likely to rely on sterilization and long-acting hormonal methods than on the birth

control pill or condoms, as compared to non-Hispanic women who rely primarily on the pill.[61]

Communication

In terms of interpersonal communication, Latinas report lower levels of comfort in talking to a partner about sex or condom use.[62] This is significant as women who speak to their partners about contraception and make decisions together about family planning are more likely to use and stay on contraceptives.[63,64] On a more macro-level of communication, researchers have found that the language barrier is a significant obstacle to contraceptive use by Latina immigrants.[65] According to the Pew Hispanic Center, 73% of foreign-born Latinas state that they do not speak English "very well" and that they do not speak English at home, compared to about 14% of U.S-born Latinas who say they do not speak English very well.[66]

Perceptions and Knowledge of Family Planning and Reproductive Health

Researchers have found that first-generation Latinas perceive a lack of explicit and visible promotion of family planning in the U.S. as compared to their country of origin (specifically, the research discussed Mexico).[67] This is related to a perception of an absence of a public dialogue about family planning in the U.S. Latinas are also more likely to report less knowledge of the reproductive system and functions.[68,69] Related to the knowledge of the reproductive functions, studies have found widespread lack of knowledge and misperceptions of (contraceptive) method safety and product side effects.[70,71,72] Latinas tend to overstate the risks of using hormonal contraceptives and

state some unfounded fears in terms of contraceptive use, while not being aware of some of the actual side effects or risks.

Cultural Norms

Cultural norms and practices play a role in women's decisions regarding family planning. For example, studies have found that Latinas' desire for larger family size and their desire for male children plays a role in family planning decisions.[73,74] Additionally, traditional gender roles and decreased power within intimate relationships also affect a woman's ability to negotiate contraceptive use, number of children, and child spacing.[75] While about nine of ten Latinos identifies as religious (with the majority identifying as Roman Catholic), researchers have found no correlation between religiosity and contraceptive beliefs.[76,77]

Health Care Access

Lack of access to health care is a key factor in Latinas' use, experience, and attitudes towards family planning and contraception. Lack of insurance, lower use of the health care system, and lack of culturally- and linguistically-relevant information are all barriers to health care access. Researchers have identified lack of cultural and linguistic access to information and services as an obstacle to contraceptive use. In studies that looked at both English-speaking and Spanish-speaking Latinas, a difference was identified in the two population's comfort and proficiency in family planning use, knowledge, and attitudes.[78] Similar findings were identified in studies that compared foreign-born and U.S.-born Latinas.[79] As stated in the **Background** section, Latinas are about three times as likely to be uninsured than non-Latinas in the U.S., with almost half

of foreign-born Latinas experiencing lack of insurance.[80] With the recent passage of the Patient Protection and Affordable Care Act (health care reform bill), the health care system in the U.S. will undergo both minor and major changes. Specific to this study, access to contraceptives will change for many through Medicaid eligibility expansions and state ability to expand Medicaid family planning coverage without the requirement of a federal waiver.[81] On the other hand, in terms of access to health care for immigrants, the reform bill includes both positive and negative provisions. On the upside, the reform bill expands funding for Community Health Centers (where many immigrants seek care) and provides funding for outreach and care provision through Community Health Workers for underserved communities.[82] However, while undocumented immigrants are exempt from the individual coverage mandate, they are entirely left out of the system by disallowing the receipt of subsidies or participation in health Exchanges even through personal funds.[83] Furthermore, the five-year wait instituted by PRWORA is left in place, leaving documented immigrants, including permanent residents in the U.S. for less than five years, without access to public benefits or related new expansions.[84] The bill also further marginalizes reproductive health from health care by creating redundant and burdensome provisions that serve to stigmatize and isolate abortion care from other health care.

Socio-economic Status

The socio-economic context within which Latinas live plays a role in their family planning access and decisions. Although Latinas participate in the labor force at a similar rate than non-Hispanic women, a disproportionate percentage of Latinas in the

U.S. live in poverty and are low-income.[85] This lack of economic means creates instrumental and perceived barriers to health care access. Low-income Latinas may not be able to afford the cost of contraceptives while also not being eligible for public assistance due to immigration status. Recent immigrant, foreign-born Latinas are more likely to be low-income. There is a wide discrepancy in income levels between U.S.-born and foreign-born Latinas, with a disproportionate representation of foreign-born Latinas in the low-income and poor economic categories.[86]

Contraceptive Sabotage and Intimate Partner Violence

Research into intimate partner violence has identified contraceptive sabotage as a common tool used by perpetrators of abuse within the context of intimate relationships.[87] Male abusers will sabotage contraceptives (poke holes in condoms, slip condom off before ejaculation, destroy part or all birth control pills, etc.) or completely impede use of contraceptives by their female partner as part of a controlling and coercive dynamic. Abusive partners will also use fear and misinformation to control use of contraceptives by telling their female partners that contraceptives are dangerous or may cause harm to them. Women and adolescents who are victims of intimate partner abuse are much more likely to experience unintended pregnancy, sexually transmitted diseases (including HIV and AIDS), and state that they do not have control over the number or spacing of their children.[88,89] Research has found both forced continuation of an unwanted pregnancy and forced termination of a desired pregnancy to be common in abusive relationships.[90] Prenatal health and wellbeing is also compromised for women in abusive relationships.[91] Significantly, researchers have

found maternal homicide (homicide within a year of the resolution of a pregnancy) to be the number one cause of death in the postpartum period.[92,93]

Latinas suffer from intimate partner violence at similar rates as other women (about 25.5% nationally, and 36.6% in Kentucky).[94] However, immigrant Latinas face additional barriers to seeking help or resources for intimate partner violence. Barriers similar to those in health care access (linguistic and cultural barriers, lack of transportation, etc.), plus a lack of familiarity with U.S. laws in terms of domestic violence create added hardships for immigrant Latinas. Research shows that Latinas are less likely to seek help at domestic violence shelters than other women and may therefore have fewer options in dealing with an abusive partner.[95] The situation is further complicated for undocumented women who may lack financial recourse for leaving an abusive relationship and the fear of being deported if the legal or law enforcement systems become involved.

It is important to consider the role that violence, forced sex, and contraceptive sabotage play in the lives of immigrant Latinas, and in turn, in their ability to access and use family planning services or methods. Violence in an intimate relationship can significantly affect a woman's perceived access to contraception vis-à-vis her partner's control, coercion, and threats in terms of its use.

Limitations

Overall, there is a limited amount of literature addressing the family planning experiences, beliefs, and knowledge of foreign-born Latinas. There is a particular dearth of information of foreign-born Latinas in new Latino settlement states, such as

Kentucky. The information available on Latinos in Kentucky is primarily focused on labor and employment.

Other study population limitations include a tendency not to differentiate or combine foreign-born and U.S.-born Latinas, despite the fact that significant socio-economic differences exist between these two groups. Further, a large proportion also focused on adolescents or very young adults. The study setting of much of the research lent itself to population bias as many of the studies were conducted at health care settings or the sample of study participants was identified through their use of a health care service. As Latinas have a high-uninsured rate and have less access to health care services, by selecting a study population from those accessing health care, the results can be skewed.

The research also primarily focused on individual determinants, and less so on structural or environmental determinants as factors in family planning or contraceptive use, knowledge, or access. A limited analysis of the broader social context within which Latina immigrants live was prevalent. Related to this, the review of the literature did not identify analysis of the historical context of Latinas' use of, access, or attitudes towards family planning and contraception. As there have been significant instances of unethical government actions related to forced or non-consensual sterilization and contraceptive experimentation, it is important to consider the impact that such collective memories or stories might have on individual attitudes and experience with contraception. Finally, very limited research was found that provides a voice to Latinas.

A summary of the parameters and criteria developed for a literature review on family planning experiences, knowledge, and perceptions of Latinas is presented below. A more complete literature review results table is included in Appendix A.

Table 1. Literature Review Key Words

Latinas	AND	Birth control
OR		OR
Hispanic		Family planning
OR		OR
Latin*		Contracept*

Criteria:

- Studies prior to 1996 will be excluded.
- Commentaries, opinions, and editorials will be excluded.
- U.S. based only.
- Adult immigrants only.
- Foreign-born Latinas (studies on U.S.-born Latinas will be included if a distinction is not made between U.S.- versus foreign-born, or if both groups are included).

Background On Conceptual Framework

Reproductive Justice

The term reproductive justice came into use in 1994 by the Black Women's Caucus at a national pro-choice conference. The group took a holistic view of women's health, viewing the issues of comprehensive reproductive health through a social justice lens. The reproductive justice framework posits reproductive policies that advance social justice by placing gender, race, class, culture, sexuality, age, and geography at the forefront of reproductive issues and policies. Reproductive justice addresses the whole person through a holistic, multi-disciplinary, inclusive approach to protecting and strengthening reproductive rights and health. Reproductive justice becomes a framework, a strategy, and a goal in undoing oppression based on gender and other socially-mediated identities. The concept of self-determination is central to reproductive justice as it refocuses the community from an object to be acted upon to a self-directing actor.

According to SisterSong Women of Color Collective, Reproductive Justice has three dimensions: Theory, Strategy, and Practice. The theory offers a new holistic and intersectional approach to analysis. Strategy proposes new tactics for connecting diverse and often disconnected organizations, movements, and issues under the human rights and social justice framework. The practice infuses the lived personal experience into individual and collective advocacy and activism.[96] Reproductive justice is brought into practice through grassroots efforts and approaches often directed by leadership representative of communities of color.

This framework is grounded on the concept of intersectionality and recognizes the need for an intersectional analysis, where the ways and degree to which multiple social, economic, biological, and political realms intersect and interact are determinant of the options and exposures and, in turn, outcomes that are most accessible and likely to individuals and communities. Intersectionality also refers to the multiple identities that individuals experience at once (i.e. gender, race, class, immigration status, social class, etc.) and the need to see and work with the full individual and her multiple identities, realities, and roles.

Ultimately, reproductive justice takes aim at the social determinants of reproductive health by addressing the root causes of the current inequities in the reproductive health care and legal systems.

Reproductive Justice, Immigration, and Latinas

According to the National Latina Institute for Reproductive Health (NLIRH), "[T]he reproductive decisions of Latina immigrants are under intense scrutiny in the immigration debate."[97] Further, NLIRH makes the following points in linking immigration and reproductive justice:

- Immigration policy has significant consequences in terms of immigrant women's reproductive health.
- Immigration policy is often used as a mechanism for controlling the reproductive decisions of immigrant women.
- Immigration and reproductive justice activists share many common goals.

Immigration is a key aspect of reproductive justice for immigrant Latinas and other immigrant communities. For many immigrant women, their identity as immigrants is at the forefront of their identity and provides a lens through which all of their experiences are understood. While originally the concept of reproductive justice emphasized intersectionality with race and ethnicity, groups like the NLIRH, the Asian Communities for Reproductive Justice, and the California Latinas for Reproductive Justice, have put immigration and its role in identity and experience, at the forefront of reproductive justice work. In this way, reproductive justice advocates have incorporated analysis and advocacy around immigration policy into their work.

Social Determinants of Health

The World Health Organization (WHO) refers to the social determinants of health as the "social conditions in which people are born, live, grow, work and age, including the health system" and informed by a "growing understanding of the remarkable sensitivity of health to the social environment."[98,99] Inherent in this approach is the governments' responsibility to implement and enforce policies that promote and protect health equity. The concept of social determinants of health builds on the ethical principles of health equity, human rights, and the fair distribution of power.[100] This framework pushes us to look beyond the health care and public health sectors of services and policies and to view health outcomes as a result of multiple (and inequitable) exposures and opportunities at various levels of society and in realms not traditionally included in health analysis (justice, education, agriculture, housing, labor,

religion, transportation, energy, environment, security, immigration, and media for example).

Within the social determinants of health theory, the concept of power provides a source of analysis and guide to action. The concept of power informs our understanding of health equity and socially just political processes. The social determinants of health framework recognizes the influence and impact of the systems of power, such as the social and economic structures, upon individual and collective health. As identified in the report, A Conceptual Framework for Action on the Social Determinants of Health, feminist theory lays out four categories of power: 1) power as the ability to coerce or influence, 2) power as the ability to organize and change existing hierarchies, 3) power as the result of collective action, and 4) power from individual consciousness.[101] The participation of the community, as individuals and a collective, is implicit in these categories.

CHAPTER III
APPROACH AND METHODOLOGY

Conceptual Framework

This research project places the issues of policy development and policy implementation within the context of women's lives and community realities. In this context, gender, race, ethnicity, immigration status, and class significantly affect policy influence and impact at the individual and community level. Further, the concept of access is considered to encompass not just instrumental aspects of access such as health coverage, transportation, affordability, and others, but also includes the perception of access. The perception of access is influenced by policy and how policy is communicated to and understood by the community.

Non-health factors are widely acknowledged to affect health at the individual and community level, both directly and indirectly. I have, therefore, chosen to apply a social justice and equity framework that combines what is commonly referred to as social determinants of health and the reproductive justice frameworks in my approach to methodology and analysis for this project. Like the social determinants of health framework, reproductive justice similarly takes a holistic, ecological approach in explaining the socio-political conditions that predispose health options, and hence health conditions and status. In terms of methodology, this combined framework,

rooted in the lived experiences of individuals and communities, calls for a qualitative approach to research, necessitating the voice of the community to be included in the research process.

Definitions

We can further understand the concept of social determinants of health through its components. The following definitions further define the research questions of this project.

- Socio-economic and political context: This is a very broad category that encompasses policies, political and economic systems, social and cultural norms and values, and other systems of power that shape the structural determinants of health, described below.

- Structural determinants of health: This term is intimately related to the socio-economic and political context, and together these two concepts are also called the *social determinants of health inequities.*[102] Structural determinants of health refer to the distribution or processes through which some individuals and groups are more or less exposed to certain resources, opportunities, disadvantages, etc. This can also be understood as "the social processes underlying the unequal distribution of these factors between groups occupying unequal positions in society."[103] These include income, education, gender, social class, occupation, sexual orientation, geographic location, religion, and race/ethnicity among others. Structural barriers, then, are the ways in which we interpret and value or undervalue these structural determinants. For example, sexism is a structural barrier in societies where biological gender is

interpreted and valued in a way that makes members of one gender group have less access to opportunities and resources.

- Intermediary determinants of health: This term refers to factors that are causally connected to the structural determinants of health. These are the "downstream" factors resulting from the interaction of the structural determinants and the socio-economic and political context. Included in this category are "material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself as a social determinant."[104] For example, in the United States, health insurance would be an intermediary determinant of health.

- Intersectionality: sociologists originally posited this concept in the 1960s as part of the work of feminists of color who argued that women of color do not experience discrimination based only on gender, but also on race, class, and other identities. The human rights framework alludes to this approach in its recognition of the various categories of human rights and their interdependency and stating that violation of one type of human right affects all other categories. SisterSong, a leading reproductive justice collective, recognizes intersectionality as the central approach to understanding women's realities. This concept articulates the overlap of the various systems of oppression in people's lives. In other words, intersectionality is where, what, and how people actually live. It does not provide for a neat analysis of dissected issues or realities, rather, it submerges itself in the complexity and messiness of lived experiences, where multiple identities, roles, and realities merge to create unique permutations. The key to intersectionality is the understanding that in isolating any

identity, right, or issue, one loses the ability to truly understand and address the experiences of people (individual or collective).

- Access (instrumental): The concept of access is an "ill-defined term."[105] In public health, the notion of access has been expanded beyond markers such as insurance coverage, health care utilization, affordability, and a usual source of care. Although there isn't a single public health definition of access, many researchers and practitioners have understood it to entail instrumental components affecting access. As stated by Pechansky and Thomas, the concept of access has been applied to "factors which influence entry or use...viewed as a concept that's somehow related to consumers' ability or willingness to enter into the health care system."[106] This broader definition includes things such as transportation, hours of operation, location of health care service, proximity or accessibility by public transportation, etc. Some definitions also include childcare, language access, and cultural competence.

- Perception of Accessibility: The perception of accessibility is affected by the instrumental access components above and refers to the psychosocial aspects of access. Although the broad application of the term access entails numerous important elements, it is limited to factors characteristic of the health care system itself or of a "fit" between the health care system and the individual or group.[107] Factors outside of the health care system affect individuals' and groups' perception of accessibility. Experiences with or knowledge of others' experiences with instrumental access shape beliefs about the possibility of accessing services. Further, community-level and societal-level factors also affect the perception of accessibility. Community attitudes and media coverage of

immigrants and immigration affect individual and collective perception of accessibility. Policies that restrict access of immigrants to public benefits have been found to restrict access to services not just to those groups actually targeted by the policy but to other groups as well who may perceive themselves as similar to the targeted group (i.e. welfare reform). Similarly, restriction of one type of public benefit leads to decreased use of other public benefits, whether those are also restricted or not. In this way, policies can set the tone on how groups are perceived, valued, and how that group believes the "system" or community, as a whole perceives them. In effect, the perception of accessibility may act as a barrier that precedes the instrumental aspects of access. Before a person is faced with questions of transportation, childcare, affordability, or even language, they may perceive a lack of accessibility as a result of the social attitudes and dialogue around immigrants and immigration. Further, because of the power of word of mouth and the relative isolation of many immigrant groups in new settlement states, the perceptions of a few can become the perceptions of many. Issues of language, status as immigrant, as well as racism play into this concept as well. Parallels may exist between this concept and that of institutionalized racism. This concept will be developed further inductively throughout the research process through interviews with both Latina immigrant community leaders and advocates, and providers at the local and state level.

Structural Determinants of Reproductive Health

From the two above-described frameworks and the idea of perception of accessibility, the idea of structural determinants of reproductive health arises. This

concept includes various socio-economic, cultural, and political factors, such as gender, race, socio-economic status, ethnicity, immigration status, rural-urban location, religion, sexual identity and orientation, and parenthood. An important aspect of this worldview is that none of these factors can be disentangled from others, and therefore it is the interaction of various factors with varying degrees of influence on each individual that create specific and unique experiences and social position.

All of these factors can be explored from the perspective of power inequality and inequity. Due to various systems of oppression (racism, sexism, classism, xenophobia, homophobia, etc.), individuals belonging (or perceived as belonging) to certain groups (of race/ethnicity, gender, socio-economic status, immigration status, etc.), are more likely to experience intermediary determinants leading to ill-health and other socio-economic conditions associated with decreased status, power, and self-determination. Take the case of an undocumented immigrant: because of current immigration policies and welfare policies and concomitant societal attitudes about immigration (and racism and xenophobia), an immigrant is likely to be undocumented, experience low-wage jobs with little protections or benefits and low educational-attainment, which in turn increases the likelihood that an immigrant will be poor, which in turn increases the likelihood that immigrants will lack access to health care, quality housing, and suffer from poverty-associated health conditions.

The demand for cheap labor in the U.S. combined with foreign- and trade-policies that support the poor remaining poor in developing countries, maintains the steady flow of undocumented, low-income immigrants into the U.S. Immigration policy

makes it difficult for immigrants to enter the U.S. through "legal" channels or to change their status once they have entered the country without documentation or overstayed a visa; welfare reform made it more likely that low-income immigrants will lack access to public (health and social) benefits; lack of legal standing in the U.S. makes it more likely that immigrants will live in substandard housing (where credit history is not required) and will be exposed to unfair economic practices in labor and housing, with no legal recourse. All of these elements help to isolate and make "invisible" individuals, and undocumented immigrants as a class of people, from the broader benefits that society offers its members. Further, because this is a reality that is commonly known by and communicated among low-income and undocumented immigrants, the perception of lack of access to public benefits and to other societal goods and opportunities contributes to shaping the decisions and beliefs of these populations. This multi-dimensional framework can provide context to the disproportionate incidence of illness and negative health outcomes in a vulnerable population.

This framework is explored and fleshed out inductively through the research project as it interacts and is shaped by qualitative methods of data gathering and findings. The structural determinants of reproductive health lens guides and structures the methodology used in the research process as well as shapes the content and final product of the research. This has been accomplished through the coding of interview data, development of emergent codes, comparison of codes and findings, and analysis of codes. Once the key informant interview data codes were analyzed, these inductive findings were compared to the concepts of social determinants of health and reproductive justice. These two frameworks provided a foundation and context for the

findings of this analysis, and lead to the groundwork of the structural determinants of reproductive health concept.

Study Design And Methods

This study used a nonexperimental, descriptive design. Primary data sources were gathered from in-depth, semi-structured key informant interviews with two populations:

1) professionals in social and health service organizations in Louisville, Kentucky, persons working in the policy realm at the state level, and

2) foreign-born Latina immigrant informal community leaders participating in one of the grassroots groups of the Latina Women's Movement (a project of the La Casita Center).

The final products of this research project are

1) this written report of the findings and analysis with recommendations and a Plan for Change,

2) the initial development of the structural determinants of reproductive health framework (included in this report), and

3) an Executive Summary document in both English and Spanish (to be developed once the dissertation is completed). These products

will be shared with a) the Latina Women's Movement groups in Louisville, b) advocates and advocacy groups working with Latinos in Louisville and Kentucky, c) social and

health service providers, including safety net clinics and hospital systems in Louisville, d) policy organizations at the state level working with Latinas and on reproductive health issues, e) national organizations working with Latinas and reproductive health (i.e. National Latina Institute for Reproductive Health, SisterSong), and f) academic and research institutions in Louisville and Kentucky. The investigator will also work on presenting findings will also be presented at public health conferences and through professional journal articles. The hope is that through sharing these findings and recommendations at the grassroots, organizational, and policy levels, that action can take place around some of the recommendations. Ideally, the action would be guided by ideas and advocacy by participants of the Latina Women's Movement groups.

Methods

Key Informant Interviews

According to the UCLA Center for Health Policy Research, key informant interviews are "qualitative in-depth interviews with people who know what is going on in the community."[108] The goal of these interviews is to collect first-hand knowledge about a specific topic from a variety of people who are familiar with the topic and the community in question. Two interview guides (one for professionals and one for Latina community leaders) were used for the interviews, which were conducted in person and audio-recorded on a digital-recorder. The guides were pre-tested with individuals who fit the participant criteria but did not participate in the study. The guide for informal Latina community leaders in Spanish was also shared with individuals who work closely with Latina immigrants to check on idiomatic use of language, literacy level, and

making sure that the questions were understood to ask what was intended. Each participant was interviewed once. Interviewees were contacted via e-mail and interviewed in person by the P.I. in English, and in person in Spanish in the case of foreign-born Latina immigrant community leaders.

Approval for this study was received on May 25, 2011 from the University of North Carolina Chapel Hill Public Health-Nursing IRB.

Data Collection

Primary data for this study was collected through key informant interview participants. Key informant interviewees were given the option of selecting where they would like the interview to take place, including their office/place of work, to ensure confidentiality during the interview process as well as their own sense of personal comfort. Many people chose coffee shops as the location of the interview. The P.I. selected the most private spot in the coffee shop to conduct the interview. Some of the informal community leaders chose their home as the interview setting, while a few others chose to have the interview at the nonprofit organization, La Casita, which provided us with a private room to conduct the interview. The interviews were audio-recorded on two audio-recorders (a digital recorder and a tape-based recorder for back-up), and notes were taken from these recordings identifying key ideas. Audio-recorded data was then transcribed verbatim (in original language recorded) by a professional transcription service. Transcripts were checked for accuracy against recordings and notes. Transcripts were loaded onto Dedoose data analysis software where a database of all interview participants was created.

Data was coded and themes were identified in an iterative manner. No titles, positions, or names of organizations are used in this report. Quotes are only used when authorized by the interviewee. Quotes in this report are assigned to the general category label (see table below). Names of participants will never be used or disclosed in any iteration of this research study.

Journal of Reflexivity

Due to the researcher's role and identity as a Latina immigrant who has used and has perceptions of access to family planning, a journal of the researcher's experiences, thoughts, and perceptions has been kept all along the data collection and analysis process. These notes acknowledge the bias as a participant observer, and also explore how the researcher's identity, status, and experience can influence what information is and is not shared (and how it is shared) with her by the study participants. Entries to the Journal were made both as a debriefing element after interviews in a more routine manner as well during the analysis process to note ideas, and at unplanned times when an idea about the study came about when reading an article, hearing the news, or during a conversation.

This exercise has provided an element of reflexivity and has also served to capture thoughts and biases as they occur rather than relying on hindsight of the investigator's experiences and thoughts at the end of the project. The investigator also documented the overall research process and decisions and actions regarding methodology in this Journal. Journal entries also served as a starting point for some memo writing as ideas written in the Journal were linked to the themes identified

through the coding process. The Journal was during the coding process and the memo-writing process, and portions of the Journal or ideas presented in the Journal were used when appropriate to support the development of memos and categories.

Throughout this report, sections titled Reflections and Observations will incorporate sections from the Journal of Reflexivity to provide a richer analysis and presentation. Including these thoughts and observations taken through the data collection and analysis process contributes to keeping the discussion grounded in the reality that the investigator is a participant observer and that an unspoken source of data comes from my own lived experiences, perceptions, and multiple identities.

Matrix Used During Interviews to Label Participants

DATE: ________________

CATEGORY OF PARTICIPANT		
Social Service Professional		
Health Service Professional		
Policy Professional		
Latina Community Leader		
LOCATION	Louisville	State-level

QUOTES ALLOWED: Y N

File Number: ________________

The matrix above was used with every interview, including the file number of the recording so that notes and descriptor data could be linked to the correct file for

transcription and analysis. An interview key table was created to track all interviews and transcripts. The table is included as Appendix F.

Study Setting

Louisville is the largest city in Kentucky. It is bordered by Indiana on the north and sits on the Ohio River. Although Kentucky is often referred to as a Southern state, Louisville is considered by its residents to be both Southern and Midwestern. After merging the city and county (Jefferson County) governments in 2003, Louisville Metro became the 17th largest city in the U.S. with a population of over 700,000.

Like the rest of Kentucky, Louisville is predominantly white, although Louisville has a smaller percentage of white population than the rest of the state (Kentucky is 87.8 % white whereas Jefferson County is 72.7 % white). Until the 1990s, Louisville had a relatively small immigrant population, made up of primarily European and Canadian immigrants. Since the early 1990s, Louisville, like many other Southeastern cities, experienced a dramatic surge in immigrants from Africa, Asia, and Latin America.[109]

Although Louisville's immigrant population is still relatively small compared to other U.S. cities, it is growing rapidly and is highly diverse in terms of country of origin and income levels, with some highly educated immigrant groups as well as low-income, low-educational level immigrants. A report written by the Urban Institute found that Louisville's immigrant population was more highly educated than the overall immigrant population in the U.S. However, undocumented immigrants are not counted in official immigrant population counts and where therefore not accounted for in the report.

Among the city's diverse and growing immigrant population, Latin American and African immigrants are over-represented in low-income groups and have higher poverty rates than native Louisvillians and European and Asian immigrants.

Louisville also has a large refugee population due to the presence of multiple refugee resettlement agencies in Louisville that bring a higher-than-average portion of refugees to Louisville, with 15 percent of the immigrant population in Louisville being refugees (in contrast to an average of 7 percent of the national immigrant population).[110]

One result of the growing immigrant population is the growing number of ESL (English as a Second Language) students in the public school system, with an estimated 78 languages spoken by families with children in the local public school system.[111]

Sources and Study Population(s)

Two types of participants were recruited: 1) professionals in the social service, health service, and policy fields that serve the Latino population in Kentucky, and 2) foreign-born, Spanish-speaking, adult Latina immigrants who are informal leaders in the Latina Women's Movement groups in Louisville, Kentucky.

Key informants all live and work in Kentucky, and work at the local or state level (for policy). All interviewees were adults, and a total of 20 interviews were conducted. The initial plan was for close to half of the interviews to be with Latina community leaders and the other half about equally distributed among the types of providers. In the end, the P.I. conducted 11 interviews with providers and policy professionals, and 9

interviews with Latina informal community leaders. Of the 11 provider interviews, 5 were health providers, 3 were social service providers, and 3 were policy professionals working at the state level.

Some participants were both a professional provider and Latina. The P.I. has noted this on the Participant Label Matrix and as part of the analysis. Initially, these participants were analyzed as part of the provider population and, when appropriate, further insights were obtained through analysis of Latina identity.

Reflections and Observations

At the end of compiling and honing in the list of providers to be invited to participate, all persons remaining on the list are women. Two men were on the list, however, one was eliminated due to his lack of close interaction with Latina women on issues of family planning and reproductive health; the other (a male physician that many Latinas have gone to for obstetric care) was contacted but never responded. It is primarily women who work on issues of reproductive health (except for male physicians) in Louisville.

Of the provider population, more than would be expected is Latina (first generation and U.S. born). Five of the 11 providers I interviewed are Latina; three are first generation, and two are second generation. Is it a form of solidarity that Latinas who achieve professional status devote themselves to working with Latinos and issues affecting Latinos? Is it something they choose or do they feel obligated to do it? In my personal experience, I was not initially interested in working on issues affecting Latinos after graduate school (14 years ago), but I was often sought out to represent or speak

for Latinos and work on issues of immigrants. This is something I initially resented as a form of reductionism. Eventually, I found myself compelled by the realities of Latino immigrants in the U.S. and felt that my education and training could contribute to the discussion. There is definitely a sense of "duty" in my working on issues affecting Latinos. It may be a form of solidarity—and of not forgetting where you come from.

Most of the women who are providers who are not Latina, speak Spanish very well. Pointing to the importance of cultural and linguistic competence in working with the Latina immigrant population.

I have not taken note in the data of the varied socioeconomic levels of the Latina women I'm interviewing. Socioeconomic level is not a part of the descriptors I am collecting. While members of the Latina Women's Movement are predominantly lower socioeconomic status, that is not the case with all of the members. There is a wide variation and diversity in the members in terms of education and income. This is more apparent to me as it is most convenient for many of the women that I meet them at their home, I have been to a few of the women's homes. Most women mentioned not having attended university education, but one woman I interviewed actually had 3 master degrees from her home country and talked about how her father only allowed her to marry when her fiancée agreed that he would let her attend the university as much as she wanted. Those with advanced education are a minority, and the majority of women who belong to the Latina Women's Movement have limited educational attainment, with a reportedly sizeable portion not having the equivalent of a high school education.

It is very interesting that among those women who are perceived as informal leaders within the Movement, there is tremendous diversity: one woman is illiterate, another one has multiple university degrees, some live in a hospitality house in an older part of town, others have very large homes in new suburban complexes. All but one of the women has children.

Recruitment

The P.I. has many years of work and volunteer activity in the Latino community as well as the provider/advocate community in Louisville and Kentucky. As such, the P.I. compiled a list of potential individuals to include in the interviews and shared this list with key Latino community leaders in Louisville to get their insight on who might be missing from the list. Because of the P.I.s extensive involvement in the Latino community (past President of the Hispanic Latino Coalition for 2 years, and member for 5 years, and most recently involvement as a leader in a coalition of immigrants and immigrant service providers advocating against the SB 6 anti-immigrant bill at the local and state level), and connection to other Latino community leaders throughout the state, the P.I. is confident the final list of key informants included a good sample of providers and policy professionals familiar with Latino immigrants and women's health issues. For identifying Latina informal community leaders, the P.I. worked through the Latina Women's Movement groups based in Louisville, Kentucky. The Latina Women's Movement is supported by the nonprofit, La Casita Center, and has 12 women's groups (all foreign-born Latinas) in the Louisville area.

The program coordinator for La Casita works with all of the groups and is familiar with the women who function as informal leaders for the groups and broader community. Further, the P.I. has worked with many of these women through programs offered at La Casita Center and is familiar with some of the women who are active in the community as informal leaders for the Latina community. The program coordinator shared information about the research project with the women's groups, and women who expressed interest in participating were given the P.I.s contact information, as well as printed copies of the project description. While a number of women expressed interest in participating in the study, most of the women who were interested stated that they would prefer for the P.I. to call them.

The investigator discussed with the program director that only women who stated that they wanted to be participants should share their phone number with her. The program coordinator then shared the women's phone numbers and first names with the P.I. The P.I. then called the women to review the research project description, ask them again if they were interested in participating, and set up a time and place to meet if after the phone conversation they remained interested in participating. In total, the P.I. was given the phone number and name of 11 women, and 9 were interviewed.

For the providers and policy professionals, the P.I. personally contacted each of the individuals on the list via electronic mail and provided them with information on the proposed research project and the intent to interview them for 30-45 minutes on the topic of family planning and reproductive health realities of Latina immigrants in Kentucky. A research project fact sheet was sent to all participants via electronic mail

once they responded indicating their interest in participating in the interview. The P.I. also offered possible dates and times for the interview once they responded that they wanted to participate. Potential participants then selected a date and time and a preferred location for the interview. A total of 14 email invitations were sent and 11 providers and policy professionals were interviewed.

The table below provides information on all interview participants. Further, the charts below also present demographics of those interviewed. A total of 20 in-depth, semi-structured interviews were conducted between June 7th, 2011 and July 8th, 2011.

Table 2. Participant Descriptor Table

Area of work	Ethnicity	Location	Population type	Date of interview	Country of origin	Years in KY	Years in the US	Age
Policy	Latina	Statewide	Provider	6/7/11				
Policy	non-Latina	Statewide	Provider	6/8/11				
Social Service	Latina	Louisville	Provider	6/8/11				
Health Service	Latina	Louisville	Provider	6/10/11				
Health Service	non-Latina	Louisville	Provider	6/13/11				

Area of work	Ethnicity	Location	Population type	Date of interview	Country of origin	Years in KY	Years in the US	Age
Social Service	non-Latina	Louisville	Provider	6/15/11				
Health Service	non-Latina	Louisville	Provider	6/21/11				
Social Service	Latina	Louisville	Provider	7/8/11				
Health Service	Latina	Louisville	Provider	6/22/11				
Policy	non-Latina	Statewide	Provider	7/5/11				
Health Service	non-Latina	Louisville	Provider	6/24/11				
Informal commun-ity leader	Latina	Louisville	Latina community leader	6/27/11	Peru	17	17	48
Informal commun-ity leader	Latina	Louisville	Latina community leader	6/29/11	Mexico	15	15	43

Area of work	Ethnicity	Location	Population type	Date of interview	Country of origin	Years in KY	Years in the US	Age
Informal commun-ity leader	Latina	Louisville	Latina community leader	6/30/11	Mexico	9	9	57
Informal commun-ity leader	Latina	Louisville	Latina community leader	7/1/11	Mexico	6	9	30
Informal commun-ity leader	Latina	Louisville	Latina community leader	7/1/11	Colom-bia	8	8	63
Informal commun-ity leader	Latina	Louisville	Latina community leader	7/4/11	Mexico	7	12	29
Informal commun-ity leader	Latina	Louisville	Latina community leader	7/6/11	Mexico	10	16	38
Informal commun-ity leader	Latina	Louisville	Latina community leader	7/8/11	Guatemala	9	9	35

Area of work	Ethnicity	Location	Population type	Date of interview	Country of origin	Years in KY	Years in the US	Age
Informal commun-ity leader	Latina	Louisville	Latina community leader	6/21/11	Mexico	10	10	45

Figure 1. Participants by Area of Work

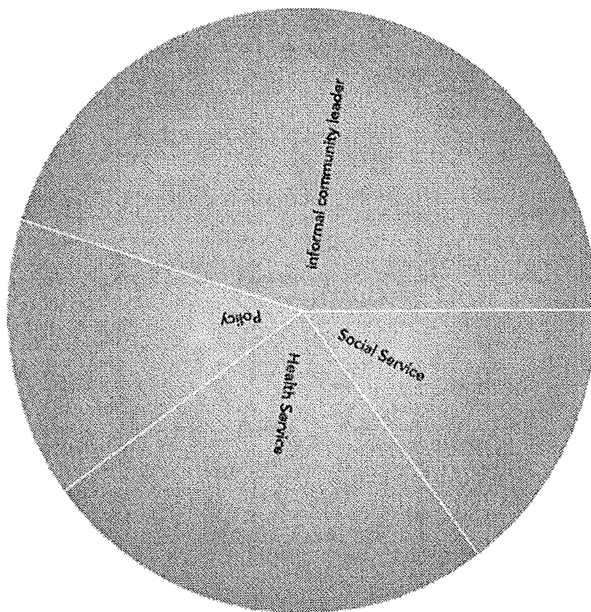


Figure 2. Participants by Ethnicity

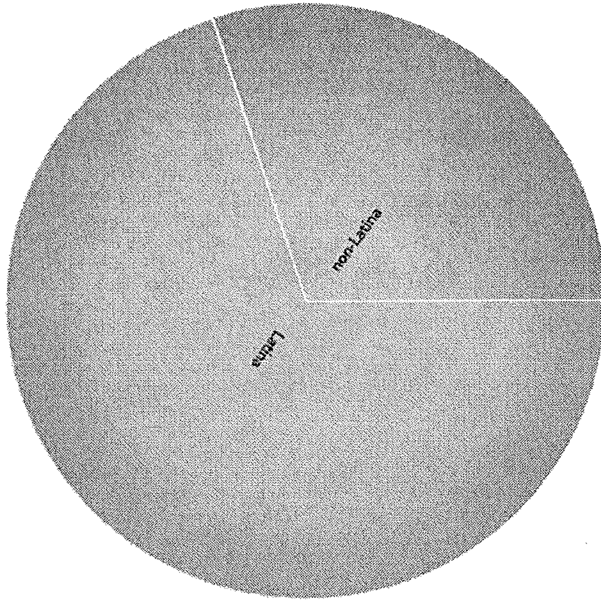


Figure 3. Participants by Population Type

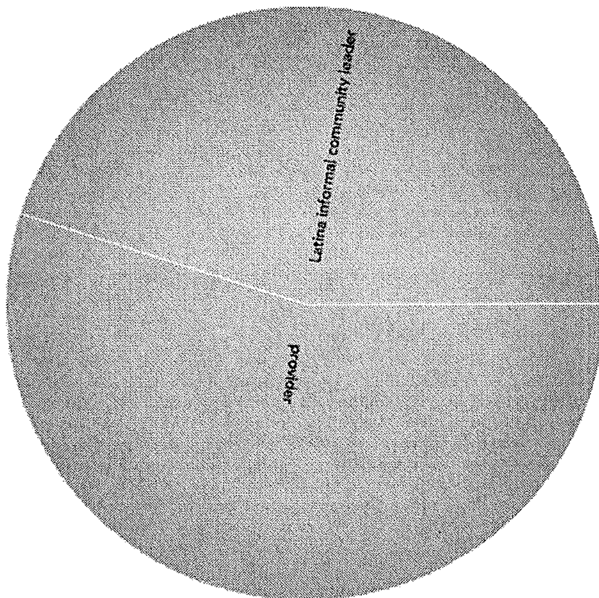
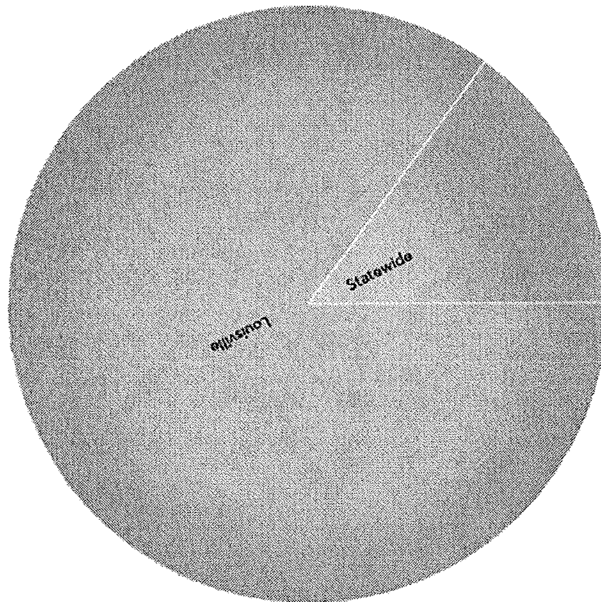


Figure 4. Participants by Location



Reflections and Observations

As a Latina immigrant who has heard all her life about how Latinos tend to be late, have a "loose" concept of time, etc., I am actually rather punctual. This "time" issue is widespread and institutionalized in strange ways. For my own wedding in Peru, we invited people 30 minutes before the actual ceremony in order to make sure guests would actually be there for the ceremony. This is a common practice in Peru and possibly in other Latin American countries. Most people know that invitations to parties and dinners are within an hour of the time given. In my experience in Peru, there are also great differences in terms of understanding or communication of time and distance between rural and urban populations. I am wondering if the same is true in other Latin American countries (or even worldwide)?

As I work to schedule interviews with women who come predominantly from rural areas of Mexico, Central and South America, it is difficult to set a specific time and date for interviews. Mostly I get things like "some time next week", "in the evening some time", "on Monday, but we'll check in to see when—I'll call you when I can that day". It is hard to plan for my days as I keep a busy schedule and have young children who require childcare when I do interviews in the evenings or weekends (which is when many women can meet due to work obligations). I found myself experiencing some frustration and being annoyed that a stereotype about Latinos was feeling so real to me. I am one Latina that tends to be quite punctual, and I know many who are that way—although I also know many who joke about "Latino time" as they walk in late for meetings. I am also trying to remind myself that there is a class privilege involved in this punctuality, a matter of having attended university and worked in environments where timeliness is expected. I am also from a large urban center in South America, not from a rural area. The difference between the ease with which I can schedule interviews with providers versus Latina community leaders (mostly low income, informal leaders) is drastic. A number of the providers are Latina, but scheduling is done very much on a "professional" approach, whereas my interactions with the Latina community members are more personal, based on "confianza" (trust). One woman already said she wants me to interview her at her home and she wants to make me a big Peruvian breakfast (she knows I'm Peruvian too). It is a different approach and it is taking me aback—it is both pleasant and frustrating all at once. It is definitely making me think about my own identity as Latina, as a professional, as an urbanite, as a middle-class, educated woman. Privilege is rearing its head in an uncomfortable way—it is

good to make me aware of it. At the same time, I very much enjoy the openness and trust with which the woman I interviewed spoke to me today. She said she was telling me things that she's too embarrassed to talk to other people about, that she hasn't talked about with providers. I am straddling two worlds, as immigrants often do.

Inclusion/Exclusion Criteria

For the provider key informant interviews, participants selected had to meet the following criteria:

1. Work in Kentucky either at the local or state level, but can be employed by government, for- and not-for-profit organizations, or function as a volunteer, for at least three years.

2. Key informants can be male or female and all will be adult. (All key informants were female)

3. Interviewees will be from Louisville (largest urban area in Kentucky, and largest Latino population) and interviews will also be conducted with individuals working at the state level on women's health issues, who may be located in Frankfort (state capital).

4. Interviews were conducted by the P.I. in English.

For the Latina immigrant community key informant interviews, participants must have lived in Louisville, Kentucky for at least one year. All participants in this category were adult women who participate in one of the women's groups in the Latina

Women's Movement, a grassroots network of 12 support groups facilitated by the nonprofit La Casita Center. All interviews were conducted in Spanish by the P.I.

Reflections and Observations

Although I had not determined exclusion criteria based on age beyond requiring all participants to be 18 years of age or older, I had anticipated mostly recruiting reproductive age informal community leaders. However, I made the decision to definitely include women past reproductive age because the population I am recruiting from is a network of support groups (Latinas only) where a number of women serve as informal leaders. These women are the source of information and advice for many other women, so whether the woman I interview has had individual experience with family planning herself in Louisville or not is not a deal-breaker for the interview. In fact, because she is older, she may have younger women ask her questions about this sensitive topic. It is important to include these women in the sample. Further, two such women expressed interest in the interviews. Two women who said they were of "grandmother" age participated in the interviews. They both told numerous accounts of women coming to them for information and advice.

Tools, Instruments, and Equipment

A key informant interview guide with open-ended questions was used with each key informant participant group. The guides are attached as Appendix C. These guides were piloted with two individuals who work with the Latino community and one Latina community member. The two interview guides contain some questions that address the same issue but are asked in different ways to strengthen the tools' reliability. The

P.I. used the web-based analytic software, Dedoose (http://www.dedoose.com/#). The investigator also maintained a Journal of Reflexivity to capture the research process and the investigator's thoughts, perceptions, and insights during the process. The investigator took notes during each interview on the Participant Matrix (page 35).

Delimitations

While this study seeks to shed light on the experiences, perceptions, and attitudes on foreign-born Latina immigrants in regards to access to family planning, due to the approaches used (qualitative versus quantitative) and the small study population, findings cannot be presumed to apply to all or most foreign-born Latina immigrants.

This study lays its geographic parameters within the state of Kentucky, as an example of a new-settlement destination for Latin American immigrants. The majority of interviews were conducted with providers in Louisville, Kentucky—the largest urban area in Kentucky. The sample of Latina informal community leaders was limited to women in Louisville, Kentucky.

Analysis

A total of 20 key informant interviews were completed for this study. Data saturation was reached at around the 7th interview with the informal community leaders, so it was felt that 9 interviews were sufficient. In terms of the providers and policy providers, it was decided to give priority to health providers, as they seemed to have the most intimate knowledge of access to family planning issues. While

experiences differed among provider groups, similar themes were identified through all provider groups and data saturation was reached at around the 9th interview.

The key informant interviews were digitally audio-recorded and transcribed verbatim. The interviews conducted in Spanish were transcribed in Spanish and analyzed in Spanish. All interview digital recordings were sent to a professional transcription service, with all identifying information stripped from the recordings and labels for the recordings. To address concerns of reliability, the investigator double-taped all interviews; first read through all of the transcripts to familiarize herself with the information and checked against original recordings and notes; and checked multiple times that the file number and descriptors applied to each transcript was in fact the correct descriptor set. She also reviewed notes taken during the interviews prior to beginning the analysis. Notes of all methodological, data management, and research decisions were kept in the P.I.s Journal of Reflexivity to strengthen validity.

The investigator then entered the transcribed data into a database to be analyzed thematically using software for qualitative analysis (Dedoose--http://www.dedoose.com/#). Data was entered by participant type and descriptor fields were developed for each participant. The descriptor fields are stripped of identifying information. The investigator conducted a thematic analysis using the notes, transcription scripts, and audio-recordings. Line-by-line coding was initially conducted of all the data collected and over 50 codes and sub-codes were identified through this process. As part of an iterative and continuous comparison process, a second phase of coding was conducted where codes were compared to codes and codes were compared

to data excerpts under each code. Through this second level of coding, the number of codes was reduced to 26 codes and 7 sub-codes. Many of the initial codes were merged with other codes, while some were eliminated, as they were too broad. Again, to address reliability concerns, quotes were checked against the code definition during the analysis of the code reports to ascertain fit between tagged excerpts (quotes) and code definitions.

Following the second phase of coding, code reports were created that contained all the excerpts tagged under each code. Analysis was conducted within each code report to identify subthemes, and glean differences and similarities among participant population types. During this phase, the investigator also began creating memos to capture emergent themes and ideas, and inserted relevant quotes into the memos. The conceptual frameworks presented in this proposal were used as a guide and lens for analysis.

Once the code report analysis was completed and initial memos were written, the memos were compared to each other and relationships between these categories were elucidated. Groups of memos that were theoretically related were brought together to develop broad concepts and categories. A process of theoretical sorting took place to organize categories, link categories to each other, and provide a theoretical grounding to the memos and categories produced. Charmaz states that theoretical sorting "gives you a logic for organizing your analysis and a way of creating and refining theoretical links that prompts you to make comparisons between categories." [112]

Once these broader categories of related memos were developed, the themes and categories identified through the analysis were further reviewed to identify key findings as related to the research questions and sub-questions.

Key findings and related implications were developed through continued comparison of codes, memos, and through referring back to the data. Analysis was continuously grounded in and driven by data.

The investigator's journal of reflexivity that was kept from the beginning of the research process documented assumptions, experiences, thoughts, and bias from the investigator's perspective. This journal activity strengthened the credibility and validity of the data collection and analysis process. The journal explored issues such as what things the participants may or may not be telling her because of her identity, status, or experiences as well as evolving thoughts and perspectives on the research process and emerging codes. Reflections on if and how these groups of participants differ, the investigator's assumptions about how they would differ and why, were documented in the journal of reflexivity. This comparison provided another dimension to the analysis. The journal also served as a record of any methodological decisions made throughout the study.

Finally, the use of quotes grounds the themes and findings and provides another level of credibility. The analysis in this project is driven by the data in the form of participants' voices.

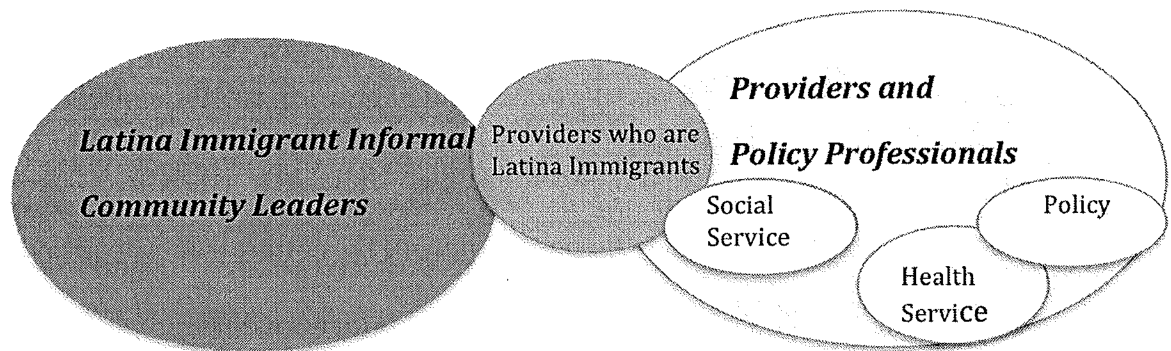
Reflections and Observations

Line-by-line coding is time-consuming but I feel like that is the most honest and systematic way of going about this analysis. I am aware that because I am a Latina immigrant myself and because I have worked with the provider and policymaker community for so long that I am at risk of assuming things as I code. I believe line-by-line coding provides the most protection from this risk.

Theoretical Sampling

The investigator employed a constant comparison approach throughout the analysis process. While performing analysis based on all participants' data, the investigator also compared the data based on participant population (professional providers versus Latina immigrant community leaders) to elucidate themes along those lines. As originally planned, the investigator analyzed the data by looking at the following variables within the codes developed:

Figure 5. Population Variables



The main analysis was conducted along the lines of the two primary groups: Latina immigrant informal community leaders and providers/policy professionals.

Analysis was refined by looking at themes within and among the professional category (social service organization, health service organization, and policy), and finally, professionals who are Latina immigrants represent a separate category that was used to probe further. The combination of key informant interviews, the journal of reflexivity, the literature review, and the comparison of data provided the study a level of theoretical sampling. By using these different sources of information about the use and perception of accessibility of family planning by immigrant Latinas in Louisville, Kentucky, the investigator has provided various ways of looking at the issue with the goal of accomplishing a more multi-dimensional and complete view.

Once findings were identified, the investigator performed a brief literature review to compare findings of this study to recent studies looking at family planning and reproductive health of foreign-born Latina immigrants was conducted. The investigator looked for and noted both similarities and discrepancies between this study's findings and those of other projects looking at similar issues. It is worth noting that the investigator found a few articles and reports addressing access issues and reproductive health of foreign-born Latinas published since the proposal for this project was written. However, these studies looked at Latina populations in states with a history of immigration, rather than a new settlement state such as Kentucky.

IRB and Ethical Considerations

An application was filed with the University of North Carolina at Chapel Hill Institutional Review Board (IRB) prior to beginning any of the research. Research (including recruitment) began in June 2011 once approval had been attained.

IRB approval required a total of four resubmissions. In the end, it was determined that the IRB was not comfortable approving this project with the original methodology of Photovoice. The combination of a highly participatory method, with a vulnerable population, and a sensitive research topic, was perceived by the IRB to place the potential research subjects in excessive risk. There seemed to primarily be a concern over coercion due to the P.I.s relationship with both the nonprofit, La Casita Center, and her familiarity with many of the women in the women's groups. While the P.I. is not employed through La Casita nor has she ever been paid by the organization, she has partnered with the organization on projects serving the Latina community and has frequently been to La Casita for events and workshops. The P.I. has facilitated workshops on women's health issues for women's groups at La Casita and other locations in Louisville.

Privacy and Confidentiality

For key informant interviews, appointments were made ahead of time to give the interviewees opportunities to schedule a time and place where they could talk in a private space. Audio-recorded responses attributable to an individual interviewee will remain confidential and stored in a password-protected computer that is solely in the investigator's possession. The computer (laptop) is backed up on a remote/virtual

service (Carbonite) that is also password protected and available only to the P.I. At no point will the name or any other element that may allow the reader to ascertain the specific individual or organization be identified.

Inducements, Coercion, and Costs

For key informant interview participants there was no monetary or explicit non-monetary inducements to participate. Participants were not paid. The only cost was their time and transportation to arrive at the meeting place of their choosing. Due to IRB concerns about coercion, the investigator did not directly recruit informal community leaders. Rather, the program director at La Casita, who regularly interacts with the women's groups, provided information to the women's groups participants about this study.

Benefits, Risks, and Mitigation of Risks

All research projects inherently carry some level of risk to those participating, and some offer some level of benefit to participants in direct or indirect manners. The potential benefits of this study are twofold and were described to all participants through an informed consent form and process: 1) to research and broader community and 2) to participants.

1) *To research and broader community*: Very limited knowledge and data currently exists in terms of Latina reproductive health in Southern states, and even less in Kentucky. There is limited body of work that provides a voice to the experiences of Latina immigrants in their own language and in a culturally-relevant manner. Because

of the inclusion of Latina community leaders and advocates, this research will provide insights into the role that family planning plays in Latinas' lives and health. This research will contribute to the current state of knowledge of the reproductive health beliefs, experiences, and perceptions of accessibility of Latina immigrants in states with new immigrant communities, such as Kentucky. This research will also provide new knowledge and insights for the local and state community in Kentucky in terms of addressing the reproductive health needs of the growing immigrant Latina population through community-informed policies and programs. Further, because this project is focused on applicable products, the advocacy community in Kentucky and beyond will have access to a synopsis of findings in English and Spanish. This product will be made available to any interested nonprofit, advocacy or service organization that serves or represents the Latino community.

2) *To participants*: Key informant interview professional participants may acquire further insights into the Latino population in Kentucky that they serve or represent but no immediate benefit is anticipated for these participants. For Latina immigrant community leaders, there may be some positive impact in having the opportunity to speak for themselves and their community on an issue that is seldom spoken about publicly. Because the women are "informal" leaders, the experience may also contribute to their self-perception as advocates and leaders for their community.

Potential risks to participants of this study were as follows:

For key informant interview participants the risks are minimal. Risks were discussed with participants during the informed consent process and an opportunity was given for participants to ask questions in regards to both potential benefits and risks.

Informed Consent

A fact sheet describing the research project was sent to the participants ahead of the interview via electronic mail and was also delivered in person at the time of the interview. Written consent was obtained from each interviewee before beginning the interview or beginning to audio-record.

For all the informal community leader interviews, the interview was conducted in Spanish and the consent form and project description were also provided in writing in Spanish. The consent form was also read out loud to all informal community leader participants by the P.I. prior to beginning the interview. Participants were asked if they had any questions about the consent form before signing the consent form. Written documents were written in Spanish by the P.I., who is a native Spanish-speaker, and standard Spanish-language translations of the consent form document available through the UNC website was used. Participants often did ask clarifying questions about the project. Of interest, many informal community leader participants expressed concern about the language of the consent form. They felt that the wording and length of the consent form was intimidating, and given that many immigrants are fearful of giving their names to government officials and other agencies, they asked the P.I. why it was necessary to have so much information about potential risks and negative outcomes. This was an opportunity to have a conversation about rights of persons

participating in research studies and also a lesson to the P.I. in terms of the literacy level of participants being matched to the writing level of the consent form. It also highlighted the fear that immigrants experience in any situation where they are asked to sign their name. All participants said they felt comfortable having me use their quotes, their country of origin, how many years they had been in the U.S. and Kentucky. Each of them also asked to make sure that their name would not be used with any of their quotes.

Reflections and Observations

Almost all of the community member participants have said that they are uncomfortable with the consent process. Many said they don't like the way things are stated in the consent form; that it is intimidating and makes it sound very scary. They ask me many times "but you are just going to ask me questions and I'll answer them, right?" They are confused as to why I have to go through all the sections in the consent form, and are particularly disturbed by the potential risks section. As I read the consent form out loud to them, I encouraged them to stop me and ask me questions as we go through the consent form, and most of them did. While the consent form is in Spanish, the tone and level of writing of the standard sections of the form is somewhat intimidating. I believe that if the women did not know me, they would hesitate to participate. I believe the standard consent form available through the UNC website should be reviewed to better balance the provision of complete information and accessibility of the information, with attention given to the literacy level and tone of the Spanish translation.

Duration and Participant Time Commitment

Key informant interviews lasted anywhere from 13 minutes to over one hour. All participants agreed to permit the use of their area of work (health service, social service, policy professional), location (Louisville versus statewide), and, in the case of informal community leaders, their country of origin, age, and years in Kentucky and the U.S.

CHAPTER IV
FINDINGS

Study findings were developed through an iterative, emergent themes approach. The results of this grounded theory analysis are organized according to the original research questions. The first research question, and its sub-questions (How do professional service providers and policy professionals compare with foreign-born Latina immigrants in terms of their understandings and expressions of ...) are answered below in this section. This section also includes the initial development of the structural determinants of reproductive health. This is an emerging framework that assists in understanding the multiple factors and levels at play in Latina immigrants' access to family planning.

One of the goal of this study was to explore the topic of family planning in a participatory manner and to provide a channel for the voices and experiences of the participants. To this end, the findings are presented in a way that retains the conversational tone of the participants during interviews. Further, as with the analysis, the findings are data-driven, and therefore the words of the participants are the leading voice presented. Language and choice of words convey meaning, and therefore, the investigator has chosen to present the quotes in the original languages and to provide a translation of the Spanish-language quotes following the original quote.

Findings

Overall, providers working closely with the Latino community are well-aligned in their understanding and perceptions of access to family planning with the perspectives presented by foreign-born Latina immigrant informal community leaders. This is particularly true in the case of providers who are Latina immigrants themselves. However, providers who speak Spanish and work closely with the community have a strong sense of empathy for the circumstances of Latina immigrants, and their perceptions of barriers and facilitators to access were also closely aligned with those of the Latina informal community leaders.

Those providers who do not speak Spanish and serve the Latino community only as a portion of their overall service-population, are the least closely aligned with the experiences and perceptions of Latina informal community leaders. This finding highlights reports that Louisville is a highly segregated city with limited experience with immigrants. This finding is also congruent with statements by many providers that the sizeable Latino community in Louisville remains invisible to the non-Latino community unless they actively work with them.

Reflections and Observations

The rhythm and tone of the interviews is different with the community members. With providers, they hear the topic and they seem to put that "hat" on. With each question, providers are ready with an answer. With the community members, it is much more informal, there is a good chunk of time devoted to chatting, catching up, asking about

children, how the summer is going, whether we like the heat, etc. Informal community leaders are also more anxious about the interview.

Community members are concerned with answering the questions "right" and are afraid that they'll answer it "wrong". Statements of a desire that my project will help make services better are often shared at the end of the interview. There are pauses in the interviews with community members, and often it is because they are afraid that they'll say something they shouldn't or will answer the question wrong. I was asked to stop recording by one participant so she could ask a question, then to start again. I was also asked by many of the community members to tell them what types of questions I would be asking so they could be ready. One person actually asked me to please read all the questions first, before we started the interview (but after consent).

I am reminded during these interviews that they are doing something that they are not necessarily comfortable doing (being interviewed, answering questions they are not sure they know the answer to) and that they do it because they want me to (and they trust that I also want to) work towards improving conditions for Latinas in our community. Participating in these interviews is a form of solidarity with other Latina immigrants. It is an example of their leadership in the community, although all of the women I interviewed are uncomfortable with the term leader being used for them.

The informal community leaders are participating, in part, because they trust me. When I ask them at the beginning of our meeting how much they know about this project, they all state that not much. The Program Director at La Casita Center (who is the one doing the recruiting) has been sharing the Project Description and recruitment

message with them. It seems that the women who decide to participate are doing it because they know me and want to support me in this project. They know it has something to do with health and Latinas because they know that's what I work on, but very few of the women has really had an idea of what the study is about until we go over it in person and with the consent form. This echoes what they have told me in terms of services—women talk about being more likely to go somewhere where they know someone, or have been told of the place by someone they know. "Confianza"—trust, familiarity. It seems that they decide they will participate when they hear that it is a project I am doing (even though I am not involved in recruitment, in order to minimize coercion). Some of the women share very personal things with me during the interview, beyond what I ask in the questions.

I feel that these interviews are something special. I don't want to exaggerate the importance for fear of feeling self-important, but I do feel that the women I speak with are stepping out of their comfort zone to do this because they believe it might have a positive impact on the Latina community and because they trust me. It is an honor and a responsibility to do this work.

The women (informal community leaders) I interview express anxiety about being interviewed. I assumed they meant that they were concerned about their identity, but when I reiterated I wouldn't use their names anywhere, they said that wasn't the problem. They were concerned about giving me valuable information and were anxious about their information being useful for the study. They also expressed hope that the study would help improve services for Latina immigrants. It seemed from

what they said to me that they decided to participate in the interviews in part because they knew me and trusted me, and because they believed that I might be able to influence how programs are given for Latinas. Some specifically talked about "people like me" being able to make a difference because I speak English and Spanish, and I'm Latina and understand the issues for Latinas but also work in the world of providers and non-immigrants. It made me keenly aware that I was both an insider and an outsider to them. I was enough of an insider to merit their trust and for them to share personal stories and give of their time and invite me to their homes. I was enough of an outsider that they believed I could influence providers.

I. How do professional service providers and policy professionals compare with foreign-born Latina immigrants in terms of their understandings and expressions of:

1. The social, political, and cultural context of Louisville, Kentucky.

a. Kentucky is described by providers as poor, racially homogenous, politically conservative, and challenged by numerous and severe health problems. These conditions, plus a reported **cultural resistance to change**, hinder the ease with which new populations can integrate into the broader community.

"Kentucky is a poorer, less educated, less healthy state than most other states in the United States." Social Service Provider

"Kentucky, compared to the rest of the United States, I would say is its own third world country." Health Service Provider

Most providers and policy professionals concur that Kentucky is politically conservative, citing powerful right-wing politicians from Kentucky, such as Mitch McConnell and Rand Paul. Some providers explain that due to this political context, organizations and individuals are not as proactive or outspoken on issues of reproductive health:

> *"But because of the political climate in a lot of places, we do not proactively take a stand on reproductive choice in a lot of instances." (Policy Professional)*

Expanding upon how reproductive health issues are addressed in the state, a policy professional refers to the strong influence that religion has in the state:

> *"I think there's also the strong presence of the Catholic Church or other faiths that discourage that or adopt very strict gender rules. So I think you need to do out-of-the-box work..." (Policy Professional)*

Another policy professional puts it this way:

> *"The state is primarily registered Democrats, although Republicans get elected more, I think statewide, than Democrats, and that means that our Democrats are voting for Republicans. We have a minority population in all 120 counties, but the minority population is like a very small percentage of the demographics of Kentucky." (Policy Professional)*

Kentucky is often described as a southern state, although many in Louisville like to say they are Midwestern. One policy professional speaks to this mixed identity this way:

> *"Part of Kentucky likes to say that we're not southern, but when it comes to race relations, services for women, education, we are not as progressive as many of the other states that are moving. We just – we rank in the bottom third of just about every indicator there is related to women." (Policy Professional)*

A cultural resistance to change is described by many providers. This issue often comes up after the interview is over, as a few providers convey frustration with various situations related to services for immigrants. However, some providers discuss it during the interview within the context of an environment that is less open to change as part of this overall conservative background:

> *"Culturally, it's, I'd say, fairly conservative overall, as far as just sort of approach to change, and new ideas, and incorporating innovations into the community. On the one hand, there's pockets that are I think pretty innovative, but I think, based on especially in the health community, extremely conservative, and not on the cutting edge of healthcare delivery innovations by any means." (Health Service Provider)*

Demographically, Kentucky is predominantly white, with little diversity and limited experience with immigration:

> *"I know that traditionally it hasn't been a state that immigrants come to as a first choice." (Policy Professional, Latina)*

When asked how one might compare Kentucky to the rest of the U.S., providers generally answer that Kentucky is poorer, more conservative, less diverse, and overall behind in how well new populations, like Latino immigrants, integrate.

> *"But I can tell you that compare Kentucky from the rest of the country, Louisville or Kentucky's learning behind. Like, compared to California, Texas they don't ha – we don't have – in Kentucky there was not a lot of experience with immigrants previously. Now, it's getting there, but they see some resistance build up." (Social Service Provider, Latina)*

Providers also provide comparisons of Louisville to the rest of the state of Kentucky.

> *"So Louisville is different from the rest of the state in that it's more multicultural, multiethnic but different from the rest of the nation let's say like big cities like Miami or New York or Houston, California were it still has, I think, a predominantly Anglo-Saxon base." (Health Service Provider, Latina)*

Another provider echoes this sentiment:

"It's relatively progressive compared to other parts of the state." (Health Service Provider)

Despite being described as a comparatively progressive city, Louisville is also characterized as "still a fairly segregated city" (Social Service Provider) A provider at a health service organization states

> *"I think that our communities in Louisville are probably ...are very segregated" (Health Service Provider)*

Another provider at a different health organization explains it this way:

"Like I have friends who have more traditional jobs, and they're like, 'What, there are refugees here? What, there are immigrants here?' So I think there's very clear demarcations of that part of the culture in the city." (Health Service Provider)

A provider at a social service organization explains some of the dynamics in Louisville in terms of its culture and how close-knit it is:

"I describe to people who ask me about Louisville, as a big city that feels like a small town, in terms of our population. We're the biggest city in Kentucky, and so I think those of us who live here kind of identify ourselves as from the big city. But on the other hand, it's a city where southern culture is predominant, and therefore a lot of people are connected through family ties, through growing up together, going to the same place of worship or living in the same neighborhood. And so people who are native to Louisville really rely on the connections for integrating into the community or participating in the community." (Social Service Provider)

This close-knit social context, where people have known each other and their families for generations, can also create resistance to immigrants.

Providers describe Kentucky as reflecting the overall national attitude towards immigrants, but with less experience with Latino immigrants than the rest of the country.

"I don't think Kentucky is as embracing of the Latino population as they should be. I believe that there is – there are so many stereotypes that are attributed to the

immigrant population, not only from whites to Latinos, but I think from other minorities to Latinos, and I think probably a lot of that is because of just the dialogue that's going on right now in the country about immigrants." (Policy Professional)

While some providers refer to a resistance or Kentucky as not welcoming to Latinos, others describe the Latino community as being invisible:

"I don't think they have realized yet how minority, in this case Latinos, is impacting the state. They haven't – either don't want to realize it or don't want to work on it, don't want to pay attention to it, that we're growing by the day." (Health Service Provider, Latina)

Another health service provider agrees, "I think that, for the most part, in Louisville they're just not seen."

Latina providers also express frustration at the limited knowledge in Kentucky of other cultures and the tendency for people who have little exposure to people from other countries to pack all immigrants into one box:

"Not everybody who speaks Spanish are from Mexico. We do not eat beans. Not all of us. But they just tend to assume that we're all from the same place because we speak the same language. So I think a lot of knowledge on all diverse populations and countries that we just happen to speak the same language." (Health Service Provider, Latina)

Overall, providers describe a resource-poor state with a conservative socio-cultural context that is resistant to change and slow to integrate new populations.

b. Providers and informal community leaders describe Louisville as a place in transition. As a new settlement state with an economic reliance on the growing Latino population and workforce, Kentucky is inconsistent in its political messages and actions regarding immigrants at the state and local level.

Providers and informal community leaders describe Louisville as having changed dramatically over the past decade or two. In many ways, providers describe a place that is slow to catch up with its changing demographics in terms of infrastructure, politics, and policies.

Latina immigrant informal community leaders tell similar stories of Louisville and the Latino community in Louisville having changed since they first arrived.

> *"Ya cada vez es mas y mas, aunque a veces por la situación económica también unos vienen y otros se van, verdad? Hay mucha rotación también. Y entonces si ha cambiado en ese aspecto." (Every time there is more and more, although sometimes because of the economic situation some come and some go, right? There is a lot of rotation as well. So things have changed in that respect as well. Mexico, 57 years old, 9 years in Kentucky)*

Another woman states

> *"también tenemos que tomar en cuenta que la comunidad hispana, hemos crecido muchísimo..." (we also have to take into account that the Hispanic community has grown a lot...Mexico, 43 years old, 15 years in Kentucky)*

Informal community leaders feel that Louisville has changed since they arrived, particularly in the past five to 10 years, in terms of the size of the Latino community as well as the services they were aware of. However, most state that they see new Latino immigrants go through similar experiences as they did when they arrived. Some of the women conclude that they have learned a lot since arriving so they know where to go, but that it is still difficult to find services and information for Latinos who are new to the community or Latinos that are not connected to the women's groups or other means of support. While the Latino community has grown, and in some pockets has become more organized, providers state that Latinos still lack a political voice.

"Well, unfortunately, politically they don't see themselves as strong, or it has to do sometimes because of the immigration status." (Social Service Provider, Latina)

Another social service provider elaborates on this topic of political voice:

"And for those who are documented, politically, I think that Kentucky is still a place where, due to the predominance of Anglo Saxon culture here in Kentucky, and being in the south, there's not a ton of political space for ethnic and racial minorities, period. So that is, again a space that is being slowly carved out. But even for Latina U.S. citizens who were both in Kentucky, I that there's less space for being politically active in a very public way."

Providers corroborate the experience of the informal community leaders by reporting that Louisville (and Kentucky) have changed significantly in terms of Latino immigrants in the past decade to two decades.

"I'm from Louisville so I've seen how the demographics of the city have changed over time. It's definitely a city that has become more diverse with immigrants, especially in the last ten years, there's been a huge surge in the number of Latino immigrants in the city." (Social Service Provider)

Still, providers do not feel that there is much information or understanding of the Latino community.

"The Latino population in Kentucky and in Louisville, it seems like it's kind of a mystery. There's just not a lot of information out there about this population." (Health Service Provider)

Although the Latino population has been growing over the past decade or two, Kentucky and Louisville are frequently described as still having much to learn about immigration and how to welcome and integrate immigrants into the community. Themes that were repeated included that Kentucky is not a state traditionally thought of in terms of immigrants from Latin America, and that Kentucky has been slow to recognize this influx of immigrants or to respond to it in terms of policies and programs.

One provider explained when asked about providers' roles in Latina immigrants' access to family planning:

> *"I wouldn't say they hinder as much as maybe they're just not very good at it." (Health Service Provider)*

This general sentiment is repeated by providers, with the caveat that they do not feel that there is an intention to limit or block access to services, but rather a lack of understanding of what barriers immigrants face and therefore a lack of action to remove those barriers. Providers state that there is lack of access to family planning services due to omission, but not commission, on the side of providers and organizations.

> *"Ok, so the services are there, why aren't people accessing them? The barriers that are there are not intentionally placed there. But are the barriers being addressed quickly enough and effectively enough? No. They're helping because the services are there, but they're hindering because they're not addressing them and addressing the barriers as effectively as they could be." (Social Services Provider)*

Some providers feel that the unintentional barriers that organizations and providers sometimes create for immigrants are partly there because there's a lack of positive political messaging or action around immigration in Kentucky. One policy professional provides examples of how she saw immigrants' experiences change with a change of political office at the local level

> *"...the areas where I would say are more positive are areas where there are concrete policy initiatives, message from key leaders, programs in place, resources for interpreters...For example, a few years ago in Lexington the mayor changed, and the old mayor who had been positive toward Latino immigrants left. The new mayor came in and courted or allowed space for many anti-immigrant outspoken people to come in, and it changed the whole tenor of the community." (Policy Professional)*

This policy professional goes on to say:

> *"I almost think in that community you need to have a positive proactive response in order to say it's...not a negative response...In other words, doing nothing is often times enabling labor exploitation, enabling overcrowded housing, enabling lack of interpreters, children pulled out of school to be use as interpreters, racist behaviors to flourish."*

While Kentucky has been quick to embrace the fast growing Latino workforce, including in many of its key industries, the state has failed to articulate a proactive stance on immigration or immigrants. As one policy professional puts it:

> *"For some reason, I believe, overall Kentuckians, they like the idea of immigrants being here to work, but they don't like the idea of them being able to go into a clinic or have a Medicaid card or their children to be sitting next to ..."*

Both Louisville and the state of Kentucky as a whole have changed dramatically over the past ten to twenty years in terms of diversity. Still, its reported cultural resistance to change has kept Louisville and the state in a slow state of transition.

c. Latina informal community leaders report experiencing isolation, rechazo (rejection), and fear, in part, due to systemic community deficits in language access, transportation, and community outreach and education. Despite these negative experiences and numerous accounts of perceived racism and discrimination, Latina immigrants generally describe Louisville in more positive terms than do providers.

> *"Fue mi lucha de diez años, porque diez años me duro a...adaptarme aquí a Kentucky. Me sentía completamente sola, completamente triste." (It was my battle for ten years, for ten years it took me to adapt to Kentucky. I felt completely alone, completely sad. Peru, 48 years old, 17 years in Kentucky)*

> *"...porque yo creo que eso es lo que los limita más, el miedo ..." (because I think that's what limits them the most, the fear...Mexico, 38 years old,10 years in Kentucky)*

The feeling of fear seems to underlie much of what informal community leaders talk about during the interviews. The women identify that fear exists in many forms: immigrants experience fear for numerous reasons, explored below; providers experience fear that they will be punished for working with or helping undocumented immigrants; and non-immigrants feel fear of immigrants from lack of exposure and experience with persons who are different from the majority in Kentucky.

> *"Y a la gente le da miedo, sí." (And the people are afraid, yes. Mexico, 38 years old, 10 years in Kentucky)*

Fear gets to the root of the lived experiences of many immigrants, particularly undocumented Latina immigrants, in Kentucky. Fear is how informal community leaders convey the experiences of not understanding the language; not understanding the health system; not knowing how to drive in a city with limited public transportation; of driving without a driver's license; and of not knowing if they can trust providers at clinics or other agencies. In general, there is a fear of the unknown that surrounds them and a fear of knowing that they have no legal or financial recourse to protect themselves or their families. It is a fear of being vulnerable and not being able to do much about that state of vulnerability.

> *"Pues el pensar en que te va a llevar la migra si no eres documentada, que si voy al doctor me va a llevar la migra y luego más si tengo una enfermedad, de ese tipo; o sea uno se imagina tantas cosas... Más me van a botar o qué estoy haciendo o no sé." (Well to think that the immigration is going to take you if you are not documented, that if I go to the doctor then immigration is going to take me and then what if I have a disease of that type; I mean, one imagines so many things...so they're going to throw me out or what am I doing and I don't know... Mexico, 45 years old, 10 years in Kentucky)*

Women are not comfortable seeking services they believe they don't deserve or won't be able to pay. Some women also state that they think those who are

undocumented are often the most committed to paying their bills because they don't want to call attention to themselves.

> *"...pero uno siempre está con el temor de que no, no tienes el derecho por no tener un documento y te sientes, no voy a decir avergonzado, pero sientes el temor, que no puedas cubrir igual los gastos, pero y la necesidad médica sí todavía es algo bien grande para nosotros ..." (...but one is always afraid that, well, you don't have the right because you don't have documents and you feel, I'm not going to say embarrassed, but afraid that you won't be able to pay for the cost, but, and medical needs are still a very big thing for us... Mexico, 29 Years Old, 7 Years In Kentucky)*

A concrete fear that is repeated by all informal community leaders is the fear of being stopped by police and of being deported. This fear is primarily due to being undocumented, but many also describe racial profiling, fearing that they will be targeted, whether documented or not, because they "look" Latina.

> *"Y todo, están con, con el temor de ser deportados y, y no poder estar. Entonces, eso es lo que el, el temor que le va de, de ir a – ir a, a – por esa ley establecida de que por nuestra apariencia de latinos, es de que nos van a, nos van a parar..." (And everything, they have the fear of being deported, of not being able to be here. So then, that's what, the fear of, that, because of that law that was passed, because of our appearance as Latinos, that we are going to, that we'll be stopped...Peru, 48 years old, 17 years in Kentucky)*

Some fears are extreme, like fearing being killed for trying to access a service. These fears have to be taken within the context of each person's experiences in their home country as well as their journey into the U.S.. Many Latina immigrants come from countries where they experienced significant violence, sometimes directly and personally, and other times through living in a violent environment.

> *"Tienen miedo porque no tienen los papeles de aquí, y luego piensan, y si me meto a esa clínica y me llevan, me matan, eso es mucho de eso." (They're afraid because they don't have papers, and then they think, and if I go in to that clinic and they take me, and they kill me, there's a lot of that. Guatemala, 35 years old, 9 years in Kentucky)*

For those who are undocumented, many have come across the border under extenuating circumstances and have suffered abuse, exploitation, and violence. Expecting violence for not having papers is not an exaggerated fear if past experience has indicated that violence is used as a way to control, intimidate, and punish. A woman explains that she was treated badly on her way to Kentucky, as she came over the border as an undocumented person:

> *"Y esas personas se sienten mal y se sienten mal porque aparte como te tratan cuando te vienes, en el camino y en todo; a mí me pasó cuando yo me vine aquí, a los dos nos trataron mal y aparte que yo ya había sufrido en el camino." (And those people feel bad because besides how they treat you when you come, on the trip and everything; that happened to me when I came here, we were both treated badly and I had already suffered on the way. Guatemala, 35 years old, 9 years in Kentucky)*

Immigrants' pasts remain close, even when they are far from home. While they might have left their country, they have family back home--their parents and many times their children, and they fear for the wellbeing of those they have left behind. A provider recounts the experience of one of her patients:

> *"The political mood and the environment in Mexico too with the drug cartels. I had one gal, she's kidnapped and held for ransom, $20,000. So he has four children here in the United States...And they had to get money together, they're housekeepers, they clean homes for a living...and now they pay the cartel or the people from the village $1,000 every month so they can leave the man alone." (Health Service Provider, Latina)*

Fear also arises due to not understanding or being able to communicate in English.

> *"...y además que no entendemos el inglés no sabe uno lo que están diciendo ni qué nos están preguntando, entonces ya nos asustamos y reaccionamos de diferente*

forma." (...and plus we don't understand English so we don't know what they're saying or what they're asking us so we get scared and react in a different way... Mexico, 57 years old, 9 years in Kentucky)

The situation is further complicated for Latina immigrants who's first language is not Spanish, but have learned Spanish as a second language, and now face learning English as a third language.

> *"Bueno, la más grande es ser inmigrante porque es por el miedo que tienes porque tenemos mucho miedo porque de repente algunos que manejan, de repente ya los paró la policía, les pidió los papeles y no tienen o les piden la licencia y no la tienen y otro es el, eh, no hablar inglés, nosotros, muchos de nosotros como Guatemala hablamos mam y entonces poquito que, poquito que puede en español y entonces, te sientes mal—" (Well, the biggest one is being an immigrant because of the fear that we have, lots of fear because maybe some drive, and maybe the police stopped them, they asked them for papers and they don't have them or they asked them for driver's license and they don't have it, and the other is, umm, not speaking English, and we, many of us, like from Guatemala, we speak Mam and so then the little that, the little that we can in Spanish, and so then you feel bad...Guatemala, 35 years old, 9 years in Kentucky)*

While most of the accounts of fear described by informal community leaders were of fear by immigrants themselves, some also speak of the fear that non-immigrants have of immigrants and the fear that some providers have of serving immigrants. Because of a proposed state law that would have found persons who assisted undocumented immigrants guilty of a felony, some feel that providers might be less willing to help them, and that providers may also experience fear of the immigration laws.

> *"Pues ahorita en lo que estamos viviendo recientemente con todas esas propuestas de ley anti-inmigrante, como que muchos médicos también les da miedo involucrarse más con la comunidad hispana algunos no, pero pienso que a otros sí, porque ellos pueden sentir que están siendo amenazados por el hecho de tratar a esa comunidad hispana. Entonces eso sí es como una barrera que se está creando*

dentro de la comunidad, y los, los lugares que tene... proveedores de servicios, entonces...." (Well right now with what we're living recently in terms of all these proposals of anti-immigrant laws, then there are many doctors also that are afraid of getting involved more with the Hispanic community, some not, but others, I think that others are, because they might feel that they are being threatened for the fact that they treat the Hispanic community. So that's like another barrier that is being created in the community, and the places that, the providers of services, so...Mexico, 43 years old, 15 years in Kentucky)

Along with fear, informal community leaders use the term "rechazo" repeatedly. Rechazo means rejection, and the women interviewed use this term in combination with accounts of discrimination and racism.

"Sí, todo lo que es antiinmigrante, porque... y sí pasa, o sea, uno siempre a veces siente el rechazo." (Yes, everything that is anti-immigrant, because...and it happens, I mean, one always, sometimes feels that rejection. Mexico, 43 years old, 15 years in Kentucky)

Some participants speak of this rejection, or discrimination, occurring directly in health care settings.

"En cuestión de hospitales, y de doctores, bueno de lugares, sí, sí, hay un poco más de racismo en ese sentido." (In terms of hospitals, of doctors, and well places like that, yes, there is a bit more of racism in that sense. Mexico, 38 years old, 10 years in Kentucky)

Interestingly, the same women who speak of rechazo, will state that their experience in Louisville has been mostly positive, but later in the interview they recount stories of perceived language discrimination and racism. There seems to be a desire to say that things are not so bad, to not complain, while concurrently sharing stories of things that have happened to them and to others they know that clearly represent negative experiences. Most of the women I interviewed have risked a lot to come to the U.S. When they arrive, regardless of how they feel, they see no choice but to make do. Many immigrants in Louisville, and in the U.S. as a whole, faced many

challenges in their countries. Many faced violence, racism, and discrimination in their own country, and they come to the U.S. and find some of the same challenges.

> *"No tengo otra salida, porque lo mismo que me tratan de donde vengo y asi me tratan aqui, estoy sola." (I don't have another way out because the same way that they treat me where I come from and that's how they treat me here, I am alone. Guatemala, 35 years old, 9 years in Kentucky)*

Most of the informal community leaders describe the Latino community in Louisville as lacking unity, which contributes to the sense of rejection and isolation. The majority say that they have experienced or been told of Latinos discriminating against Latinos.

> *"El rechazo de algunas personas, usualmente conoces a una persona y tal vez tratas de brindarle el tiempo, tratarle de entender y eso, pero hay personas que definitivamente no... Americanos e igual Latinos." (The rejection of some people, usually you meet someone and maybe your try to give them the time, to try to understand them and all, but there are people that definitely don't...Americans as well as Latinos. Mexico, 29 Years Old, 7 Years In Kentucky)*

The statement above also points to the highly diverse population that Latinas represent and the deep classism and racism that exist in much of Latin America.

> *"He visto más discriminación por medio de latinos que de americanos, en mi persona. No con mi experiencia, sino personas que vienen." (I have seen more discrimination by Latinos than by Americans, in my case. Not in my experience, but with people that come here. Mexico, 57 years old, 9 years in Kentucky)*

> *"Por ejemplo en este, aquí hay personas como inmigrantes como nosotros, con mucho, hay personas que te ignoran, no te hablan o te miran mal, mmm...entre nosotros como inmigrantes..." (For example, in this, here there are people, like immigrants like us, with a lot, there are people that ignore you, they talk badly to you or they look at you badly, mmm...among us, like immigrants...Guatemala, 35 years old, 9 years in Kentucky)*

As an observation during interviews, the investigator noted that the women that state that they have not experienced any racism or discrimination personally have higher educational levels and hold higher status jobs. There is also an observed

tendency for women who are of more European appearance to report better overall experiences in Louisville and to view Latinos' experience in Louisville generally in a more positive light.

The experiences of fear and rejection contribute to the general sense of isolation that most of the women describe, particularly when speaking of the first few years in Louisville. It is everything from the very big things to the seemingly small things that create a feeling of isolation for women. For some women who lived in other parts of the U.S. prior to coming to Louisville, they feel that Kentucky doesn't have as many resources for Latinos. Women talk about missing their families, missing the food from their countries. It is a loneliness and isolation experienced through all the senses.

> *"Y entonces, pero...siento que muchas veces cuando llega uno por primera vez y que no conoces a nadie y te encuentras en primer lugar con la barrera del idioma, con la barrera de la transportacion, con la barrera de que la comida aqui es bien diferent y que es bien...no encuentras...como hacer de comer..." (And then, well...I feel that many times when you get here for the first time and you don't know anyone and you find first the language barrier, the transportation barrier, and the barrier that the food here is very different and that it is very...you can't find...how to cook...Mexico, 57 years old, 9 years in Kentucky)*

> *"Pero cuando nos vinimos a los Estados Unidos entonces fue bien dificil porque yo no se ingles, yo no sabia manejar, y entonces todo el tiempo encerrada, y este...y pues fue bien dificil." (But when we came to the United States then it was very hard because I don't know English, I didn't know how to drive, and so I spent all the time locked in and ummm...and well it was very difficult. Mexico, 45 years old, 10 years in Kentucky)*

This finding of isolation as a generalized experience for immigrant Latinas builds upon past research findings of language and transportation as contributors to a sense of isolation for immigrant women. Hess et al have reported that "limited English proficiency reportedly leads to a sense of isolation for some immigrant women..." and lack of transportation can exacerbate this experience.[113,114]

Providers don't speak of the issues of fear, rejection, and isolation as frequently but those who work closely with Latino families, describe situations much like what the informal community leaders describe:

> *"The Latinos that we serve they are from low-income class. A lot of them are single mothers facing loneliness, facing housing issues, language barriers, lack of transportation. Some of the women they don't know how to drive. They don't know how to use a phone sometimes, or even they don't speak Spanish...because they speak a dialect from their own country. So they don't know about the law, and they don't know their rights." (Social Service Provider, Latina)*

This same provider goes on to say that sometimes providers just don't know how to help immigrants and other times they are simply discriminating against immigrants. She describes situations of discrimination that some of her Latina clients have shared with her.

> *"It depends on the situation, but I think sometimes it's a combination and sometimes they express directly to the ladies, 'This is not your country. You're not supposed to be here.' I mean, and that is called discrimination; a very clear action of discrimination."*

Another provider admits she was taken by surprise when one of her patients shared with her that she had been discriminated against.

> *"I saw a mom the other day, and the child was in elementary school. I said, 'Oh, I've heard that's a really good school. I'm sure you're really pleased.' She's like, 'No, I don't like it all because I feel like they discriminate against Hispanic families.' So I asked her more about that, and she said, 'There's not many of us there. It's not a big school that Hispanic kids go to.' She said, 'I feel like they discriminate against us.' So I didn't even think about their school experience beyond the language issues." (Health Service Provider)*

Providers also get to the issue of fear by speaking about the fear that a proposed immigration law at the state level has instilled in the Latino community, even though the law was not passed.

"It was an Arizona copycat, and there are still rumors that that is the law among Latinas...immigration raids that happen...there is immigration enforcement, we've seen people just yank their kids out of school or stop going to the health clinic... I think, an increasingly hostile environment for immigrants." (Policy Professional)

"And so they've also really cracked down on even people with small infractions, misdemeanors, speeding tickets, parking tickets, things that before would never get you a visit from ICE on your door, now that's what's happening. So, again, that's another ripple effect, but I think that it's definitely worth noting, that people tend to access services less." (Social Service Provider)

Providers echo informal community leaders' concern that some providers fear immigrants. Given that Kentucky is predominantly a white state with limited immigration experience (and most immigrants in the past were European and looked much like the people already in Kentucky), there is a sense that people in Kentucky are not used to and therefore at times are perceived as being afraid of, Latino immigrants.

"I think in many social services, there's a lack of understanding, there's a lack of cultural competence, and there's just a lot of fear. I'm talking on a regular basis, people who are encountering an immigrant woman for the first time or a Spanish-speaking person for the first time in their whole lives, adults, and adults who maybe have been doing their jobs for years, who, yeah, again, for the very first time are encountering someone. So I think that there is some fear, and misunderstanding." (Social Service Provider)

When hearing the stories of the informal community leaders, it is important to put them into the historical context of Latinos in the U.S. "Latinos, both citizen and noncitizen alike, have consistently been marginalized in the United States. The historical experience of Latinos in this country is one composed of multiple episodes of discrimination and exclusion."[115] To what degree Latina immigrants arrive in the U.S. with the knowledge that Latinos have historically experienced discrimination and exclusion is not clear in this study. However, as every woman interviewed had personally experienced discrimination or knew of someone who had, it is safe to

assume that discrimination, and the feeling of rechazo, is a known theme within the Latino immigrant community.

These feelings of fear, rejection, and isolation can have significant implications in terms of access to family planning. Kossler et al examined Latinas with a history of discrimination and found that over half of the women in their study reported a history of discrimination.[116] The researchers found that the experience of gender-, race-, and socio-economic discrimination negatively affected the likelihood of a woman using an effective contraceptive method.[117]

Amazingly, informal community leaders will describe these experiences and stories of fear, rejection, and isolation and at the same time describe Louisville as a place that is pretty, nice, and overall a good place to live. This may speak to the resilience of the women, as well as to the fact that most of the women hold few options or alternatives to living in Louisville. It may also be a function of the fact that the women interviewed are part of a network of supportive women's groups. The reported effect of belonging to these women's groups is discussed later in this section.

d. Kentucky's vocal anti-choice movement and increased political opposition to public funding for contraceptives combines with anti-welfare rhetoric emphasizing personal responsibility which undermines already lagging Title X funding, creating provider concerns about sustained funding for family planning services.

Despite a majority—about two-thirds, of the U.S. population supporting public funding for contraceptive methods (particularly through the Affordable Care Act provisions), there is a rising, political opposition to federal regulations for private

health insurance plans to cover the full cost of contraceptives.[118] Providers reported anxiety about losing funding as a primary barrier to family planning access for Latina immigrants in Kentucky. Providers also cited recent efforts to cut funding to Planned Parenthood in Indiana, Kentucky's neighbor to the north. Geographically, Louisville sits on the Ohio River, directly across from Indiana. The region is referred to as Kentuckiana, and some people who work in Louisville, actually live in Indiana. In fact, Kentucky borders seven states, and for people living on those border areas, what happens in neighboring states can have an impact in terms of service access as well as the political fall-out of controversial policies.

> *"Luckily, we're not facing the type of legislation that Indiana has, with Planned Parenthood funding being stripped by the state. But I hate to say, I wouldn't find that to be a farfetched idea here in Kentucky. I wouldn't be surprised if someone wants to jump on that bandwagon." (Social Service Provider)*

While Kentucky has not so far threatened to cut funding for Planned Parenthood, as Indiana has for Medicaid funding, locally in Louisville, Planned Parenthood has experienced difficulty in the past having Title X funding approved. A few years ago, the local Council in Louisville delayed disbursing Title X funds to Planned Parenthood because of very public debates about Planned Parenthood's provision of abortion services. Interestingly, Planned Parenthood in Kentucky does not provide abortion services. However, the fact that the national organization supports and other affiliates do provide abortion services, has been enough to maintain a very divisive and controversial cloud over Planned Parenthood in Louisville and throughout the state.

> *"Well, as you know we've been back and forth with Planned Parenthood not getting their fundings they need, which that will affect even though a lot of Latinos don't know about it, but it will affect." (Health Service Provider, Latina)*

Providers also discuss the limited funding they receive through Title X compared to the need for subsidized family planning services. Nationally, Title X funding has remained flat for many years, and this has been attributed, at least in part, to the political debates around contraception and personal responsibility versus government assistance in family planning.

> *"So we receive Title X funding so that we can provide services on a scale so if we have someone that's donation only and a lot of our Spanish speakers are donation only or 20% or 30% meaning they cover only 20 or 30% of the cost and we cover the rest. If they come back in it covers their exam but if they come back in for another visit, which seems more than likely, we don't get reimbursed for that. We don't get reimbursed for my time spent. When we have a Spanish speaker, that's one whole extra person that's needed for this stuff. So I guess in terms of policy when it comes to family planning and access in Kentucky is – it's funding." (Health Service Provider)*

Providers discuss the difficulty of providing comprehensive family planning services in a state that is considered highly restrictive in its reproductive health policies. In Kentucky, issues of contraceptive access and sexuality education converge with arguments around abortion. The rhetoric around abortion access in Kentucky is extreme and at times violent.

This type of environment creates fear and anxiety for both community members as well as for providers.

> *"The next thing I thought of was abortion and it's really hard to get an abortion in Kentucky...it's still very difficult to access abortion services especially if you don't speak English as well as there's a crisis pregnancy center right next door to the EMW Clinic [abortion provider clinic] and if you're a non native English speaker, you may get a little confused and go into the wrong clinic and it would be easier to be misled it seems like." (Health Service Provider)*

Another provider speaks to this concern of limited availability of comprehensive family planning in regards to the conscience clause:

> *"I think it's such a matter of personal decision. I mean I realize that there's that conscience clause and things like that but I don't think women are getting the full spectrum of like options. You know, what are their options and being talked about in really open and complete ways." (Policy Professional)*

Yet another policy professional speaks to the way that conservative politics and policies interact with limited access to reproductive health services:

> *"...and the conservative legislature continues to put barriers up. Even walking into – if they do get to the women's services facility, it's just very difficult for them to – after a well thought out decision, to even walk in the door because of all the protesting going on. I think it's very difficult. In Northern Kentucky, I don't think they can get access to any reproductive services, and I'm not talking about elective abortions. I'm just talking about just regular reproductive services because the Catholic hospitals have merged with the other hospital that perform reproductive services, and they're just not available." (Policy Professional)*

Where rhetoric about pro-choice versus pro-life run into rhetoric about personal responsibility, particularly in a time of economic hardship, funding for public programs supporting family planning becomes a target. This economic, political, as well as social tension around the provision of family planning, and other reproductive health, services seems to weigh heavily on providers working with and serving Latino immigrants, as well as with policy professionals addressing issues facing women throughout the state.

2. <u>The scope and meaning of family planning.</u>

a. Family Planning is understood by foreign-born immigrant Latinas to be a multifaceted, complex, and highly-valued concept, informed by past experiences and current social context. The primary purpose of family planning is expressed as the ability to provide their children with the attention, love, and education that they each deserve.

"...planificar a – de tener a tu familia en menor, menor cantidad de, de hijos, pero, con la finalidad de darle calidad y tiempo, de poder atenderlos a ellos. Yo no puedo decir los numerous si es uno, dos o tres, o cuatro, nos... no sé." (to plan to—to have a family in smaller size, less number of children, but with the goal of giving them quality and time, of being able to attend to them. I can't say what that number is, if it is one, two or three, or four, I don't know...Peru, 48 years old, 17 years in Kentucky)

"Sí, claro, sí, yo siento que entre menos hijos les da uno más, creo yo" (Yes, of course, I feel that the fewer children you have the more you can give them, I think. Mexico, 38 years old, 10 years in Kentucky)

Throughout the interviews with informal community leaders, it was clear that regardless of age, or how many children they had (or if they had children at all), family planning conversations were about children. The point of family planning, for the women I interviewed, is to make sure that you can provide as best as you can for the children you have.

"Y en otra manera es que, si uno no los planifica, tampoco les puedes dar, lo que cada niño merece, o lo que uno tiene como expectativa para cada niño, eso." (And in another way, if you don't plan them, then you also can't give each child what they deserve, or what one would like to give each child, and that. Mexico, 43 years old, 15 years in Kentucky)

None of the women talked about control over their body, sexual freedom, or even disease-prevention when asked about family planning. During some interviews, asking about family planning led to discussions about how to raise children in the United States. For some women, it also meant being able to have the number of children you truly want to have. A number of the women I spoke to uncomfortably stated that they did not want to have as many children as they had. They assured me that they love all of their children, but if they had been able to plan, they would not have had all of them. This was particularly the case for women who had been in abusive relationships.

"Es tener *los hijos que realmente uno quie... desea tener, en mi caso fue bien difícil." (It's having the children that one truly wa...that you desire to have, and in my case that was very difficult. Mexico, 43 years old, 15 years in Kentucky)*

A provider who works closely with Latina immigrants, says the focus on children is central.

"In the Latino community, many of the immigrants have come here saying, 'I came here for my children for a better life.'" (Policy Professional)

When women are asked about how important they think family planning is to Latina immigrants, they all respond that it is very important. They explain the reason for its importance as the ability to provide for their children, in terms of love, time, and education.

"Es importante, porque vuelvo, vuelvo y repito, es el hecho de darle calidad de tiempo a mis hijos." (It's important, because I say it again, it's the fact of giving quality to my children. Peru, 48 years old, 17 years in Kentucky)

A few women state that they feel in their countries family planning isn't really talked about, that it's not part of the culture. However, there seems to be a consistent message that women from Mexico relay in terms of fewer children being better. In fact, many of the Mexican women actually refer to the messages they heard in Mexico about having fewer children. Some of the women elaborate upon this issue, and state that while they had heard many times that fewer children is better, they did not understand why that was the case until they came to Louisville and learned about family planning in a different way through the women's groups.

"Y en nuestro país todavía no hay tantas personas que digan, —'No, vamos a planificar, vamos a tener tantos hijos.' Todavía no existe de esa manera de pensar." (And in our country there still aren't that many people that say, 'No, we're going to plan, we' re going to have these many children.' That way of thinking doesn't yet exist. Mexico, 30 years old, 6 years in Kentucky)

A few informal community leaders talked about the role of religion on family planning, and one specifically discussed how Catholic religion does not provide guidance the way she hoped it would in terms of reproductive health.

> *"Era los hijos que Dios te mande y nomás ¿verdad? Y afecta mucho sobre todo la religión porque normalmente los latinos somos católicos, y la religión católica pues no orienta cómo debe de orientar..." (It was the children that God sends you and that's it, right? And that affects everything, especially religion because normally we Latinos are Catholic, and the Catholic religion, well, it doesn't provide the guidance that it should...Mexico, 57 years old, 9 years in Kentucky)*

Another woman states that the way she was raised was very influenced by religion, that in turn affect her knowledge and attitudes towards family planning.

> *"Mucho, sí, yo creo que sí afecta mucha gente todavía por sus costumbres, o por, ¿cómo se le puede llamar? Por religiones o por eso, todavía este... nos educan en ese sentido..." (A lot, yes, I think that it affects many people because of their customs, or because, how can I can say it? Because of religions, and that, they still raise us in that way. Mexico, 38 years old, 10 years in Kentucky)*

Many women talked about how gender roles, and specifically how machismo, affects the attitudes and ability to practice family planning. Machismo is discussed as a cultural barrier to family planning:

> *"Yo sé que es complicado porque nuestra cultura no es tan... es más... no sé, no sé si la cultura americana sea... la verdad no lo sé, pero en la que a mí respecta, sí son muy machistas todavía." (I know that it's complicated because our culture is not as...it's more...I don't know, I don't know if the American culture is...the truth is I don't know, but in respect to my culture, they are very machista still. Mexico, 30 years old, 6 years in Kentucky)*

Another woman talks about how women are raised within strict gender roles that emphasize a more passive role for women. Women discuss gender roles beyond machismo, with a few of them talking about how they feel that their cultures and the

way they were raised leaves women vulnerable and undervalued. The majority of women talked about marrying very young, late teens or maybe 20.

> *"Usualmente nos enseñan que nos tenemos que casar, y vivir con una pareja tal vez por toda la vida, respetarla y hacer... como un machismo pero no, nos desprotegen como mujeres, no nos dan el... no nos enseñan que también tenemos valores que, que deben respetarnos, que somos mujeres y que somos importantes y ya es, es mucho de lo que ha pasado en nuestro países, que siempre tenemos que aceptar muchas cosas, en respecto a la pareja, tenemos que aceptar bastantes cosas y nos desprotegen..." (Usually they teach us that we have to get married, and live with one partner, possibly for the rest of your life, to respect them and do...like a sort of machismo, but they don't, they don't protect us as women, they don't give us...they don't teach us that we also have value, that they should respect us, that we are women and we are important and it's, it's a lot of what has happened in our countries, that we always have to accept too many things, in terms of our partner, we have to accept lots of things and they leave us unprotected...Mexico, 29 Years Old, 7 Years In Kentucky)*

Women made the connection between traditional and rigid gender roles and the ability to make informed decisions about reproduction:

> *"Cuando la mujer tiene que ser muy sumisa y obediente, y comportarse decentemente pero sin sexo, ¿verdad? Entonces, como que eso el afecta a uno mentalmente, porque, por ejemplo, a mí me pasó con mi primer embarazo, yo realmente no quería tener ese... o no quería embarazarme, pero como yo estaba embarazada, no tenía otra opción mas que continuar con esta persona, y tener al bebé; pero pienso que si hubiera sido los papás o la familia más abierta, hubiera tomado una decisión muy diferente." (When the woman has to be very submissive and obedient, and behave decently but without sex, right? Then, that affects you mentally, because, for example, it happened to me with my first pregnancy, I really did not want to have...I did not want to get pregnant, but since I was already pregnancy, I didn't have another option but to continue with this person and have the baby; but I think that if I'd had parents or a family that was more open, maybe I would have made a very different decision. Mexico, 43 years old, 15 years in Kentucky)*

Mirroring what is reported by informal community leaders, Maternowska et al find that "reproductive decision-making is a combination of personal preferences and socio-cultural factors...reproductive health outcomes are influenced, in addition to other factors, by the power inequity in the family and society...."[119]

Further, her research identified that men have a cultural pressure to become fathers as an expression of masculinity. Indeed, a preference for larger families was found among recent Mexican male immigrants.[120]

One woman talked about the incongruence of Catholic teachings about family planning and machismo:

> *"Ay, es que son muchas cosas, porque yo sé que la religión católica se enfoca mucho a todo lo natural, que la ovulación y ese tipo de cosas; desde mi punto de vista es muy bueno. Pero la cultura y las tradiciones no estamos preparados para eso, porque el machismo pues es "cuando a mí se me antoja y se acabó", que no qué esperarnos, –"Que nos tenemos que esperar a que no estés ovulando"–, o que: –"Cuando si queremos un hijo lo vamos a hacer cuando estés ovulando"–, no, no, ellos... estoy cansada, y yo no necesito, –"Y es cuando yo quiero no cuando tú me digas o cuando se pueda"–; entonces yo creo que eso es difícil." (Oh, it's just that there are lots of things, because I know that the Catholic religion focuses a lot on what's natural, on the ovulation and that kind of thing; from my point of view, that is very good. But the culture, the traditions, we are not prepared for that, because the machismo, well, it's 'when I want it, and that's that', not that we wait, 'that we have to wait until you ovulate', no, no they... 'I'm tired and I need...' It's 'When I want to not when you tell me or when we can'--; so I think that it's difficult. Mexico, 57 years old, 9 years in Kentucky)*

Addressing family planning is complicated by many cultural taboos.

> *"Hay muchos tabús, hay mala información o no. No es mala información, no se maneja bien la información. Pienso que nuestra cultura... es que son muchas cosas." (There are lots of taboos, there is bad information or no...Not, it's not bad information, we don't handle the information well. I think that our culture...there are just lots of things. Mexico, 30 years old, 6 years in Kentucky)*

A woman from Mexico relays the difficulty in even talking about family planning:

> *"Hay mucho de nuestra cultura, no podemos hablar sobre cosas de sexualidad o... métodos anticonceptivos o algo, es algo que allá es muy criticado, muy, vulgar sería para allá, usualmente no puedes hablar ni siquiera de tus partes de tu cuerpo, y es algo bien difícil ahí." (There are lots of things in our culture, we can't talk about things about sexuality or...contraceptive methods or something, it's something that is very criticized there, very, it would be considered vulgar there,*

and usually you can't even talk with your parents about your body, and it's something very difficult there. Mexico, 29 Years Old, 7 Years In Kentucky)

Women cite general attitudes about sex playing a role in the idea and practice of family planning.

"A mí me acostumbraron mis papás a que si tienes sexo con alguien es hasta que te casas; todavía estoy media anticuada...Incluso hablar de 'vagina' se me hacía algo sucio, para mí 'sexo' era 'sucio', era algo malo" (I was raised by my parents that if you have sex with someone it's when you're married; I'm still a little old-fashioned...even talking about 'vagina' felt like something dirty to me, to me 'sex' was dirty, it was something bad. Mexico, 45 years old, 10 years in Kentucky)

These cultural norms and attitudes towards sex, the body, and family planning affect how women view and access family planning. One woman spoke of the discomfort she experienced when talking about reproductive and sexual issues, and especially receiving care from a male provider:

"Sí, da vergüenza si lo hablo con cualquier persona, y especialmente si digamos, vamos al médico, nos tocaba un ginecólogo hombre, como que ahí ya no nos...Sí, ya no hablamos." (Yes, it's embarrassing, if I talk about it with any person, and especially if, let's say, I go to the doctor, and I got a male gynecologist, then, it's like we don't...well, we just don't talk. Mexico, 43 years old, 15 years in Kentucky)

Another woman expanded on the way cultural attitudes about sexual and reproductive issues can lead to delaying gynecological and reproductive health care because of the discomfort it causes:

"Porque normalmente en nuestros países aunque sabemos que nos lo tenemos que hacer nunca vamos con el doctor, ni mucho menos a ese tipo de chequeos que nos molesta tanto como es un Papanicolaou y ese tipo de cosas ¿verdad? que los dejamos a un lado..." (Because usually in our countries even if we know that we have to do it, we never go to the doctor, especially for those types of check ups that bother us so much, like the Pap and that kind, right? We leave it to the side...Mexico, 57 years old, 9 years in Kentucky)

Women experience discomfort discussing sexual and reproductive issues with providers and also with other Latinas. A woman explains that she has experienced

being judged by other Latina immigrants for wanting to learn about family planning and wanting to teach her children about these matters.

> *"No, yo pienso que es difícil, es bien difícil porque una persona que no sabe, pero ahora que las cosas es más abierta aquí y todo, pero con nosotros como mujeres, como ejemplo donde yo vivo en mi país, en Guatemala pues en México también porque yo he hablado con las muchachas. "Bueno es que no tienes que hablar de eso porque eso no se habla, porque no sirve, porque les estás enseñando a los niños a ser, como... yo no le voy a contar eso a mi niño, yo no le voy a decir nada, ella no tiene que saber nada porque sino ella va a ser prostituta", es lo que dicen." (No, I think it is hard, it's really hard because a person that doesn't know, but now that things are more open here and everything, but with us as women, for example, when I lived in my country, Guatemala, and in Mexico too because I've talked to other women, 'Well, you shouldn't talk about that because that's not something you talk about, because it's no good, why are you teaching the children to be...I'm not going to tell my children that, I'm not going to tell them anything, she doesn't need to know that because otherwise she's going to be a prostitute,' that's what they say. Guatemala, 35 years old, 9 years in Kentucky)*

For many women, maintaining the traditions and customs of their country is an important way of maintaining their identity. Women convey this by expressing internal dilemma about adopting new attitudes while trying not to reject the attitudes of their parents and culture. Some women explained that they didn't want to offend or disrespect their family by doing things very differently. Others wanted to maintain the sense of belonging to their family and their culture, and they feared being excluded if they changed their views dramatically. Informal community leaders perceive attitudes as being a lot freer in the U.S. in terms of sex and family planning, and fear that some Latinos might believe that talking about and using family planning is becoming "gringa" (Americanized):

> *"...que te juzgan que te estás haciendo gringa, te dicen, porque estás haciendo cosas que no debes." (...that they judge you that you're becoming Americanized, they tell you, why are you doing things you shouldn't be...Guatemala, 35 years old, 9 years in Kentucky)*

"Porque es a lo que a nosotros nos enseña, es algo que no quieres... en mi opinión o en lo que pasaba conmigo es mi cultura es lo que yo traigo desde que nací, no quiero romper con eso porque no quiero ser diferente a los míos, a lo que yo considero mío, mi origen, no quiero hacer algo que me dife... que tome la diferencia entre mí y ellos, esa era una de las ideas que yo tenía, pero es que mi familia hizo algo así y ellos hacen esto, y es realmente la cultura es bien fuerte y eso, pero hay cosas buenas, hay cosas realmente bonitas, no todo es malo, pero si es más educación y más información." (Because it's what we're taught, it's something that you don't want...in my opinion or what happened to me is that my culture is something that I brought with me since I was born, and I don't want to break with that because I don't want to be different from my people, from what I consider my own, my origins, I don't want to do something that will...that will draw a difference between me and them, that is one of the ideas that I had, because my family did things this way and they do this, and it's really that culture is very strong and that, but there are good things, there are really good things, nice things, not everything is bad, but definitely more education and more information. Mexico, 29 Years Old, 7 Years In Kentucky)

The social, economic, and cultural realities of their new home influence and change the women's attitudes towards family planning, even as they desire to hold on to their cultural identity and values. Maternowska et al, in studying reproductive decision-making of recent Mexican immigrants in Mexico, state "...traditional family-centered ideals and values, reinforced by culturally ascribed gender roles within families of origin, remain strong, but are also under strong social and economic pressures to change."[121]

As women change their attitudes and practices with time, they try to remember what it was like when they first arrived and had not been exposed to some of the information that they have now. One woman states that she tries to understand other Latina immigrants who don't realize that they need family planning because she says she once did not realize how important it was for her.

"Yo no me daba cuenta que yo los necesitaba, que yo como que es algo que necesitas diariamente y que no lo ves, que no quieres creer que es algo necesario,

que está ahí, todo el mundo te lo está... te lo pueden estar regalando, pero tú no te das cuenta, no has aprendido que es algo que necesitas; crees que no es necesario, crees que no es tan importante cuando realmente sí es importante, y eso es algo que yo aprendí." (I didn't realize that I needed it, that it was as if it is something that you need every day and you don't see it, that you don't want to believe that it is something necessary, that it's there and the whole world...they could be giving it away to you and you don't realize it, you haven't learned that it is something that you need; you think that it's not necessary, you think it's not really that important when it really is important, and that is something that I learned. Mexico, 29 Years Old, 7 Years In Kentucky)

In all interviews, discussion about family planning begin and end up returning to, the topic of children. Some women include the topic of parenting in family planning.

"Y, por otro lado, también planificación familiar en cuanto a apoyo para los niños, y cómo ser mamá o papá con los niños, para ayudarlos, apoyarlos a ellos, que tengan la calidad." (And on the other hand, also, family planning in terms of support for the children, of parenting the children, to help them, support them, for them to have quality. Peru, 48 years old, 17 years in Kentucky)

Women bring up concerns about retaining their culture and raising their children with values that they hold important when discussing family planning.

"Mi mayor preocupación. El hecho de ver que nuestra cultura es distinta en el aspecto de las costumbres, la – lo – la moral." (My main concern. The fact that our culture is so different in terms of customs, to the, the, the moral aspects. Peru, 48 years old, 17 years in Kentucky)

The same woman goes on to speak about how children in her culture are raised very differently from children in the U.S., even though all of her children were born in the U.S.:

"mis hijos están acostumbrados de una forma y los, y los americanos están acostumbrados a otra forma, otras costumbres." (My children are used to one way, and the, the Americans are used to another way, other customs. Peru, 48 years old, 17 years in Kentucky)

Another woman considers how to educate your children as one of her main concerns:

"si tenemos hijos, cómo educar a los hijos..." (If we have children, how to educate those children...Mexico, 43 years old, 15 years in Kentucky)

Yet another woman who does not have children identifies the raising and education of children as one of the main concerns of the Latinas that she knows:

"Para las mujeres Latinas yo creo que la educación de sus hijos..." (For Latina women I think that the education of their children...Mexico, 57 years old, 9 years in Kentucky)

Women always circle back to the importance of family planning in order to provide children with a good upbringing. One woman explains that while she heard a lot about family planning in Mexico, it was not explained well. Many women felt that although they'd heard about family planning in their country, they did not understand it in a way that helped them make decisions. In many ways, what the women may be referring to is that while the message of family planning is present in Mexico, it is provided without visiting or addressing the many cultural and religious beliefs and practices that play integral roles in the attitudes and practice of family planning of Latinas. The women interviewed recognize the multiple factors that play a role in their understanding and practice of family planning. Cultural gender role norms, cultural taboos around sex and sexuality, religious influence around family planning, and the pressures of immigration on the ability to provide for their children are some of the factors that women articulate as essential to their views of family planning.

"... pues allá en México te dicen mucho de la planificación, pero en realidad tampoco se ponen así como aquí lo aprendimos de profundo, con profundidad, que me encantó como lo... a lo mejor si lo hicieran en todas partes así, no hubiera tanto niño sin... ¿cómo se dice? Sí, nacería tanto niño, o sufrimiento de los niños, no ve que los niños son los que sufren; como más conscientes de lo que hacen, es bien importante eso." (Well, over there in Mexico they tell you a lot about family planning, but in reality they don't present it that way like we did here, we learned it in-depth, with depth, that I loved...maybe if they had done it that way in every

place, there wouldn't be so many children...how do you say it? Yes, so many children would be born, or the suffering of the children, because it is the children that suffer; so like more conscientious of what they do, that's very important. Mexico, 45 years old, 10 years in Kentucky)

b. While all Latina informal community leaders interviewed highly valued family planning, most expressed a lack of comfort and knowledge about family planning and contraceptive methods prior to coming to Kentucky and participating in the Latina women's groups.

During the interviews, women were asked about family planning and where they learned about family planning. All women converged on the idea of family planning being focused on being able to care for their children and considered family planning very important. Yet, most women stated that they learned about family planning in Louisville. The exception was two women who stated learning about family planning at school and the university. These women also hold higher status jobs and are older than the rest of the participants. There may be a socio-economic or generational difference at play.

Women generally replied:

"Aquí en el grupo, en el grupo y... pues allá en México te dicen mucho de la planificación, pero en realidad tampoco se ponen así como aquí lo aprendimos de profundo, con profundidad, que me encantó como lo..." (Here in the groups, in the group and ...well in Mexico they tell you a lot about family planning, but in reality they don't give you information in-depth the way we learned it here, in depth, and I loved how we...Mexico, 45 years old, 10 years in Kentucky)

"El, el lugar – do... Como dije, cuando estudiaba escuchaba de la planificación de, de no tener muchos hijos, pero, en sí, lo que me ha hecho concientizarme mucho más de la planificación familiar, es aquí en Louisville, en el grupo de mujeres, que nos, nos – iban personas profesionales a poder hablarnos de los métodos, como poder cuidarnos, algo que realmente yo no, no – desconocía, no sabía de la – de la forma como poder evitar tener quizás tantos hijos sin planearlos o desearlos y, y

poder cuidarlos. Entonces, ahí en el Grupo ... es donde conocí la planificación familiar." (The place, where...well, like I said, when I was in school I heard about family planning, of not having too many children, but, really what made me take conscience a lot more about family planning, is here in Louisville, in the women's group, where they, professionals came to speak to us about the methods, how to take care of ourselves, something that really, I did not, I didn't know, how to prevent having so many children without planning them or wanting them, and being able to take care of them. So, really it's here in the group...it's where I learned about family planning. Peru, 48 years old, 17 years in Kentucky)

Some women felt that they did not learn about it at all, they found out about family planning through having children in the U.S.

"No, no lo aprendí en algún lugar en específico, lo aprendí yo porque he tenido bastantes malas experiencias por mis embarazos y porque desde siempre pensé que dos o tres hijos era suficiente." (No, I didn't really learn about it in any specific place, I learned about it because I have many bad experiences with my pregnancies and because I always through that two or three children is enough. Mexico, 30 years old, 6 years in Kentucky)

"Hasta desde cuando yo llegué aquí, y cuando, bueno, cuando yo llegué aquí, luego, luego yo salí embarazada desde que me casé y fue cuando empezaron a... a informarme con el doctor primero, y luego ya después cuando llegué aquí en Louisville, en estos grupos de apoyo que también dan mucha información fue donde yo me empecé a tener la información." (Until I got here, and then, well when I got here, then, I got pregnant as soon as I was married and that's when I started...to learn with the doctor first, and then when I got here to Louisville, in these support groups that also give you lots of information, that's where I started to have that information. Mexico, 38 years old, 10 years in Kentucky)

The women were also at different stages of knowing about family planning. One woman stated that she is just now learning about it.

"Ahora, eso estoy aprendiendo ahora porque yo no lo sé antes." (Now, I am learning about it now because I didn't know before. Guatemala, 35 years old, 9 years in Kentucky)

In addition to the lack of general information and knowledge about family planning and contraceptive methods, some women also shared negative experiences

they had in their home countries with family planning. A woman recalls having had a tubal ligation without consent in Mexico, without being informed of it until after the fact.

> *"Y yo sí me sentí, me sentía mutilada." (And I felt, I felt that I was mutilated. Mexico, 45 years old, 10 years in Kentucky)*

For this woman, not understanding what the clinic workers had done to her when she went in to deliver her baby made the act all the more horrible. She said that it was not until much later that someone explained what a tubal ligation was and she understood what they had done to her.

The women interviewed felt that overall the Latino community in Louisville lacks information about family planning. Women stated that the Latino community needs to have information taken out to them, but it has to be given in a way that is accessible.

> *"...pero yo creo que en la comunidad lo que tiene que ayudar a las familias, es a la información porque si ellos no están informados, ¿pues cómo van a tomar una decisión de algo que no saben? ¿Verdad? Y a veces... y tampoco no les podemos decir: –'Tienes que hacer esto porque esto es mejor para ti'–, pero podemos dar todas las alternativas..." (...but I think that there has to be help for families in the community, it's the information because if they don't have the information, well, how can they make a decision about something they don't know, right? And some times...and also, we can't say: 'You have to do this because it's better for you'—but we can give them choices... Mexico, 57 years old, 9 years in Kentucky)*

The issue of lack of information, and the need for information, came up repeatedly:

> *"Pero no hay mucha información ni hay cómo conectarla a otras redes de información..." (But there isn't much information out there or how to connect it to other networks of information. Colombia, 63 years old, 8 years in Kentucky)*

During interviews, women point out that lacking information about family planning and family planning service providers is not necessarily relegated to newcomers.

> *"Y gente que tiene mucho tiempo aquí y no sabían de lugares..." (And people that have been here for a long time and they don't know about places...Mexico, 38 years old, 10 years in Kentucky)*

Women consistently expressed a desire for more information about family planning and all contraceptive methods. Some women stated that information was the key to opening the door to new things. Without more information, women may find that they are unable to make informed decisions about an issue that they believe is very important to their lives and the futures of their children.

> *"Qué es mejor para cada una, porque no saben si es mejor que el parche, que las pastillas; ellas se confunden porque realmente no hay una información clara acerca de la elección que se vaya a hacer del método, eso sí es la pregunta, qué es mejor" (What's best for each one, because they don't know which one is better, the patch, or the pills; they get confused because really there isn't any clear information about how to choose a method, that is the questions, which is better. Colombia, 63 years old, 8 years in Kentucky)*

c. Health providers and Latina informal community leaders report that Latina immigrants have a preference for non-hormonal contraceptive methods, particularly the IUD. However, all informal community leaders seem to place a higher premium on having a full spectrum of options of methods than on any particular method.

> *"When a wide array of contraceptive choices is presented to a patient in Spanish, they skip right over the hormonal ones and go to ones that are non-hormonal. So it's not always verbalized by the patient. That's the sort of thing that we think of as private and I think our patients do, too, so they don't feel like they need to justify to us what they want." (Health Service Provider)*

> *"Entonces, sí, lo importante sería tener la información y tal vez detectar lo que la otra mujer necesite. Por que no todas las mujeres necesitamos el mismo tipo de*

anticonceptivos, sino también dependiendo su situación de vida." (So, yes, the important thing would be to have information and maybe to know what the other woman needs. Because not all women need the same contraceptives, but it depends on the situation in her life. Mexico, 43 years old, 15 years in Kentucky)

As stated by the health provider above, many of the women interviewed mentioned not wanting to take the pill because it wasn't good for them, or not being sure that it was safe if they wanted to have a baby in the future. There seemed to be a latent preference for non-hormonal contraceptives as reported by the health service providers and some of the informal community leaders. However, informal community leaders also discussed the difficulty of accessing birth control pills. Past studies have found a similar preference for non-hormonal contraceptives among Latina immigrants and Latinas have the lowest rate of contraceptive use among all women in the U.S. There seems to be some fear about the possible side effects or long-term effect of hormonal contraceptives, and specific fears regarding the ability to get pregnant in a timely manner if hormonal contraceptives are taken. During the interviews, some women implied that during the time that they wanted to have children, they did not take any contraceptives until they were finished with childbearing altogether.

> *"Pero la verdad no quiero, no quiero ponerme nada en mi cuerpo, no quiero tomar nada. Con lo que yo estoy cuidándome son con condones, por eso, porque no quiero meterme nada en el cuerpo porque todavía no estoy decidida a tener otro hijo y no quiero obstruir que el cuerpo ya no está con pastillas y con nada y se puede retrasar un embarazo, no puedo quedar embarazada rápido o no sé, pero ahorita, a un doctor después de los embarazos no le he pedido una planificación...He leído y he sabido cosas de que no son muy seguras. Además, no reaccionan tan bien en todos los cuerpos y tengo un poco de temor con esas cosas." (But the truth is that I don't want to, I don't want to put anything in my body, I don't want to take anything. I take care of myself with condoms, because of that, because I don't want to put anything in my body because I'm not sure still if I want to have another child and I don't want to obstruct my body and now it's not on pills or with anything and it could delay a pregnancy, then I couldn't get pregnant as quickly or I don't know, but right now, I haven't asked a doctor after my pregnancies for any type of*

planning...I've read and I've known things that they are not very safe. Plus, not all bodies react as well and I am a little afraid of those things. Mexico, 30 years old, 6 years in Kentucky)

It is clear that, at least for some immigrant Latinas, there remain concerns and possibly misinformation and lack of information about hormonal contraceptives.

"Pero lo de yo tomar algo, no, no era nada, nada bueno para mí. Por también cuestión de salud." (But in terms of me taking something, no, it wasn't anything, anything good for me; also because of my health. Mexico, 57 years old, 9 years in Kentucky)

The women interviewed were clear that they need more information about the choices of methods and the effects that each method would have on them. The seeming suspicion of hormonal methods coexisted in the interviews with a desire and openness to learn more about every method. Inherent in the desire for more information about all the methods, was a sense that providers do not provide enough tailored information about contraceptives. Women were very specific that they did not want to be given something unless the provider had considered her specific circumstances and needs.

"Pienso seguir reforzando en los, los métodos que hay para cuidarse a – para ambos, hombres y mujeres. Seguir explicando los, los pros y los contras de, de estos, de estos métodos en los cuales pueda tener."(I think to continue emphasizing in the, the methods that are available to take care—for both, men and women. To continue explaining the pros and cons of these methods that they can have. Peru, 48 years old, 17 years in Kentucky)

Informal community leaders as well as health providers identified a strong interest by Latina immigrants in IUDs, which can be both hormonal and nonhormonal. Both groups also expressed frustration at the difficulty in accessing this type of contraceptive because of funding. Participants identified barriers to IUDs in Title X clinics as well as through private insurance plans.

"Sí, porque mira, como mi aseguranza no me cubre algunas cosas, lo que sí me cubre es un parto; a mí se me hace como que a veces no lo creo, cómo es posible que no me quieren... por ejemplo el aparato no lo pagan, que cuesta por decir así unos $500, y un parto les anda costando, mucho, mucho, carísimos, cuando es cesárea, en mi caso; y ellos no ceden a pagar ciertas..." (Because, yes, look, my [private] insurance plan will not cover certain things, but they do cover a birth; so to me it's like I can't believe it, how is it possible that they don't want to...like for example the device [IUD] they won't pay for, and it costs, let's say about $500, and a birth it costs them a lot, a lot, very expensive, when it's cesarean, like in my case; and they won't give in on paying certain... Mexico, 38 years old, 10 years in Kentucky)

While there was a clear experience on the part of health providers interviewed that Latinas preferred non-hormonal methods, and particularly preferred IUDs, Latina immigrants interviewed emphasized the importance of getting complete information about all methods, and conveyed a willingness to consider all methods if information is presented. The apparent fear or suspicion of contraceptive methods may be a manifestation of the limited knowledge and understanding that women feel about contraceptive methods in general.

d. The focus and emphasis on children's wellbeing as a purpose and driver for family planning diminishes the disease-prevention aspects of family planning in the discussion and reported practices of Latina immigrants.

Latina informal community leaders focused on the pregnancy-prevention aspect of contraception and family planning, given that the primary aim of family planning is to enable them to provide the best situation for the children. During these interviews, they did not focus on family planning for protection from diseases. Even women who talked about learning about attending STIs workshops through the women's groups, when asked about their experiences with family planning, they did not bring up contraception as disease-prevention. In fact, some felt that if they could no longer

become pregnant (age or having had a tubal ligation, for example, or using a hormonal contraceptive), they did not have to worry about barrier contraception.

"No, pues es que yo, como yo estoy ligada no..." (No, well, since I had my tubes ties, then no...Mexico, 45 years old, 10 years in Kentucky)

There appears to be a gap in some Latina immigrants' knowledge or application of knowledge of family planning and contraceptives as a form of disease prevention.

The benefits they see to family planning are for their children, possibly to the exclusion of viewing family planning as a way to protect their personal health. In fact, the only mention of contraceptives for disease prevention by an informal community leader was in terms of her child using contraceptives to make sure she did not get pregnant or contract a disease. However, women did talk about the importance of taking care of their general health so they could in turn take care of their children. This might be a way to emphasize the importance of disease prevention aspects of family planning and contraception.

3. The (instrumental and perceived) barriers to family planning use by low-income foreign-born Latina immigrants in Kentucky.

a. Providers and Latina immigrant informal community leaders concur that access to family planning in general, and to culturally-appropriate family planning specifically, is limited for Latina immigrants by factors within and outside of the health care system.

In addition to issues of access related to immigration status, transportation, and language access (addressed below, in the Finding I.3.a.), providers and informal community leaders cited lack of outreach and awareness of services (by providers as

well as community); lack of interpreters and written information in Spanish; lack of culturally appropriate services and information; cost of services and contraceptive methods; limited funding for subsidized services; capacity of subsidized programs to take new patients; lack of coordination and communication among family planning providers; and approach to the provision of family planning as a separate service—separate from other health services and visits, as barriers to family planning service for Latina immigrants in Louisville.

Similarly, Guzman et al found that the "three central issues that have a negative effect on the health outcomes of the immigrant women...a lack of access to health insurance and basic care, the unavailability of culturally and linguistically appropriate health services, and the lack of a comprehensive framework that offers preventative care as well as services to address the specific health needs of immigrant women, including reproductive health."[122]

The first level of barriers identified has to do with a lack of outreach around family planning issues and methods.

> *"…there's not a ton of outreach. I mean, there's outreach, but there's not a huge campaign to make sure that they know all their options, where they can go, what they can get where, and all of that stuff." (Health Service Provider)*

Informal community leaders actually seemed to know a little more about places to go for services than providers believe they do. However, the informal community leaders who knew of places, particularly Planned Parenthood, had been on a tour to Planned Parenthood with a women's group they belong to, so it is likely that the general population of Latina immigrants in Louisville would not know about these services. In

fact, informal community leaders reported that while they knew of some places to go for family planning, they had learned about them recently and that most of their friends did not know of places and often asked them for advice. One Latina health service provider expressed frustration that even she did not really know of where Latina immigrants could go to receive linguistically- and culturally-appropriate reproductive health services.

> *"I don't know of a place that I can go and say I'm going to go here because I know they're going to help me in Spanish and they're going to help me choosing what is the best birth control for me. I don't know of any place." (Health Service Provider, Latina)*

Once Latina immigrants do find out where they can go for family planning, providers stated that it is difficult to get an appointment through the Title X providers, which, due to the prevalence of uninsurance among Latina immigrants, is where most Latina immigrants would seek family planning care.

> *"I think it's important just to look at access to family planning, period. Because Louisville, I've always been surprised how limited their access is to family planning. It seemed like in other cities you could just get an appointment within two weeks. And sometimes you can't get an appointment in two or three months. And you cannot control your family planning if you can't get an appointment for three months. You just can't. It's a very time sensitive health issue. And if you miss your [inaudible] appointment, and you can't get in for another four weeks, there's a very good chance you're gonna get pregnant.*
>
> *So, yeah, access to family planning. And I think it's because people are just trying to access all the Title X providers...I don't know. Because you would think that that is such an easy service to provide. And nobody's monitoring it. It's not like the Health Department knows how long it takes to get an appointment." (Health Service Provider)*

The same health provider above goes on to address what she considers a lack of efficiency in health care provision.

"…because it's separated. There's the family planning provider, which also is not the way I'm used to practicing medicine, but there's all these papers that you have to fill out. And that is a barrier." (Health Service Provider)

In Louisville, Title X providers provide family planning services separately from other health services. While this is not a problem at clinics that exclusively provide reproductive health services (such as Planned Parenthood), at the federally-qualified safety net clinics that provide all primary care services individuals would have to make a separate appointment from a general health visit to address family planning. This provider explained that in other cities, she used to be able to address family planning as part of the general visit, without all the additional paperwork. The bureaucratic aspects of the Title X program seem to also be a barrier, in terms of the paperwork that the provider describes, and possibly a disincentive for providers.

Providers expressed concerns about the cultural and linguistic appropriateness of the services provided, once Latina immigrants are able to access family planning services.

"It costs money to have an interpreter. Or it would be easier if you can have someone trained as a medical assistant that is also bilingual. But do they know that? Do they go and target bilingual Latinos to get bilingual services in their place? I don't know." (Health Service Provider, Latina)

"I am not saying that it is not presented but because it is so important that information be presented in a way that culturally is accessible, they might as well not present it. So handing a piece of paper that says here are your birth control options is probably not going to be very effective. I think that is the most common way that clinics present the information. So sure, they could say we gave them the information but it is not done in a culturally appropriate way, which leads to a lack of effectiveness." (Social Service Provider, Latina)

The importance of culturally-appropriate information, in tandem with linguistically-accessible information, is addressed by many providers. All of the Latina

providers expressed some frustration at the use of substandard translations of materials by providers and concurred with this provider that sensitive topics such as reproductive health require cultural sensitivity as well in order to truly communicate the information to Latina immigrants. An informal community leaders agrees with the idea that linguistic-accessibility isn't always enough to truly communicate about health issues.

> *"...mira vas y entonces te hablan científicamente, y entonces dices... aunque te están hablando en español [risas] pero..." (Look, you go and they talk to you scientifically, and then you say...even though they're speaking to you in Spanish (laughs) but...Mexico, 45 years old, 10 years in Kentucky)*

Once Latina immigrants have accessed the services and decided to use a contraceptive method, there are further barriers. Both providers and informal community leaders expressed frustration with the limitation on methods available to Latina immigrants due to cost and funding.

> *"Other methods which don't require daily thought, for example, intrauterine contraceptive...or a subdural implant, are far more expensive and basically not attainable, not possible for women who might choose those methods not requiring daily intake and such. So basically those kinds of contraceptive methods that are most effective are not available at all due to their cost to our Latina immigrants." (Health Service Provider)*

Another health provider at a different health organization conveys a similar experience as the health provider above. This provider refers specifically to the experience of their Latina immigrant patients:

> *"One of the things is the types of family planning services we offer. Most of the women want IUDs, and we don't put IUDs in. So that's a barrier. And so we're constantly, especially if they've already lost their medical card, it's very hard to get. We provide some, but very, very limited because of the cost. The way Title X kind of – it's not like you get paid for the IUD. But we've been really working hard on accessing. There's two programs where you can get free IUDs, and things like that.*

But I think that's one of the hardest things, because they want IUDs, and we don't provide them." (Health Service Provider)

An informal community leader finds herself on the other side of the situation described by the providers above. She explains that she knows she does not want to have any more children and would like to have an IUD inserted, but has not been able to because of cost.

> *"Me limitan, sí y es, no es tan fácil, y incluso sí en esos lugares una vez también fui a ver si me ponía el aparato, y no, no me lo ponían, me lo cobraban también, entonces, por eso no me lo..." (They limit me, yes, and it's, it's not so easy, and in fact in these places, I went one time to see if they could put the device [IUD] in, and no, they wouldn't put it in, they wanted to charge me for it too, so that's why I didn't... Mexico, 38 years old, 10 years in Kentucky)*

One provider also speaks to the need for overall education for Latina immigrants about reproductive health and family planning. She tells me that she sees many obstetric patients and they do not receive appropriate support and education during their pregnancy.

> *"I do wish that we had the resources here to conduct prenatal classes totally in Spanish." (Health Service Provider)*

A provider at a health service organization that provides family planning services sums up the situation of family planning efforts for Latina immigrants in Louisville in this way.

> *"I mean there are efforts, they're just really small and they're new. They're just getting started and building momentum. And that's kind of how I see the Latino population is. It's small now, it's new, but I think that it's only going to get bigger and more powerful. We will have their children being born here and being able – speaking both English and Spanish, being able to vote. Again, like I said, I don't think that Louisville, in general, sees that Latino population as so much of a priority at the moment. But – and that's in terms of health. If you go to certain banks and different businesses I feel like they've really kind of seized the opportunity." (Health Service Provider)*

b. Both providers and informal community leaders report undocumented immigration status, transportation barriers, and lack of language access as the primary barriers to family planning services and information. These barriers to instrumental access create a sense of fear and isolation in Latina immigrants, contributing to a heightened perception of lack of access.

> *"...y todo viene de eso ¿verdad? de que las leyes de inmigración pues son bastante rígidas y duras, y no hay acceso para las gentes latinas que no tengan documentos." (...and it all comes from that, right? That the immigration laws, well, they're very rigid and hard, and there is no access for Latinos to have documents...Mexico, 57 years old, 9 years in Kentucky)*
>
> *"I would say that the language barriers and the lack of knowledge and transportation is huge." (Policy Professional)*

Immigration status is the most frequently mentioned topic in all of the interviews, with both providers and informal community members. Immigration status took several forms in how it was presented and discussed, but often it was mentioned directly.

While immigration was often mentioned on its own, as were language access and transportation issues, both providers and informal community leaders combined all three barriers in stories as they present themselves inextricably in the daily lives of immigrants in Louisville and the rest of Kentucky.

As policies, these three factors combine to create instrumental barriers for immigrants, in particular undocumented immigrants. Most often, providers and informal community leaders address these three issues as daily experiences rather than policies. The widespread awareness of these three barriers paints them as a backdrop to immigrants' lives.

One provider describes her experience with immigrants who would avoid seeking care altogether due to immigration status.

> *"So unfortunately, a lot of the women are being afraid of going in seeking for those services because they're scared to go. They're scared they're going to ask for papers; they're scared they're going to ask for legal status. So they just stay home. When they're pregnant it gets worse because they'll show up at the ER just to deliver the baby." (Health Service Provider, Latina)*

This same provider goes on to explain how clinic practices emphasize the fear surrounding immigration status.

> *"...they're asking for papers to fill out their birth certificate. So which it was before, that was not happening. And I don't think it's an overall policy; I think it's who you get; who is your social worker...That's one example. Another one is when they come for their appointment, ask them their legal status. That's illegal. That takes place every day. Every day. I've seen it, I've heard it, I fight for it." (Health Service Provider, Latina)*

Similarly, immigrant women without social security numbers face difficulty accessing obstetric and gynecological care at the public medical school's practice:

> *"If you don't have a social security number, you cannot be a patient there. As simple as that. Unless you have about six to seven hundred dollars when you get your first bill. If you have the money, you're more than welcome..." (Health Service Provider, Latina)*

Immigrants in Louisville are aware of their limited access due to immigration status, and this contributes to their perception of diminished rights.

> *"And lack of rights due to being undocumented, usually they continue to be poor. Politically, I think a lot is related to that, that many of the people that we work with, and just I would say it's safe to say a majority of Latina immigrants in Louisville are undocumented, and that means that they have fewer rights, and that they perceive that they have fewer right. Some folks are unaware of the rights that they do have to make complaints if they're not receiving certain services, to make a complaint if their rights are being violated in some way by a social service provider, by the police, by their domestic partner." (Social Service Provider)*

This idea is corroborated by an informal community leader:

"…porque se cree que uno no tiene derecho, que no porque no tienes documentos, no tienes el derecho a un servicio, a cualquier tipo de servicio" (...because you believe that you don't have the right, that because you don't have documents you don't have a right to a service, to any type of service. Mexico, 29 Years Old, 7 Years In Kentucky)

When it comes to immigration policy, simply having restrictive policies proposed can have a long-lasting effect on the immigrant community and their willingness to seek services.

"The anti-immigrant climate in general I think is worth noting, that many of us spent a lot of time last winter opposing anti-immigrant legislation, and I believe that that legislation has a huge ripple effect, in terms of, again, it may be unfounded fears, but fears of deportation or other repercussions just for being an immigrant in the state of Kentucky. So I think that that can affect access to services as well. And, again, the legislation was not passed, but it was proposed, and that was enough to, again, really create a climate of fear and also a climate of indignation among some service providers, too. I was just speaking with an immigration attorney yesterday, who was talking about all of the new cases that she's received lately, where it appears that a service provider has turned someone into ICE, just because they personally have a beef against immigrants, and especially those who are undocumented." (Social Service Provider)

Informal community leaders weave immigration status, language access, and the experience of being rejected as they describe the concerns of Latina immigrants in Louisville.

"Primero el no tener papeles, el ser rechazado, el idioma" (First the fact of not having papers, of being rejected, and the language. Mexico, 45 years old, 10 years in Kentucky)

Informal community leaders specifically relay fears of seeking health services because of their immigration status.

"Pues el pensar en que te va a llevar la migra si no eres documentada, que si voy al doctor me va a llevar la migra" (Well to think that the immigration is going to take you if you are undocumented, that if I go to the doctor they're going to take me. Mexico, 45 years old, 10 years in Kentucky)

One woman explains the situation that many undocumented immigrants find themselves in seeking health services:

> *"Bueno, pues tan solo no tener papeles ya te limita en todo, porque pues si no tienes un social security ya no puedes tener acceso a nada; y entonces... pues ya no haces nada, pues eso no puedes accesar..." (Well, just the fact that you don't have papers limits you in everything, because if you don't have a social security number you can't access anything, so then you don't do anything, you can't access it...Mexico, 57 years old, 9 years in Kentucky)*

In terms of language access, providers explain that there is simply a huge gap in understanding by providers of the importance of providing language access for immigrants. Even with good intentions, providers can limit access by not facilitating language access:

> *"I still have a really hard time because people will come, some other people that work in our programs will come to me and say, this woman is really great and really talk about some of her strengths but yet won't provide an interpreter..." (Policy Professional, Latina)*

Another provider agrees that providers may unintentionally create barriers to accessing family planning services for immigrants:

> *"...but I think that the use of kids, family members, often partners and friends as interpreters, one can imagine that that would just cut out a lot of effective communication around family planning..." (Policy Professional)*

A Latina provider speaks of the importance to not just use interpreters but also to have an understanding of how to ask questions and the dangers of simply assuming what a woman's response means.

> *"Or someone might ask did you want to have more kids and they said yes; okay, we assume that, okay, then they don't want to be on birth control. Just go on their way; they'll be back in ten months again or a year. I think there is a huge gap that needs to be covered somehow. Not only culturally but socially, language barrier,*

and we need to I think providers here in Kentucky, we need to stop assuming and ask more questions." (Health Service Provider, Latina)

Beyond knowing how to ask questions, the cultural element of language and communication become particularly important with sensitive issues such as reproductive health.

> *"I think the obvious one is language access. We have a long way to go with language access. There are definitely cultural barriers in that just because something is in the appropriate language doesn't it make it culturally appropriate. You cannot take something that has been done in this setting in English and just translate it into Spanish and assume that you are meeting the needs of that community. That is often times what is done. So, I see that as a huge barrier to access in a number of different things, but in particular to reproductive issues and family planning issues." (Social Service Provider, Latina)*

One provider talks about how she has seen how providing language access increases access to services by Latinos:

> *"Only because we know that the more interpreters that we hire the more families we have who speak Spanish. So I think there's definitely some word of mouth on the street." (Health Service Provider)*

Language access is an issue for all Latina immigrants, not just undocumented or low-income Latinas:

> *"Language I would say is one of the biggest barriers, and not only in my work with the current organization that I work with, but past work working both as a Spanish interpreter, and doing language access advocacy, you might have the most compassionate service provider, somebody who really, really, really wants to provide a service, and it still doesn't get provided because language; it boils down to language being the reason. Likewise, you might have a very educated and anxious service consumer, who want to access a service, and it boils down to language. And I think that language access also, again, is an issue for all socioeconomic groups. I think often we think, again, if you think about stereotypes or you look at the majority, sometimes you think, Oh, gosh, well, it's really the undocumented women that have the language access problem because they're uneducated. And that's just not the case. Just as many highly educated Latina immigrant women has a problem with language and language access as lesser*

educated, and less wealthy Latina women do. So language is a barrier that just, yeah, is very, very broad." (Social Service Provider)

Women experience language discrimination concurrently with other forms of discrimination, and a woman explains how she was treated by a worker at an agency:

> *"este te ven y luego te ven como de arriba abajo, y te ven como cosa; deberían de cambiar en ese aspecto, como es algo muy personal, deberían de poner empleados que no sean... pues que no sean racistas, que no sean racistas ni que vean... Ya porque eres latino te ven mal, simplemente verlo, y no, y cortantes, son cortantes ¿no? –'Ah, no, no sabe inglés entonces no, se va a esperar'" (Ummm, they see you and then look you up and down, and they look at you like you're a thing; they should change in that aspect, like it's something very personal, they should place staff that isn't...well that's not racist, that aren't racist and that don't see...that because you're Latino they look at you badly, just looking, and no, they cut you short, they're cutting you short. Mexico, 45 years old, 10 years in Kentucky)*

Sometimes providers and agencies give women important information written down in English. A woman explains that the information is useless to her if it is in English:

> *"Porque ahí sí, uno lo bota, si eso es en inglés, que no le entiendo nada, mejor a la basura, y a mí si me ha pasado, entonces no entiendo nada, a la basura, esto no me sirve, probablemente venía información muy importante, pero si no la entiendes..." (Because then, you throw it out, if it's in English, that I don't understand it at all, better for the trash, and it has happened to me in the past, so I don't understand anything, and to the trash, it's no good, it probably had very important information, but if you don't understand it...Mexico, 43 years old, 15 years in Kentucky)*

A woman explains that she has been asked about family planning services and information by other Latinas and that she advices them to ask for language access:

> *"Pero si ellas preguntan, yo les digo: –'Tienen que ustedes preguntar que ustedes quieren que les expliquen en español'–, o por lo menos que haya un traductor, un intérprete, sí." (But if they ask, I tell them: 'You have to say that you want them to explain it in Spanish'—or at least that they bring in a translator, an interpreter. Colombia, 63 years old, 8 years in Kentucky)*

A woman explains that it takes more time to seek services when you don't speak English, and she has experienced this as she has learned a little more English:

"Ahora que puedo un poco de inglés y eso, lo hago, es entendible lo que hablo y lo hago en inglés, y reduces el tiempo, reduces el tiempo que en tu idioma no." (Now that I speak a little English, and that, I do it, and it's evident that I speak and I do it in English, and it reduces the time, reduces the time that in your language it would not. Mexico, 29 Years Old, 7 Years In Kentucky)

Low literacy levels and illiteracy further complicate language access. While Spanish is the main language that Latina immigrants speak, there are some women who come from rural areas who speak other indigenous languages and who have to learn Spanish as a second language, and English as a third. One woman who has learned Spanish but whose native tongue is Maya (Mam), tells it this way:

"Yo abrí los ojos en todo lugar porque he conocido personas que si no pueden el español, solo maya, yo puedo pues ya puedo ponerla... y aparte ya no puedes leer y escribir, y entonces esa es la preocupación que uno tiene en este lugar." (I opened my eyes everywhere because I've met people that if they can't [speak] in Spanish, only Maya, then I can help...and then you can't read or write, and so it's that worry that you have in this place. Guatemala, 35 years old, 9 years in Kentucky)

Along with immigration status and language access, transportation is mentioned both as one of the main barriers to accessing family planning services, and a policy that has a strong effect on family planning access. Transportation barriers fall into the following categories: driver's license state policy; lack of public transportation system; and not knowing how to drive.

"You can't have a driver's license in Kentucky if you're undocumented. There's no public transportation in many, many part state." (Policy Professional)

In a city, and a state, with very limited public transportation, not having personal transportation is a tremendous barrier. The city of Louisville is a city of car-owners. Providers and informal community leaders report that many immigrant Latinas in Louisville do not know how to drive. Women, particularly, are dependent on their

husbands or boyfriends for rides to appointments, or rely on neighbors and acquaintances to take them to health and social service agencies.

> *"...entonces como que sí hay muchas barreras para las mujeres, y muchas mujeres, por ejemplo, especialmente en mi país, no manejamos y el hecho de no manejar, es una barrera bien grande." (...so then it's like there are many barriers for women, and many women, for example, especially in my country, we don't drive, and the fact of not driving, it's a big barrier...Mexico, 43 years old, 15 years in Kentucky)*

Transportation certainly provides instrumental access, however, when people fear arrest due to using personal transportation, then transportation begins to affect the way people perceive their access to services.

> *"Appointments require transportation and if you have to worry that you're gonna get arrested because you don't have a driver's license then you can't function in the ways that you really would to access those things even if they are available, even if the organization that offers them is accessible and has done outreach and is actively able to help or able to provide those services." (Policy Professional, Latina)*

The same policy professional, when asked about what makes it difficult to access family planning services and information for Latina immigrants, presents the complex relationship between transportation barriers and immigration status:

> *"I mean I have to go back to the driver's license thing because that one is, I mean specifically hinders women's access. It doesn't seem related to anything but if women can't drive or have to be fearful that they're gonna get arrested because in theory, that's not something that we're used to hearing people getting arrested for but because of things like Secure Communities and the drive to steer people into the criminal justice system then the idea that it's an offense which police officers have discretion whether to arrest or not." (Policy Professional, Latina)*

Fear of being pulled over and arrested while driving without a license is a prevalent fear in the Latino community.

> *"Bueno, la más grande es ser inmigrante porque es por el miedo que tienes porque tenemos mucho miedo porque de repente algunos que manejan, de repente ya los paró la policía, les pidió los papeles y no tienen o les piden la licencia y no la tienen..." (well, the biggest is being an immigrant because it's the fear that we have,*

because we have a lot of fear, that maybe some drive, and maybe the police stops them, asks them for papers and they don't have them, and they ask for the driver's license and they don't have it...Guatemala, 35 years old, 9 years in Kentucky)

The limited, and in some cases total lack, of public transportation is further compounded by what many women described as extreme weather conditions. A Latina social services provider puts it this way:

> *"Then they don't have transportation. It's not easy. Also, we have very strange weather here in Louisville. So it's not easy to be in 100 degree walking with a child or when it's very cold." (Social Service Provider, Latina)*

An informal community member concurs, placing weather as factor in transportation as a barrier.

> *"Muy frío cuando es frío y muy caliente cuando es caliente. Y como más... ¿Cómo lo puedo decir? En cuestión de transporte, con menos transporte para las personas que no tienen transporte, relativamente no hay transporte." (Very cold when it's cold and very hot when it's hot. And what's more...How can I say it? In terms of transportation, with a lot less transportation for those people that don't have transportation, there is virtually no transportation. Mexico, 30 years old, 6 years in Kentucky)*

In a series of focus groups conducted in 2004, Latina women spoke of individuals within the Latino community charging people who do not have transportation exorbitant amounts to be driven to appointments and serve as interpreters.[123] This raises numerous ethical concerns. Particularly in cases where women seek family planning and other sensitive services, concerns over privacy and confidentiality may keep women from seeking such services.

The interaction of immigration status, lack of language access, and transportation difficulties combine to create substantial barriers for immigrant Latinas seeking family planning information and services. These barriers are experienced as

both instrumental, concrete obstacles and as emotional and psycho-social realities, contributing to the sense of fear, isolation, and rejection described in Finding I.1.b

c. Health and social service providers identify long waiting times of two- to three-months for time-sensitive family planning appointments at Title X provider clinics as a community-wide barrier to access in Louisville.

Guzman et al found in their study of immigrant Latinas that both immigrant women and the providers who serve them considered the cost of accessing birth control to include not just the actual price of the method, but also the time taken up by the clinic visit, which in turn translates into lost earnings, transportation costs, and possible childcare costs.[124]

Similarly, providers and informal community leaders in this study expressed frustration at the time it takes to get an appointment for family planning services (up to two to three months according to providers) as well as the amount of time necessary at each clinic visit.

Informal community leaders perceive that persons who do not speak English are asked to wait longer than those who speak English. An appointment that takes most of the day becomes a barrier to access as many women work and cannot take time off work, have childcare obligations, and have transportation barriers. The fact that women expect to have to spend hours at an appointment, serves as a deterrent to attempting access, thereby also affecting the perception of access.

Because family planning is particularly time-sensitive, providers state concerns about asking women to wait months for a birth control appointment.

> *"The only thing I know is the Health Departments will see them, they have to get an appointment as we speak, they have to get a first-time appointment with any of the health departments to get on birth control is a three-month waiting list. Right now. If you call them and tell them you are a new patient and you want to get on birth control, they're going to give you an appointment within three months from now. I'd be pregnant probably; I don't know." (Health Service Provider, Latina)*

Another provider concurs:

> *"It seemed like in other cities you could just get an appointment within two weeks. And sometimes you can't get an appointment in two or three months." (Health Service Provider)*

Informal community leaders also tell stories of having to wait to get appointments and spending hours at appointments. The situation seems to be exacerbated by the current economic situation, which informal community leaders say has led to most places being full and not taking new patients.

> *"Hay mucha gente ahora que los necesita y entonces ya están saturados, y entonces ya hay muchos que no están admitiendo nuevos pacientes, y los que admiten nuevos pacientes quedan bastante retirados, y ellos pues no tienen ni transporte, no manejan, ni nada de eso, entonces pues están limitadas a que el esposo pida o deje de trabajar un día para que las lleve o encontrar a alguien que las pueda llevar..." (There are lots of people that need them now and so it's saturated, and then there are lots [of clinics] that are not taking new patients, and the ones that do take new patients are really far away, and they, well, they don't have transportation, they don't drive, or any of that, so they are limited to their husband taking or not working a day to be taken there or find someone else who can take them...Mexico, 57 years old, 9 years in Kentucky)*

> *"Entonces, cuando dices, — "Tengo una cita con el doctor." Ya no puedes hacer nada más ese día, es para una cita al doctor." (So, when you say, 'I have an appointment with the doctor.' Then you can't do anything else that day, it's for a doctor's visit. Mexico, 30 years old, 6 years in Kentucky)*

Informal community leaders also spoke of long wait times on the phone when they called a service provider. One woman states that women she knew had complained that they could never speak to anyone when they called the clinic so they never were able to make an appointment and asked her for help. She explains what happened when she called the clinic for her.

> *"Y eso lo pude comprobar de verdad, que yo todo el tiempo... dicen: –'Ay no, es que va a tardar bien harto,' '¿pero por qué no vas a hacer una cita?'–, le digo, –'Es me pasé 40 minutos y eso'–, le digo, sí, yo los pasé, pasé 40 minutos en un teléfono..." (And I was able to verify that that was true, that they always say: 'Oh, no, it's just that it takes too long,' 'But why don't you make an appointment?' I ask them—'It's that I spent 40 minutes and that,' and I tell you, yes, I spent them, I spent 40 minutes on the telephone. Mexico, 29 Years Old, 7 Years In Kentucky)*

Another woman explains that she was given an appointment three months out only to have the clinic call her and reschedule it.

> *"En tres meses y yo iba ya cumpliendo los tres meses y yo iba a ir a la cita y antes de dos días me llamaron y me pusieron en unos meses más y entonces se tuvo que esperar cuatro meses en hacer cita y entonces, y ahora ya tengo la clínica, voy a donde puedo irme a la que pago..." (In three months and I was almost getting to the three months and I was going to go to my appointment and two days before they called me and they put a few more months and so I had to wait four months to make an appointment and then, so now I have a clinic, and I go to where I can go with what I pay. Guatemala, 35 years old, 9 years in Kentucky)*

While long wait times are not unique experiences to immigrant Latinas, Latina immigrants have additional costs to their time due to the difficulty accessing transportation, childcare obligations, and hourly wage labor with no sick time. The observation by numerous informal community leaders and a few providers that persons who do not speak English are placed at the end of the list regardless of when they arrive or their appointment time also raises concerns for unfair treatment of Limited English Proficiency persons, in violation of Title VI of the Civil Rights Act.

d. Informal Latina community leaders report unplanned and unwanted pregnancies due to a lack of knowledge, cost and affordability, reproductive coercion, absence of pregnancy options, machismo, and a general sense of not having control over their sexual and reproductive lives.

> *"Yo pienso que si yo hubiera venido, cuando yo llegué aquí si hubiera sabido de esto a lo mejor si pienso, que Dios me perdone porque eso estoy pensando, a lo mejor no hubiera tenido a las dos niñas, porque yo llegué bien tarde a saber todo." (I think that if I had come, when I arrived here if I had known about this, maybe I think, may God forgive me but it's what I'm thinking now, that maybe I would not have had two of my kids, because I came to know all this very late. Guatemale, 35 years old, 9 years in Kentucky)*

Over half of the informal community leaders interviewed reported having unplanned and unwanted pregnancies due to lack of information about family planning, lack of access to methods and options, lack of control over their decisions resulting from intimate partner violence and cultural expectations, and an overall lack of awareness about and affordability of family planning. These same women, plus some of the women who did not report unplanned pregnancies, also told stories of friends who had unplanned pregnancies due to similar reasons.

Informal community leaders spoke of a pressure to have children very soon after marriage at a young age. Similar to Maternowska's findings of Mexican immigrant male's masculinity being tied up to both having a child soon after marriage and of having many children, women reported an almost non-negotiable expectation by men of a child soon after marriage.[125]

> *"Pues allá en nuestros países es difícil porque... por la cultura porque allá los hombres son machistas y entonces... Allá en México, enseguida que te casas ya luego, luego quieren el bebé, quieren el bebé, y no se fijan si están listos, preparados para ser papás, si no tienen un hogar... No, ellos quieren a como dé lugar tener*

bebés, y la mujer tiene que estar en su casa sin trabajar, y este... y hacer la voluntad del hombre; y es una ignorancia muy fuerte que hay." (Well, in our countries it's difficult because...due to the culture over there the men are machista and then...In Mexico, right away you get married, and right away, they want a baby, they want a baby, and they don't see if they're ready, prepared to be fathers, if they have a home...no, they want to have babies no matter what, and the woman has to be home without working, and ummm...and do the man's will; it's a powerful ignorance. Mexico, 45 years old, 10 years in Kentucky)

Women talk about a lack of options once they are pregnant. Despite the general perception that Latinas are generally not comfortable with abortion, a few of the informal community leaders do discuss it in terms of lacking that option. Some providers also discuss the great difficulty that Latina immigrants face in accessing abortion services in Kentucky. A woman provides an account of how reproductive coercion affected her life:

"Y yo siempre le comenté que yo no quería tener ese bebé, que quería abortar pero él nunca, ni me llevaba al médico, ni me daba opciones, y cuando nació mi hija, yo le dije a la doctora entre lo poquito que podía de hablar inglés, que no quería más hijos." (And I always told him that I didn't want that baby, that I wanted to have an abortion, but he never, he didn't even take me to the doctor, he didn't give me options, and when my daughter was born, I tried to tell the doctor, with what little English I could speak, that I didn't want any more children. Mexico, 43 years old, 15 years in Kentucky)

The issue of affordability was raised by many informal community leaders, both within the context of lacking insurance and even for those with insurance.

"Muy difícil, sí. Porque uno, quiere uno cuidarse, pero todo eso es carísimo y también tiene que ver lo... es muy caro cuidarse uno. A veces sale más barato yo creo tener el bebé que..." (Very hard, yes. Because one wants to take care of oneself, but everything is so expensive and also it's got to do with...it's very expensive to take care of yourself. Sometimes it's cheaper to have the baby I think...Mexico, 38 years old, 10 years in Kentucky)

Another woman talks about not being able to go through with a planned tubal ligation, in part due to cost.

"...hacerme una operación como planificar, y no la pude llevar a cabo por... en gran parte fue por lo económico..." (...to have surgery for family planning, and I couldn't carry it through...in great part because of the economic aspect...Mexico, 29 years old, 7 years in Kentucky)

Two health service providers weigh in on the cost concerns facing Latina immigrants seeking family planning:

"And always with the concern about where they're gonna get healthcare because being undocumented they don't have health insurance so they're always asking, 'Well how much does that cost?' and, 'How much does this cost?'" (Health Service Provider, Latina)

Another provider talks about barriers to family planning services:

"So cost being one thing. And then language. I guess those are two of the biggest ones." (Health Service Provider)

A number of the women wove in stories of abuse and coercion into their stories of immigration. Women with experiences of reproductive coercion understood family planning differently, and access takes on an added dimension. Research continues to grow in this area, showing that women in abusive relationships often report lack of control over sexual and reproductive decision-making, contraceptive sabotage, and coercion to both carry unwanted pregnancies to term and to terminate wanted pregnancies.[126,127,128]

A woman explains what some of the main concerns she sees among Latina immigrant women in Louisville.

"Si estamos en violencia es... mejor dicho, cómo salir de la violencia, cómo evitar que tu pareja te controle, cómo evitar quedar embarazada, cuáles opciones tienes, entonces como que sí hay muchas barreras para las mujeres." (If we are in violence...rather, how to get out of the violence, how to avoid having your partner control you, how to avoid getting pregnant, what options you have, so then there's lots of barriers for women. Mexico, 43 years old, 15 years in Kentucky)

Some providers also recognized the role that intimate partner violence plays in immigrant women's lives, and how immigration status puts them at increased risk as a victim of violence. The providers who spoke of abuse were aware and familiar with the reproductive coercion tactics that women endured, such as forced sex, unwanted pregnancies, contraceptive control and sabotage, and lack of autonomy in making health and contraceptive decisions.

One policy professional speaks about hearing a panel of survivors of violence, and one woman is recounting how she experienced unwanted pregnancies as a result of intimate partner violence and reproductive coercion, and due to lack of language access, even though she did access health services, she was not able to get support in family planning:

> *"one of the survivors on the panel talked about how she really wanted to scream out at a medical clinic. I don't want any more children, and she didn't have the words. So I think it's – I don't even think we know the extent of the lack of access..." (Policy Professional)*

A woman who has disclosed that she was in an abusive relationship, discusses her reaction when she found out she had had a post-partum tubal ligation without her consent in her country:

> *"–"¿Pero por qué me lo hicieron? ¿Por qué? A ver, yo quiero que... yo no me voy a salir de aquí"– me puse como loca, –"No me voy a salir de aquí hasta que me dejen como estaba"–, y luego: –"Mi esposo ya no me va a querer y me va a botar" ('But why did you do that to me? Why? Let's see, 'I want that...I'm not leaving this place'...I became crazy,-- 'No, I'm not leaving here until you leave me the way I was,'—and then: 'My husband is not going to want me and he's going to kick me out.' Mexico, 45 years old, 10 years in Kentucky)*

This woman's story also points to the added difficulty faced by immigrant women in intimate partner violence. Many women do not feel they have the financial

recourse to leave an abusive partner once they are in the U.S. because they don't have family or friends to provide support. With no ability to speak the language, with limited or no transportation, and often no legal immigration status, women feel trapped in abusive relationships. Immigrant women may not be aware of the laws in the U.S. to protect them in cases of domestic violence, and they fear the police because of the increase in programs such as 287g and Secure Communities where local and state law enforcement become involved in immigration enforcement. Unwanted pregnancies and young children can make women less able to leave an abusive partner.

A woman explains how intimate partner violence interacts with family planning and the ability access and make decisions about family planning. She also provides insights and recommendations on how to support women in her situation:

> *"Yo pienso que es eso también porque por ejemplo, si digamos, si yo en este momento estuviera en violencia doméstica y alguien estuviera ejerciendo control sobre mi, no tendría la capacidad de captar toda la información o de entender la información porque a veces, es más el miedo a lo que tu pareja va a decir si tu decides tomar una decisión como tomar pastillas, como, este... cualquier otro tipo de método, como que a veces eso también nos crea una barrera, una barrera para poder tomar decisiones... yo no sé tal vez las mujeres que estén en violencia doméstica, es difícil tomar decisiones, dependiendo del tipo de abuso que haya; pero si en las clínicas o en los... en los este, centros médicos hay información tal vez, no faltará una que se decida, ¿verdad? O que pregunte, pero para mí lo más importante, lo más importante es cuando va uno a los médicos, es que la pareja en algunas situaciones se quede afuera, que no entre, porque, eso te, te... limita." (I think that's it also, because, for example, let's say if I was in domestic violence now and someone had control over me, I wouldn't have the ablity to capture all of the information or understand the information, because sometimes, it's more the fear of what your partner is going to say if you decide to make a decision like to take pills, or like, ummm...any other type of method, so like that also sometimes creates a barrier, a barrier to be able to make decisions...I don't know, may be women who are in a domestic violence situation, it's hard to make decisions, depending on what type of abuse there is; but if in the clinics or in the... in the medical centers there is more information, maybe, there will be one who will decide, right? Or that will ask, but for me the most important thing, the most important is that when one goes to*

the doctor, that the partner stay outside for some situations, that he not come inside, because, that, that...limits you. Mexico, 43 years old, 15 years in Kentucky)

Another woman explains how being in an abusive relationship added to the difficulties of being a new immigrant.

> *"Pero cuando nos vinimos a los Estados Unidos entonces fue bien difícil porque yo no sé inglés, yo no sabía manejar, y entonces en todo tiempo encerrada, y este... y pues fue bien difícil; y gracias a Dios ya salí ...salí de eso y estoy aprendiendo, aprendiendo al venir a este grupo y me estoy encontrando a mí misma, y me siento bien, me siento mejor sin la pareja que me estaba hostigando, que me estaba siempre magullando como se dice, pisoteando..." (But when we came to the United States the it was very difficult because I don't know Enlgish, I didn't know how to drive, and then I spent all the time locked in, and umm...and well it was very hard; and thank God, I got out...I got out and I'm learning, learning when I come to this group and I'm finding myself, and I feel good, I feel better without a partner that is harassing me, that is always bruising me, how do you say, stepping on me...Mexico, 45 years old, 10 years in Kentucky)*

4. <u>The facilitators to family planning accessibility (perceived and instrumental) by low-income foreign-born Latina immigrants in Kentucky</u>.

a. Informal community leaders converged on the concept of Confianza (trust) as a key to perceiving organizations as accessible. Confianza was described in relation to individuals as well as organizations, and always involved a bilingual, and often bicultural, person as an intermediary of the relationship with an organization.

> *"Conocer a la persona, esa es la única manera en la que puedes hacerlo." (Knowing the person, it's the only way that you can do it. Guatemala, 35 years old, 9 years in Kentucky)*
>
> *"I think people know when they are in a safe space. I don't know that I have a better way to explain that other than people just know when a space is their space." (Social Service Provider, Latina)*

A deep and constant theme in all of the interviews was the importance and need for confianza, for trust. This may partly be a function of Latin American cultures

emphasizing personal relationships more than U.S. culture does, and of the importance of the family. It may also a function of many Latina immigrants in the interviews coming from rural areas, where people are more likely to know their providers and others in the community by name. Guzman et al address a related finding when they state"...Hispanic cultural style of communication tends not to be direct, preferring to establish comfort and rapport before discussing other matters. For some women, a 15-minute appointment did not provide sufficient time for them to become at ease with a provider or feel comfortable asking potential sensitive or embarrassing questions."[129] This cultural communication style played out in the interviews. With the informal community leaders, and the foreign-born Latina providers, I always knew to build in extra time, so we could chat and catch up on things before and after the interview. While this happened to some degree with all of the interviews, it was particularly long with the Latina participants.

Confianza, as used by the participants, seems to entail a number of components: to some degree it requires language access, for some women it also meant cultural connection; for all it meant someone who took the time to get to know them; someone who sees them as a whole person and recognizes what is important to them. Often, the inclusion of the family in the conversation (asking how the family is, recognizing that decisions are often made for the good of the family) provides a level of confianza. Confianza requires that the person be polite, considerate, and open to getting to know the person without prejudging. At some level, confianza is something that needs to be cultivated over time. It requires an investment of time. Confianza is often discussed in the context of relationships.

"...I think the first thing that needs to be done is get the trust from these women. They are in a new country. There is a lack of language. Unfortunately there is a lack of legal status. They're scared. So the first thing we need to build is the trust between providing the birth control or the family planning care and let them know that there is a trust. Let them know that there is information, that we're going to build this relationship that we're going to build is not going to affect you in any way. We're not going to take the information that you've given us to the immigration services." (Health Service Provider, Latina)

Confianza is particularly relevant in terms of sensitive topics, such as family planning. For the Latina immigrants I interviewed, talking about sexual or reproductive health is difficult. All of the informal community leaders stated that it was not something they or the other Latina immigrants they knew were used to discussing with other people. Some specifically said that they felt this was similar in different countries, giving examples of how in their country, they felt that it was considered inappropriate to talk about such things. For some women, even discussing their body parts felt difficult. Some women stated that they felt that they would be judged by others if they talked about or seemed knowledgeable about family planning. Some of the women interviewed specifically said that others from their country might think they are "prostitutes" if they hear them talking about family planning.

Confianza was a theme in both populations:

- *Informal community leaders* said that this was something they valued and something they worked on and nurtured through the women's groups. Establishing a level of confianza in the groups is what made it possible for them to discuss and learn about sensitive topics like family planning. They want to hear other Latinas' stories and take their advice. However, women need to know that their stories, questions, and information shared will be treated with respect and confidence in the groups. So

confianza among Latina immigrants facilitates information-sharing and action in terms of family planning. All the women interviewed talked about other women coming to them for advice, and even accompanying other women to clinics or to get information. In effect, the women interviewed, were identified as knowledgeable and people with whom other Latinas have confianza. Having informal community leaders become knowledgeable about family planning and providing advice in a nonjudgmental way to others in the community is one of the perceived purposes of the women's groups for the women interviewed. One woman speaks to this role in the community. In the interview, she is talking about the fact that other Latina women come to her with questions about family planning, and she thinks it's because they trust her and women don't feel comfortable talking about these issues to someone unless they know and trust her:

> *"Pero a lo mejor las otras personas sí con quien le tengan más confianza, porque sí es cierto, hay personas que me han hablado, seguro me tienen más confianza en ese aspecto..." (Well, but maybe with other people that they trust, yes, because it's true, there are people that have talked to me, probably because they trust me more in that respect...Mexico, 57 years old, 9 years in Kentucky)*

- Confianza was also discussed in terms of having *trust between providers/organizations and Latina immigrants.* Latina immigrants often did not know the name of the clinics they visited, but they knew the location and the name of the person that they dealt with. They went to the clinic because of the relationship with a person, because of the trust they'd built with a particular person. Often, that person was Latina as well, but other times, it was simply someone who spoke Spanish and took the time to talk to them, hear them, and asked them questions that made the women feel that she really cared about them.

> *"...when they know somebody directly in that organization, they feel more comfortable with that contact person – that specific person." (Social Service Provider, Latina)*

Women also talked about volunteers who would talk to them about an event or a clinic and who supported them in making the decision to go to the event or clinic, calling them, reminding them, insisting that they go. This type of ongoing communication and relationship was valued and noted as key to developing trust with an organization.

Women also conveyed that giving full explanations, complete information about an issue inspired trust of a person.

> *"Yo pienso que para mí lo principal es eso, que lo expliquen claro, que lo expliquen claro... Sí, confianza, que te den confianza." (I think that for me the main thing is that, that they explain it clearly, that they explain it clearly...yes, trust, that they give you trust. Mexico, 45 years old, 10 years in Kentucky)*

Another provider reiterated the importance of trust and relationship-building, adding that confianza is also about approaching and presenting issues in a culturally-relevant way.

> *"Yeah, just that I think that you can have the number of pamphlets translated into Spanish that you want. But the real work and the real change comes from relationship-based work. Where folks are engaged, where there's trust, and where it's done in a holistic way, where family planning is not seen in a vacuum, where it's not seen as "the" only piece. Because, really, it's part of a individual, and a family's health in general. And I think that the Latina women that I've worked with respond best thinking of it in that more global way. And so there are ways that we can be integrating it into other work and other education as well." (Social Service Provider)*

A Latina health provider adds to this notion of trust requiring culturally-relevant approach by stating that she doesn't even do workshops where someone speaks English and it gets interpreted because she feels that something is lost that way. She believes

that doing the work in Spanish is the way to do it to really reach the Latina immigrants she works with.

> *"I don't fool with English/Spanish because you'd lose a lot of the bonding, the familiarity with – the friendship because after so many years, we're friends, we're friends. They call me. I invite them to things that I do because I like to do other extracurricular things. They come and see. Yeah, we spend time together. Baby showers, someone dies, yeah they call me...it was like everybody knew I was there so they'd come and knock on my door even if I was with a patient" (Health Service Provider, Latina)*

During the interviews, when women are speaking positively about a family planning experience they've had, they almost always use the term confianza in its description. They describe different situations, with the constant of trust. One woman speaks of trust in the women's groups:

> *"Que hagan muchos grupos así como los que hicieron aquí, en la Casita Center, porque así somos puras latinas y entonces agarramos... platicamos y agarramos confianza y entonces nos atrevemos a hablar de nuestras intimidades y todo eso; y entonces es más que ir allá y con un doctor que no conoces, y luego pues aquí son seguidas las clases y dan unos consejos y es diferente..."(They should do lots of groups like the one they did here, at La Casita Center, because that way we are all Latinas and then we develop...we talk and we develop trust and then we dare to talk about intimate things and all that; and then it's more than going there with a doctor that you don't know and then, well, here the classes are ongoing and they give you advice and it's different...Mexico, 45 years old, 10 years in Kentucky)*

Another woman speaks of how trust could be used to increase access in a clinic setting:

"Yo creo que si hubiera en todas las clínicas un lugar donde se anunciara como que hay un lugar o alguien latino, alguien anunciando con lo que la gente puede llegar ahí con la confianza, no sé, como por decir un consultorio exclusivo para gente así, que no tenga miedo y pueda llegar a pedir información, sobre todo en español. Yo pienso que podría mejorar, o sea que la gente sepa que llegando a cierto lugar ahí van a encontrarlo, no con las mismas que están atendiendo a toda la gente que es, sino que hubiera como una oficina exclusiva para eso." (I think that if in all the clinics there was a place where they announced that there is like a place or someone Latino, announced that the people could come here with all the trust/confidence, I don't know, like an office that's exclusive for people like that [Latinos needing family planning], so they wouldn't be afraid and they could come and ask for information, especially in Spanish. I think that it could improve, so that people knew that going to a certain place they are going to find it, not the same people that are attending to you, but a place that is exclusively for this. Mexico, 38 years old, 10 years in Kentucky)

Another woman who had toured Planned Parenthood with the women's group, talked about considering Planned Parenthood one of the places where she would feel comfortable going for family planning services:

"En Parenthood te ofrecen bastante ayuda, te ofrecen confianza, te dan confianza. No sé si porque sean mujeres o porque vean casos extremos, porque tratan enfermedades, me gusta ese lugar." (In Parenthood they offer you a lot of help, they offer you confidence/trust, they give you confidence/trust. I don't know if it's because they're women or because they see more extreme cases, because they treat diseases, I like that place. Mexico, 30 years old, 6 years in Kentucky)

Interestingly, a few of the informal community leaders mentioned Planned Parenthood as a place they would go to for family planning. The foreign-born immigrant Latina community does not seem to have an awareness of the divisive political rhetoric about Planned Parenthood present at both the local and national level. Most women also don't remember the name well, but refer to it by location or call it that place we visited with the group, and when I state the name, they then call it Parenthood. The investigator is aware that the local Planned Parenthood has made many efforts to be more linguistically- and culturally-accessible, hiring bilingual staff and starting some

outreach efforts in Spanish. The fact that women who were intereviewed and mentioned Planned Parenthood were also part of the community tour that the women's group organized, may also have conveyed a level of confianza on Planned Parenthood.

While women did not specifically refer to health departments as places they trust, when asked who they thought should be responsible for family planning for Latina immigrants and who should provide the services, many of the informal community leaders and some of the providers state that they believe that local health departments can play a unique role in increasing access. For many Latinas, government-run agencies are a familiar source for family planning. For providers, providing family planning is within the scope of what they believe local health departments should be doing for their communities. In Kentucky, there is a health department in every county, and as such can provide access to family planning in rural and urban areas.

However confianza is defined, it is considered essential to access by informal community leaders and some providers, and also seems to make the experience more pleasant or positive.

b. All informal community leaders and some providers identified the use of women's groups, peer-to-peer models of education, and community-based workshops as the preferred vehicle for providing information about family planning and family planning services to Latina immigrants.

"···to distribute good information through these peer leaders is really, I think, the ideal way. And it's coupled often with your rights on language access, which again, I think is the key to getting good health services..." (Policy Professional)

"Bueno, que Latinas Unidas, es algo que nos ha hecho crecer como mujeres, y muchas de las que hemos crecido dentro de estos grupos, hemos aprendido bastante, y lo ideal sería que, todas tratáramos de poner un poquito más y expandirnos más para llevar esta información a las demás mujeres porque por ejemplo, a mí personalmente lo que a mí me ayudó es escuchar la historia de una mujer, y oír las opiniones de una mujer" (Well, that Latinas United [a women's group], it's something that has made us grow as women, and many of us that have grown within these groups have learned a lot, and the ideal thing would be that, all of us try to put a little bit more and expand ourselves to take this information to the other women, because, for example, for me personally what really helped me was to hear the story of another woman, to hear the opinions of a woman. Mexico, 43 years old, 15 years in Kentucky)

The women's groups, part of the Latina Women's Movement, are referenced by all informal community leaders in these interviews and by a few of the providers. These groups are the source for the Latina immigrant informal community leader participants recruited for this project. The women attend one of 12 groups throughout the city and some of the women become informal leaders within the groups, becoming facilitators of the groups for example, or collaborating in planning and coordinating events, workshops, etc. This network of groups was initially and exclusively viewed as a good source for the informal community leaders. However, during the interviews, it became apparent that the women considered the groups key to their current state of knowledge and comfort level with family planning information and access to services. All of them specifically pointed to the groups as the source of their knowledge of family planning, saying that they really learned about it in a way that made sense to them through the groups.

"Sí, sí, definitivamente con los grupos o platicando con otras mujeres, es como uno aprende porque... muchas veces en las clínicas pues vas es a lo que es tu consulta y

nada más, pero no a... o a veces uno tiene pena o miedo pedirlos o... no sé si tengan la información que uno a veces quiere, entonces, realmente todo ha sido en base a los grupos..." (Yes, yes, definitely with the groups or talking with other women, it's how one learns because...many times in the clinic well you go and it's just for your appointment and nothing more, but not...or sometimes one is embarrassed or afraid to ask...I don't know sometimes if they have the information that one wants, so, really everything has been through the groups. Mexico, 43 years old, 15 years in Kentucky)

Informal community leaders state that prior to participating in the groups they knew very little and would not have known where to go for family planning (or some other health services), but having learned about the places and met some of the people that work in those places, they now know about the places and the services and can tell other women about it and support other women in going to those places and in making decisions.

The women interviewed participated in different groups, so it was not one particular group that had this experience. Many of the women who were interviewed had attended a group program focused on reproductive justice, offered through La Casita. All informal community leaders interviewed feel that the safest way to learn about these sensitive issues is through groups. Many talked about the groups as being life-changing.

"Gracias al – mi grupo de ..., al movimiento de mujeres y de todo lo que está conllevando, es como – me siento ahora una mujer ahorita justa, una mujer liberada, una mujer con muchos proyectos en la vida, algo – todo totalmente distinto que no me sentía antes de estar aquí y sin conocer." (Thanks to-- my group at..., in the women's movement and all that is involved in that, it's like—I feel now like a just woman, a liberated woman, a woman with many projects in life, something—totally different that I didn't feel before being here and without knowing. Peru, 48 years old, 17 years in Kentucky)

Many of the women wanted similar types of groups to be offered to men, so they could learn about family planning and other issues too.

The groups are described as a place of safety, of confianza. While the idea of using groups was selected as a way to provide support and information in a culturally-relevant way, the form and structure of the groups was developed in a very purposeful way to increase privacy, confidentiality, and a sense of safety. The women speak of the Acuerdos (agreements, see Appendix E) in the groups as a way to encourage a safe and confidential learning space. Each group reviews these Acuerdos at the beginning of each session.

Women talk about having had to change how they relate to other women as a result of coming to the U.S., and learning how to support others, how to help others, through the groups. One woman describes this phenomenon this way:

> *"...introducir o enseñar a nuestras mujeres latinas a respetarnos, a tener en cuenta nuestros acuerdos del Movimiento de Mujeres que normalmente nuestros países ni siquiera sabemos de qué se trata respetarme a mí misma o respetar la historia de mis amigas o de desconocidos, y ese tipo de acuerdos que normalmente nosotros en nuestro país alguien me dijo algo y lo primero que hago es decírselo a la otra y ya se lo dijo distorsionadamente y no guardó la confidencialidad. Entonces yo pienso que ahí entra nuestros grupos de mujeres, enseñar a nuestras mujeres latinas a respetarse y a tener acuerdos, y a su vez, yo creo que eso motivarlas para que lo retrasmitan a sus hijos y a su familia ¿verdad?; y si están siendo tratadas abusivamente o una cosa de ese tipo, que ellas se den cuenta y que despierten que valen mucho y que pueden hacer cosas por ellas, más al escuchar las historias de las mujeres que van a nuestros grupos." (...introduce or teach our Latina women to respect ourselves, to keep in mind our Agreements of the women's movement that normally in our countries we don't even know what it means to respect myself or respect the story of my friends or strangers, and that type of agreements that normally in our countries someone tells me something and the first thing I do is go tell it to another person and it's been told in a distorted way and without keeping confidentiality. Mexico, 57 years old, 9 years in Kentucky)*

The women recount stories of empowerment, of growth, and of becoming leaders (although most if not all of the women were very uncomfortable with the term leadership: lider) when they speak of their experiences with the women's groups.

"Entonces como que es, parte de lo que me impedía tomar una decisión, y lo sabía en la escuela, pero no, en el tema más profundo, yo aprendí un poco como más, cuando estábamos en el grupo de sembradoras, fue donde fuimos ya, como que diálogo es más abierto así podemos entender mejor acerca del tema, que como que... ya uno se siente más segura, con más seguridad, con más libertad de hablarlo y es cuando aprendes más todavía" (So then it's like it was part of what kept me from making a decision, and I knew it at school, but not in a more in-depth way, I learned it sort of more, when we were in the Sembradoras groups, that was when, like the dialogue was more open and we could understand things about the topic better, that it was like...one feels more sure of oneself, with more confidence, with more liberty to talk about it and it's when you learn more still. Mexico, 43 years old, 15 years in Kentucky)

Of the 11 providers interviewed, five had had some involvement with at least one of the women's groups. Some of these providers were very closely engaged with the women's groups, while others made occasional presentations or participanted in special events with the groups. They describe the women's groups as well as a specific program addressing reproductive justice for Latina immigrants.

"La Casita Center has the Sembradoras programs targeting just reproductive justice issues in general and creating a safe environment where women can come together and share their experiences. Learn about resources, learn about different things that affect them as women and affect their families. But, learn about them in a culturally appropriate way in a safe space. In a place where they feel safe to ask questions to maybe debunk some myths and to just learn from one another, which I think is important." (Social Service Provider)

The importance of presenting family planning within a broader context is emphasized even for the program specifically addressing reproductive justice.

"And it's an 18-month experience curriculum that starts with that very basic understanding our bodies, understanding anywhere from anatomy to family planning options to all of the things that surround it. The curriculum is designed and facilitated in a way that is customizable to a particular group of women, but to Latina women in general, recognizing some of the cultural, religious barriers, stereotypes, understandings that people may come with, and then addressing those, and opening up space. I think it's a really powerful and unique space." (Social Service Provider)

Another provider also involved with the women's groups, speaks to the importance of trust in the success of the women's groups.

> *"There is trust in the group, and women are usually very forthcoming about saying, well I went to this place and here is how I found what I needed. So, that is a space where women share together and people are connected as well." (Social Service Provider, Latina)*

The groups are also highly flexible and respond to the interests, needs, and readiness of the group.

During the interviews for this project, the investigator was invited to the homes of some of the informal community leaders, as that was their preferred space for the interview. The fact that Louisville does not have one "Latino neighborhood" became even more apparent. The women interviewed live spread out throughout the city, there isn't a single place that is "where Latinas live". Not only did this observation provide added context to the barriers that Latinas face in terms of transportation and for providers in terms of providing services near where Latinas live, but it also emphasized the immense commitment the women of the Latina Women's Movement have to the groups and workshops they participate in. Women drive long distances, and often have to ask for rides from other women or from their partners, in order to attend a women's group session.

The group described above that focused on reproductive justice issues met Tuesdays from 6-8pm.[a] Some of the women who participated in the interviews were part of that group. It is apparent to me now that some of the women drove very long

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[a] In the interest of full disclosure, it is important to state that the investigator was one of the developers and original facilitators of the Sembradoras de Justicia Reproductive program described in this section and referred to by some of the informal community leaders.

distances (some even 30 minutes each way) to get to the group. The women brought their kids with them to the night-time group. Although childcare is always provided at the group meetings, as is some form of food and drink, the children were often tired or falling asleep by the time the group ended. Bringing to the fore that I am a participant observer, when I co-facilitated the reproductive justice group, I also brought my kids to the group meetings. I am reminded that it was always hard convincing the kids to go to this group meeting, 20 minutes from our home, after school, during the week, and then drive home usually around or past their bedtime. This experience I had with the women's group provides a new perspective on the level of interest and commitment to learning and sharing and supporting each other through the various groups when I realize just how far they live from the place where we met.

> *"Ah, para mí se me hace que es más cómodo, cuando te la dan así, cuando somos grupos o cuando se hacen charlas o talleres como que uno tiene más aceptación, ¿no?" (Oh, for me it's more comfortable, when they do it this way, when it's groups or when they do talks or workshops, it's like there's more acceptance, right? Mexico, 43 years old, 15 years in Kentucky)*

One of the goals of the women's groups is that the group participants will share information and knowledge gained through the groups with their families, their friends, and others in the Latino community. Because the groups also weave in information about immigrant rights and what to do in cases when immigrants are asked for documentation and such situations, some of the women who participate develop into informal community leaders. Some of the women begin to co-facilitate their group, help with organizing events, and other such leadership roles. It was apparent in the interviews, that the women took this role seriously. There is a sense of solidarity among the women, while at the same time a very strong presence of humility, as the

women interviewed felt uncomfortable claiming the title of leader and often prefaced their stories of providing assistance for someone else with a statement that they are not experts in this area.

> *"Y también pues, aunque yo no soy sicóloga ni nada de eso, pero pues muchas veces vienen y me hablan cuando necesitan algún apoyo ya que ellos no tienen acceso a los servicios médicos, mucho menos a un sicólogo ni nada de eso, porque no hablan el idioma y aparte pues no cuentan con algún... con una tarjeta de seguro de salud ¿verdad?" (And then, well, even though I'm not a psychologist or anything like that, but well lots of times they come and they talk to me when they need some support since they don't have access to medical services, much less to a psychologist or anything like that, because they don't speak the language and plus they don't have any...a health insurance card, right? Mexico, 57 years old, 9 years in Kentucky)*

Women describe sharing what they have learned with other women.

> *"Dentro del Movimiento de mujeres latinas he aprendido bastante. Con otras mujeres latinas siento que he ayudado un poco con lo que he aprendido con el Movimiento de mujeres, he ayudado a otras mujeres latinas que no tienen acceso a información. No quiero decir que yo tengo toda la información obviamente, y por un momento también pasé por estar desinformada o sin saber a dónde ir, pero siento que he ayudado a algunas mujeres latinas en darles información, en darles, no quiero usar la palabra consejo, sugerencia". (Within the Latina Women's Movement I've learned a lot. With other Latina women I feel that I've helped them a bit with what I've learned in the women's movement, I've helped other women that don't have access to the information. I don't want to say that I have all the information obviously, but for a moment I was also without information and not knowing where to go, but I feel like I've helped some Latina women in giving them information, in giving them, I don't want to say advice, but suggestions. Mexico, 30 years old, 6 years in Kentucky)*

It seems that women outside of the groups also recognize some of the women within the groups as potentially more informed about services in the community. A few of the women interviewed stated that women have approached them and asked them questions about various subjects, including family planning and contraception.

> *"...veo que hay muchas mujeres que viven preguntándome a mí que dónde comprar "x" pastillas que no se las dan, que a dónde acuden, mujeres jóvenes que están en edad reproductiva; pero sí no hay mucha información acerca de eso, ni tampoco*

qué es mejor para ellas o cómo localizarlos." (...I see that there are lots of women that are asking me where they can buy such and such pill that they don't give them, and where can they go, young women of reproductive age; but there isn't much information about that, or what's best for them or how to find them...Colombia, 63 years old, 8 years in Kentucky)

The informal community leaders feel it is their responsibility to carry the information they have gained through the women's groups to other women and individuals in the community.

> *"Pues yo creo que como... pues también seguir, seguir en el camino, como los grupos de mujeres seguir informando, y seguir... aunque les diga una y otra vez, a lo mejor como las sembradoras ¿verdad? sembrando la semilla, y los que la escuchen pues lo puedan trasmitir a la gente que no viene, o que digan... si encuentran a alguien que necesite ese tipo de servicio, pues que les digan dónde lo pueden conseguir; o sea más bien, pienso yo, como la red de Sembradoras, ¿verdad?" (Well I think that...well, also to continue, to continue down this path, continue providing information with the women's groups, and to continue...even if you say it over and over again, maybe like the Sembradoras [sowers of seeds], right? Sowing one seed, and those who hear it, well they can then share it with people that don't come [to the groups], or that they can say...if they find someone who needs that type of service, well they can tell them where they can get it; so I think really like the network of Sembradoras, right? Mexico, 57 years old, 9 years in Kentucky)*

Women's groups are also the venue that all informal community leaders identify as the most comfortable for learning new topics.

> *"Y en cuanto a las mujeres sí, serían más grupos, más charlas; aprendes mucho, aprendes mucho y no sé, la información de dónde están los productos e información de... pues todo lo de salud, eso." (And in terms of women, yes, I would say more groups, more talks; you learn a lot, you learn a lot and I don't know, the information about where the products and the information is...well especially in everything about health, and that. Mexico, 29 Years Old, 7 Years In Kentucky)*

In response to a question about how they believe access to family planning for Latina immigrants can be improved, women reply:

> *"Pues haciendo grupos como los que hicieron aquí, y hacer con sicología y todo, nos dan confianza y entonces... explicar todo lo que nos explicaron porque fue bien amplio, yo nunca había recibido unas clases así; a mí me encantó, y creo que a mis*

compañeras también" (Well doing groups like they did here, and to do them with psychology and all, they give us confidence/trust and then...to explain everything they explained to us because it was very broad, I had never received classes like that; I loved it, and I think my classmates did too. Mexico, 45 years old, 10 years in Kentucky)

Informal community leaders describe the women's groups as a place where they can access information about family planning and where to seek family planning services without concerns about immigration, language, childcare, or fear.

"Sí, por los grupos sé más porque... por aquí en la calle que yo vaya aquí, allá, no se entera uno, ni televisión, y no se.., de otro modo uno no se entera, y si uno va al doctor también tiene, antes de ir al doctor, también te piden montón de requisitos, aseguranzas, todo... entonces no te dan la información no más así, o sea, entonces es muy difícil agarrar la información, en este tipo de grupos, sí, porque este, pues ahí es gratuito y... eso es no más que la gente que quiera ir, y también que la gente que se quiera acercar pues sí puede tener información, pero así al público así en general, no creo que mucha gente sepa de estos lugares." (Yes, through the groups I know more because...around here on the street if I go here, there, you don't find anything out, nor television and I don't know... how else can one find out, if you go to the doctor you have to, before you go, they ask for so many requirements, insurance, everything...so then they don't give you the information just like that, so then it's very difficult to get that information, in these types of groups you can, because, ummm, well it's free and...that's it that the people want to go, and so that the people that want to come they can have the information, but just like out in the public, like in general, I don't think too many people know about these places [family planning clinics]. Mexico, 38 years old, 10 years in Kentucky)

While women's groups and workshops are a good way to learn about family planning and where to receive such services, women still have to access clinics and providers to receive the actual services and methods. Some women talk about gaining confidence through the groups in how to ask questions of health care providers.

"...te digo, he ido cambiando yo, he ido expresándome un poquito mejor y preguntando más..." (...I'll tell you, I've changed, I've been expressing myself a little better and asking more...Mexico, 29 Years Old, 7 Years In Kentucky)

This aspect or possible effect of participation in the women's group is particularly significant given that Latinos have been found to be "less likely to get preventive

services, adhere to treatment regimens, seek out health information, or ask questions during a medical encounter, and they are more likely to hae unmet medical need."[130] Further, research indicates "peer support and skills development" can increase "knowledge, skills, and confidence...to manage their health and health care."[131,132]

It is important to note that the women interviewed for this project had been members of the women's groups for several years. Groups address a wide variety of topics, without any single focus. It is also important to point out that women may attend groups for months or longer before topics such as family planning are presented. Each group progresses at it's own speed and stage of readiness. The purpose is to develop trust and comfort and a sense of safety and support within the groups through a variety of topics (such as art and crafts, music and dance, cooking, healthy eating, exercise, parenting). More sensitve and challenging topics are brought in as the group expresses an interest in the topic, or as appropriate given circumstances (for example, workshops on what to do in the case of an immigration raid were offered when word of immigration raids began to surface in Kentucky). This gradual approach to topics takes time and is premised on the necessity of trust and relationship-building for sustainable change. While testimonies from informal community leaders indicates that this is an effective and well-received approach, evaluation is needed and identification of funders interested in supporting such a diffuse and unfocused approach is necessary to it's continuing existence. As one provider states regarding evaluation and measures of success for programs such as the women's group approach:

> *"I think how one defines success is different. Because you might say, Okay, so do we count how many times they've accessed family planning services? Or do we count*

how many times they've had abortions? You know, what actions do we count in order to measure the success. But I really think that with this type of program, what you have to measure is increased knowledge, and increased awareness, and increased ability to share that knowledge and awareness." (Social Service Provider)

c. Informal community leaders identified removing some of the numerous steps needed to access contraceptive methods as a way to increase timely access to family planning. Access to contraceptives through pharmacies, urgent care clinics, and other channels that don't require appointments or prescriptions or insurance or documentation was suggested and more closely reflected the experiences of Latina immigrants in their home-countries.

Informal community leaders and providers identified a number of layers of barriers to family planning services (described in Finding I.3.a) that make it difficult to access information and services. Some of the informal community leaders discussed ways to eliminate some of those barriers and ease access to the services needed.

Specifically, women spoke of finding ways to access contraceptive methods that did not require insurance, doctor's visit or prescriptions, or immigration documentation. One woman spoke to the barriers she identified to getting birth control pills in Louisville:

"Es que aquí no puedes ni comprar las pastillas así. Entonces todo eso es bien difícil, no es... en otro lado, al menos en México, en otro lugar se puede comprar en una farmacia, y aquí no, tiene que ser todo recetado. Entonces si tú no tienes dinero para ir a un doctor, entonces cómo vas a tener también para... Es más, incluso yo he sabido de amigas que encargan las pastillas de México." (It's that here you can't even buy the pills like that. So everything is very difficult, it's not...in other places, at least in Mexico, in another place you can buy them from the pharmacy, and not here, you have to get a prescription. So then if you don't have the money to go to the doctor, then how are you going to...What's more, I even know of friends who

have the pills sent to them from Mexico. Mexico, 38 years old, 10 years in Kentucky)

Women recounted stories of friends who find creative ways to bypass all the barriers to access in Louisville.

> *"Y bueno, otra amiga que también está aquí, que es parte del Movimiento, ella trae las pastillas de México; a ella se las manda su mamá o se las trae su mamá, o ella las trae de allá las pastillas porque te digo que aquí no puede conseguir. Hay otra amiga que ella va y se pone el aparato allá y se viene para acá, pero no le da... sigue yendo con el doctor y nomás la checan. Pero todo eso es más fácil en otros lugares conseguirlos así, sacar una cita y te lo ponen, y aquí no." (And well, another friend that's also here, part of the movement, she brings her pills from Mexico; her mom sends them or brings them for her, or she brings them because she can't get them here. I have another friend that goes and she gets the device [IUD] put in and then she comes here, but they don't give...she just keeps going to the doctor for check ups. But everything is easier in other places to get them, just get an appointment and they put it in, but not here. Mexico, 38 years old, 10 years in Kentucky)*

This finding corroborates Guzman et al who found "evidence that some Hispanic women were bypassing the traditional medical community to access birth control."[133] Guzman et al specifically identified women seeking contraceptive methods from Mexico as well as purchasing contraceptive pills at local bodegas without prescription as strategies undertaken by immigrant Latinas.

Maternowska also found that women in her study travelled to and from Mexico to access contraception. "A substantial, if not surprising, finding is that some women went to great lengths to obtain a method including crossing the USA-Mexico border to acquire it..."[134]

There have been some efforts in the U.S. to explore the possibility of making contraceptive pills, and other methods currently under prescription, available over the counter. Concerns persist in terms of this new access creating a disincentive to seeking

preventive care such as papanicolau exams and the potential use of birth control pills by women with contraindications for its use. However, this study indicates that women who are not accessing contraceptives through clinics and health providers, may also not be able to access preventive services at those same health centers.

Informal community leaders' interest in receiving full information on all methods, however, might indicate that some women may be hesitant to simply purchase contraceptive pills without comprehensive information. This interest in comprehensive information about all methods plus the real concern for health contraindications, make some form of contraceptive counseling desireable. It is possible that receiving information from a pharmacist would satisfy the need for information on the "pros and cons" of the method.

One informal community member specifically proposed that family planning could be provided through venues such as the "Walgreens Clinics", where no appointment is needed.

> *"Entonces yo pienso que sí, sería más fácil también algún lugar así como... o farmacias donde te atienden de una gripa, también que te atienda alguien que te dé algo para cuidarte también." (So then I think that yes, it would be easier if also there was a place like...or pharmacies where they see you for the flu, then they also can see you so you can take care of yourself [in terms of contraception]. Mexico, 38 years old, 10 years in Kentucky)*

d. Informal community leaders and many providers identify bilingual and bicultural staff and volunteers as essential to increasing use of family planning services by Latina immigrants.

Providers and informal community leaders concur that having bilingual and bicultural (or culturally competent) staff serves to increase instrumental access in terms of allowing providers to understand what patients/clients say as well as being able to speak to them. It also is important that providers have some cultural understanding of of their patients and that they have some sense how being an immigrant might affect the person's interaction and reaction to the health system.

While the importance of linguistic access seems much more self-evident, cultural competence is particularly relevant because of the high proportion of undocumented immigrants in Kentucky. A provider at a health organization explains

> *"I think that if you're not culturally competent someone might see that as really fishy or refuse service or why do you have two different names? Because these – we have a lot of undocumented people that are essentially living outside of the system. They don't have a driver's license or if they do have driver's license they don't – they can't get insurance. And I think that we don't have any foreign born employees here, we don't have anyone that really has any firsthand experience with immigration, and the loop, everything that you have to – all the barriers that immigrants have to deal with. So I can see a lot of other agencies dealing with that just have – not understanding the issues that immigrants face, especially undocumented immigrants versus the rest of the population. I mean our entire – the entire population that we see, I would say all in all typically is going to be lower income and face a lot more challenges. But with our undocumented group we have – they're facing poverty, low income on top of being stopped by the policeman could mean winding up in jail or being sent back so those are added stresses that unless you're aware that may really affect the care that you provide to your patients." (Health Service Provider)*

Informal community leaders report feeling very happy when they receive information in Spanish.

> *"Pero cuando te dan información en español es magnífico, entonces eso como que eso hace más fácil el acceso; y otra cosa, que se ha implementado mucho, mucho, el... lo de los intérpretes, a veces no funciona como uno quisiera, ¿verdad? Pero, por lo menos, es algo." (But when they give you information in Spanish, it's wonderful. Then that's like it makes access easier; and another thing, that has been*

implemented a lot, a lot, is...it's interpreters; sometimes it doesn't work the way one would like it, right? But, at least, it's something. Mexico, 43 years old, 15 years in Kentucky)

This finding is aligned with Hess et al who states "[R]esearch indicates that immigrants have more positive experiences with the health care system when services are delivered in their own language, but many medical centers do not have staff members that speak multiple languages." [135]

Women seek out providers who speak Spanish and that they believe will understand them. In Louisville, there are a few private physicians who are Latino, and informal community leaders state that many people will seek out their services. The investigator is aware that many Latina women seek the services of one Latino obstetric physician so they can receive prenatal care in Spanish.

"Sí, por lo menos, muchas veces, he escuchado personas que por ejemplo se enferman y van con el primer médico hispano que encuentran, o sea que... bueno, eso es lógica porque, es el único que piensan ellas que habla español, entonces, a veces son privados y no... no es el mismo costo de una consulta, o de un método anticonceptivo que si lo hace una clínica de gobierno o algún otro lado." (Yes, at least, lots of times, I've heard about people, for example, that they get sick and they go with the first Hispanic doctor they find, so...well, it's logical because, it's the only one that they think speaks Spanish, so, sometimes they're private and they don't...it's not the same cost for a visit, or for a contraceptive method, as when you go to the government clinic or somewhere else. Mexico, 43 years old, 15 years in Kentucky)

A provider recognizes the gap in the health system in Louisville in terms of prenatal care for Latina immigrants.

"I do wish that we had the resources here to conduct prenatal classes totally in Spanish." (Health Service Provider)

While women spoke of wanting more service providers to speak Spanish, there was also a recognition of the importance of learning English. Informal community

leaders spoke of the difficulty of learning English, but all of them talked about taking classes to learn English.

> *"¿Qué lo haría más fácil? Híjole, que aprendan el inglés, pero aparte de eso de que aprendan... pues la información en español." (What would make it easier? Well, geez, if they learned English, but aside from that, that they learn, well having information in Spanish. Mexico, 57 years old, 9 years in Kentucky)*

Previous studies have found that some immigrants face greater difficulty in learning English because of their limited literacy skills "in any language".[136] As many of the immigrants in Kentucky are low-income persons from rural areas, literacy skills are of concern to the local Latina population. There are also immigrants who speak Spanish as a second language, with their primary language being a dialect with no written language. These facts should be taken into consideration in developing English as a Second Language classes.

e. Informal community leaders, and some providers, identified engaging Latino men through grassroots and education efforts as a necessary step in opening up access to family planning for Latina immigrant women.

> *"...en mi opinión he pensado no únicamente la información tiene que llegar a la mujer sino también al hombre, que en nuestra cultura es mucha parte el machismo y la mala información también del hombre." (...in my opinion I have thought not only about the information that needs to reach women but also men, that in our culture there is a lot of machismo and bad information on men's part too. Mexico, 29 Years Old, 7 Years In Kentucky)*

Informal community leaders often mentioned the need to include men in education about family planning. They acknowledged the positive effect of women's groups and workshops for women in learning about family planning and reproductive

health, but they highlighted that without the support of their partner it is sometimes not possible to carry out family planning decisions.

> *"...nuestras parejas nos dice: –'No uses eso o esas son tonterías'–, las ideas que ellos traen también es algo que en nosotras hace mucha presión como pareja. O sea, ellos también necesitan información." (...our partners tell us—'Don't use this or that silliness'--, the ideas that they also bring with them is something that creates a lot of pressure as a couple. So, they also need information. Mexico, 29 Years Old, 7 Years In Kentucky)*

Especially as many women conceive of family planning as being the understanding, the plan that a couple develops in terms of how many children they can take care of and provide for, only including women in family planning education does not really address family planning but rather may contribute to burdening women with contraception negotiation.

> *"Entonces, bueno, lo que yo creo que pienso ahora, yo pienso que es muy importante planear, tener familia o hablar con tu pareja y todo..." (Then, well, what I think now is that it is very important to plan, to have a family or talk with your partner and everything...Guatemala, 35 years old, 9 years in Kentucky)*

Family planning is often presented as a bilateral decision, and women highlight the importance and necessity of bringing men into the fold.

> *"Bueno, es que a lo mejor... a lo mejor la mujer lo puede estudiar y saber, pero trasmitírselo al hombre yo me imagino que eso es lo más difícil ¿no?... Entonces como que la cultura en ellos todavía es ese machismo y es todavía más difícil entender que esa es información para los dos, porque la sexualidad es de los dos." (Well, it's that maybe...maybe the woman can study about it and know, but to transmit it to the man I would imagine is the hardest part, right? So then the culture in them [men] is still machismo and it's hard to understand that that information is for both of them, because the sexuality is both of theirs. Mexico, 57 years old, 9 years in Kentucky)*

Women discussed the difficulty of carrying out family planning decisions when male partners do not respect that decision.

"Sabes que debes tomar en cuenta... no, no debes tomar en cuenta, debes hacer un poco entrar en razón a tu esposo, porque no siempre, a lo mejor una latina puede estar en la mejor disposición de planificar y hay días de planificar y hay momentos de planificar dependiendo, y hay muchas parejas que no respetan eso. Entonces, también desde ahí hay que educar a la pareja, porque no depende de uno completamente la responsabilidad, si no están de acuerdo, si no estamos de acuerdo. (You know you have to take into account, no, not take into account, but you have to make your husband come into reason, because they don't always, perhaps a Latina can have the best intentions to plan and there are days to plan and there are moments to plan depending, and there are many partners that don't respect that. So, from there you have to educate the partner, because the responsibility isn't completely just yours, if they're not in agreement, if we are not in agreement. Mexico, 29 years old, 6 years in Kentucky)

Women talked about machismo and how that interferes with some couple's ability to talk about and carry out family planning. Many women also discussed the misinformation that men receive form each other and perpetuate in their relationships. Inherent in women's statements was the sense that men did not consider it their responsibility to learn about family planning, but rather relied on myths and misinformation about contraceptives. Maternowska found in her research that male participants considered contraception to be a woman's issue.[137]

It is also important to involve men because the women interview placed a high value on being in agreement with their partner about how many children to have. Women talked about the ideal being family unity and having a shared vision for the family they want.

"Lo primordial, pienso de estar de acuerdo con, con nuestros esposos, estar – que ellos, este, piensen – tengamos los dos una sola idea. Pienso que esa es la forma como puede, puede trabajar la planificación y eso es lo que nos va a ayudar a poder, este, llegar a un buen acuerdo." (The main thing, I think is to be in agreement with, with our husbands, to be—that they, ummm, think—that we have together one shared idea. I think that is the way that, that family planning can work and that is what is going to help, ummm, to arrive to a good understanding. Peru, 48 years old, 17 years in Kentucky)

Providers also agreed that involving men was important. A provider who works with the women's groups explains it this way:

> *"Ultimately, it is the women's right but it is the family's responsibility to come together. I think that if the men aren't there then that is a huge barrier we are going to continuously run up against. So, I think to do men's work and engage the men that this is your responsibility too is important to break some of the stigma. To debunk some of those myths so that they also understand what it even means and what it doesn't mean." (Social Service Provider, Latina)*

Providers also talked about the importance of working with men, while recognizing that very little work currently occurs with boys or men.

> *"I don't know of many efforts that are focused on men or boys, and so that would be another arena to explore, doing that work in a culturally competent way..." (Social Service Provider)*

In fact, during all the interviews, services and programs described were very much focused on women. The exception was a youth outreach program that included some Latino youth through Planned Parenthood. Maternowska found a similar barrier in her study of Mexican immigrants in California: "One barrier that may in fact reinforce men's general lack of involvement in the reproductive health care process is men's perception of the services available to them...family planning services were considered 'women's services'"[138]

Providers discussed stigma and myths that exist in the community and the importance of including men in a culturally- and linguistically-appropriate dialogue about family planning and the couple's responsibility in making decisions about how many children they want to have and when they will have children.

f. Most informal community leaders identified their church as a place they seek and receive information, support, and services. Many women suggested churches as a place to provide information on family planning.

Many informal community leaders identified churches as a potential partner in outreach and education on family planning. Many of the existing women's groups actually take place in churches, so for the women it was a natural place to hold more educational workshops. A few women did question whether family planning sessions could be given through the churches in a way that provided full information:

> *"Pues las iglesias, pero... porque también la gente muchas veces acude a las iglesias, pero pues ahí si siento como que hay... no sé, dan preferencia a una línea y no dan opciones para todo, ¿verdad? aunque... porque es decisión de cada persona y de cada pareja lo que tiene uno qué decidir." (Well the churches...because many times people go to the churches for help, but then I think that there is...I don't know, they give preference to one line and they don't give all the options, right? Even though...because it's each person's decision and for each couple to decide. Mexico, 57 years old, 9 years in Kentucky)*

Churches play a central role in the lives of many Latina immigrants, both because of the significant role of religion in Latin American culture and also because churches have been very active in supporting immigrants in this recent anti-immigrant environment. In fact, the Catholic Church has been vocal in supporting immigrant rights when few other institutions have spoken out for immigrants. As Hess et al stated in regards to the National Conference of Catholic Bishops, "...many national religious organization have issued statements urging policymakers to create an immigration system that offers 'hospitality, service, and justice' to immigrants".[139] At the same time, the Catholic Church (with the exception of organizations like Catholics for Choice) has been a vocal opponent of abortion access. Despite the practices of most Catholics in the

U.S., the Catholic Church does not condone use of contraception or sterilization for family planning. Therefore, while the Catholic Church has been a strong supporter of immigrant rights nationally and locally, and locally provides significant support to immigrant families, it also plays a role in limiting Latina immigrants' access to comprehensive information regarding family planning.

Due to the limited infrastructure in Louisville and Kentucky in regards to services and support for immigrants, churches and other faith-based organizations have often stepped in to fill in the gaps in needed services for immigrants. Hess et al found a similar situation in the locations studied for their research project.[140]

When discussing places that provide support and information to the Latino community, the church was the main place that women identified as a place to go to for information.

> *"Pero para mí se me hace más cómodo, por ejemplo, si uno hace una charla en las iglesias, o en las escuelas, o en los grupos, entonces como que es más fácil aceptar toda la información." (But for me it's more comfortable, for example, if one does the talks in the churches, or in the schools, or in the groups, then it's like it's easier to accept all the information. Mexico, 43 years old, 15 years in Kentucky)*

While churches and faith-based organizations are serving vital roles in providing immigrants, particularly undocumented, low-income immigrants, with basic needs and providing a place of comfort by offering services in Spanish, they are less likely and able to provide reproductive health services. Hess et al found that congregations who did provide any form of family planning were limited to natural family planning.[141]

The issue of the Catholic Teachings regarding reproductive health and contraception has been particularly salient in Louisville in the past few months. At the

time that this project is being conducted and written up, the local public teaching hospital is going through a merger with a Catholic health care entity. There has been a lot of public discussion due to the limitations that the Catholic Ethical and Religious Directives have on medical practice at a hospital. The investigator has been intimately involved in this situation through her role as the vice-chair of the local Board of Health and has thus been a part of these discussions around provision of reproductive health, with a special focus on access and equity concerns. Some of the providers interviewed for this project brought up the issue of the merger during the interview. One social provider was very concerned about the effect the merger could have on Latinas given that tubal ligation is a preferred method of contraception for Latinas in the U.S.

> *"And then I think that just hearing about this huge merger of hospitals that's happening, and I'm not nearly as versed on all the details as I'd like to be, but that, I mean, it's so alarming to me what the repercussions could be. Most of the women that I work with are served by U of L public hospital. And I know that many of them when they give birth, will request to have their tubes tied when they give birth, so they can just get it done and over with at that hospital. And I know that that's not an option at Catholic hospitals." (Social Service Provider)*

This merger has been publicized as a way to expand the hospital's ability to provide indigent care given the growing need in the community. This situation mirrors and reiterates the complicated relationship between the Catholic Church and Latina immigrants: while much of the Latina community could benefit from expanded indigent care services, many Latina immigrants stand to lose access to full reproductive health services at the public hospital where most of the Latino immigrant community seeks hospital care.

While a few of the women's groups are physically located in church buildings, the content of the group sessions is independent of the church as the groups are facilitated and supported by a nonprofit organization not associated with the churches. The nonprofit, and those who work with the groups, have, however, worked on developing relationships with individuals at the churches so that they are allowed to use the space for the groups. Sessions addressing reproductive health issues are only a fraction of the sessions provided by the groups, so it may be that couched within a broader goal of empowerment and support, churches can support similar efforts for Latina immigrants.

5. The role of policies in access to family planning services and information.

a. Providers and informal community leaders easily made the connections between non-health policies at the federal, state, and local levels and access to family planning and other health services. Primarily, immigration policies, Title VI and other language access policies, and transportation policies were cited as policies that affect the ability of Latina immigrants to access family planning services and information.

During the interviews, informal community leaders and providers were asked what role policies play in Latina immigrants' access to family planning. Both populations frequently mention immigration policies, language access policies, and driver's license laws. Providers and informal community leaders identify these same issues as barriers to access, and raised these issues again from a policy-perspective. As stated by Guzman et al, "[P]olicy influences clinic practices which in turn interact with women's cultural beliefs, customs, and norms."[142]

Because eligibility for public programs is dependent on immigration status, immigration policies indirectly affect whom providers can care for. Due to federal eligibility policies, as well as Kentucky's decision not to waive the 5-year waiting period for public benefits or provide coverage for undocumented through state-only funds, undocumented Latina immigrants have limited access to Medicaid coverage regardless of income level. Hess et al also identified policies affecting eligibility for government-funded services as one of the two types of policies affecting access to health services by Latinas.[143]

According to Medicaid policy, many immigrants will receive presumptive eligibility Medicaid coverage, but this coverage only lasts for 12 weeks, so most women reportedly choose the end of the pregnancy for coverage. Immigrant women are also eligibile for emergency coverage by Medicaid, which covers the cost of the deliviery. However, undocumented immigrant women loose Medicaid coverage soon after delivery. This policy is widely known in the Latina community and combines with fears about immigration to limit access to reproductive health services:

> *"En unos de mis embarazos no fui a todas las coberturas de citas médicas, solo fui a aliviarme; una o dos citas... una cita antes de mi embarazo, como de 8 meses, y la próxima para aliviarme, y era la opresión que yo sentía o el miedo que... de lo que escuchaba: –'No tienes derecho a servicios médicos porque no tiene los documentos'". (For one of my pregnancies I didn't go to all the medical visits, I only went to deliver; one or two appointments...one appointment right before my pregnancy, like at 8 months, and the next to deliver; and it was the oppression I felt or the fear that...what I heard, that: 'You don't have a right to medical services because you don't have papers. Mexico, 29 years old, 7 years in Kentucky) This limited Medicaid coverage of prenatal care and family planning also becomes a barrier to post-partum family planning. "I think the issue of being uninsured very shortly after delivery is the big impact, because so many women want IUDs." (Health Service Provider)*

Policies about documentation and eligibility exist at every level, including the local and organizational level. Some providers explain that if a person is undocumented and cannot produce a social security number and other identifying documents, they are not eligible for the sliding scale fee options at the public medical school's obstetric practice. So undocumented, uninsured individuals end up paying more than others in this case, or simply avoiding care altogether.

> *"According to your income, you have to bring different kinds of papers that will prove your income and base it within the scale from five, four, six, according to your income. And they're very reasonable fees that you can pay...if you don't have a social security number or you're not a legal resident of Kentucky, you cannot be placed on any type of scale. You pay 100 percent." (Health Service Provider, Latina)*

In fact, the mere fact of having policies that require asking about immigration status serve to limit access to services.

> *"...llegabas a pedir un servicio médico: –'¿Tienes algún tipo de documento? ¿Estás legal aquí?'–, o tal vez no lo hacían con la intención, pero ellos necesitaban la información, pero uno se sentía mal porque decía: –'Ay no, pero cómo le voy a decir que no tengo papeles o algo'–, pero era como un mal empiezo, mal empiezo, para mí era un mal empiezo; sí necesitaba la información y eso, pero no creo que necesitaban la información de si eras legal o no eras legal..." (...you arrive to get a medical service: 'Do you have documents? Are you here legally?'—or maybe they didn't do it with that intention, but they needed that information, but you already feel bad because you say: 'Oh no, but how am I going to say that I don't have papers or something'—but it was like a bad start, bad start, for me it was a bad start; if they needed the information and that, but I don't think they need to know if you are legal or not...Mexico, 29 years old, 7 years in Kentucky)*

Another informal community leader agrees that service providers ask for identification, which many undocumented immigrants do not have.

> *"...porque cuando te vas a una clínica siempre te piden si tienes un ID con foto..." (...because when you go to the clinic they always ask you if you have a photo ID...Guatemala, 35 years old, 9 years in Kentucky)*

Guzman et al finds that fear of being deported are "exacerbated by document requirement of clinics and especially present in localities that had established policies and law enforcement strategies aimed at deterring illegal immigration."[144]

The other policy Guzman et al identify as creating barriers to access for Latinas, are those related to immigration enforcement.[145] Yolanda Vazques states that "[I]mmigration and criminal law have increasingly become inter- twined."[146] This close policy-level relationship between immigration, criminal law, and law enforcement, creates significant barriers for Latina immigrants in terms of both instrumental and perceived access.

In Kentucky, as in a growing number of states, undocumented immigrants are not allowed to get a driver's license. Along with this state-level policy, Kentucky also participates in Secure Communities and the 287(g)[b] programs. The state's participation in Secure Communities and 287(g) has purportedly increased the perceived frequency with which people are pulled over by police and has created an atmosphere of fear. One of the results of these programs and the state's driver's license policy is that people stay close to home and therefore possibly don't seek services they need because of distance.

> *"Because they don't want to travel to other places in the city because they're driving without driver's license... and then they drive very slow, they follow all the*

[b] "Under 287(g) Memorandum of Understanding agreements, local law enforcement are permitted to perform immigration functions concerning identification, processing, and detention of immigrants." (Vazquez, Yolanda, "Perpetuating the Marginalization of Latinos: A Collateral Consequence of the Incorporation of Immigration Law Into the Legal Justice System," (2011) Scholarship at Penn Law. Paper 373. Available online at http://lsr.nellco.org/upenn_wps/373"Under 287(g) Memorandum of Understanding agreements, local law enforcement are permitted to perform immigration functions concerning identification, processing, and detention of immigrants." (Vazquez, Yolanda, "Perpetuating the Marginalization of Latinos: A Collateral Consequence of the Incorporation of Immigration Law Into the Legal Justice System," (2011) Scholarship at Penn Law. Paper 373. Available online at http://lsr.nellco.org/upenn_wps/373

rules, they know how not to get in trouble. But they try to keep their job and their life around the area that they live" (Health Service Provider, Latina)

Although Secure Communities and 287(g) are intended to target criminal activity, informal community leaders expressed a profound fear of being detained, arrested, and deported for common activites such as driving and even for seeking services without proper identification and documentation. In fact, it is estimated that close to 80 percent of those detained through these programs are detained for low-level offenses "such as traffic offenses or petty juvenile mischief...since the program's inception."[147]

Providers spoke of the Secure Communities initiative:

"There are many local initiatives such as efforts to cut off immigrants from services. Kentucky is partner with the Secure Communities' Initiative, which is a federal initiative to allow the Kentucky State Police to turn over immigrants to ICE if they apprehend them." (Policy Professional)

Informal community leaders talked about instances where individuals were pulled over, arrested, and later deported. These deportations have been separating families all around the country, and the situation in Kentucky has been no different. These family separations can be emotionally and financially devastating for families.[148] Increasingly, women with young children are swept up and deported by these programs, leaving children separated from their mothers and often placed in state custody.[149] These stories and experiences lead Latina informal community leaders to perceive that these policies are a form of racial profiling and that Latinos are targeted regardless of immigration status.

"···por esa ley establecida de que por nuestra apariencia de latinos, es de que nos van a, nos van a parar..." (...because of that law that was established that because

of our Latino appearance, that they are going to, they are going to stop us...Peru, 48 years old, 17 years in Kentucky)

Vazquez identifies four general categories of consequences resulting from removal of family members through Secure Communities and 287(g): "psychological effects, economic effects, increased mistrust in local law enforcement, and increased strain on civil society resources, community services and local charities."[150]

Lack of language access policies (or lack of enforcement of existing policies) in combination with immigration and transportation policies, create both significant instrumental access barriers and tremendous fear, isolation, and sense of rejection that contribute to a perception of lack of access.

b. The lack of implementation and enforcement of policies is cited by many providers as a barrier to access. Specifically, problems with implementation of Title VI of the Civil Rights Act and unclear eligibility and documentation policies for provision of services were identified by providers and informal community leaders as reasons for Latina immigrants not seeking family planning services.

While providers and informal community leaders cite numerous policies as contributing to a lack of access to family planning for Latina immigrants, providers also focus on the ineffective enforcement of certain policies. Providers particularly focus on the lack of enforcement of language access through Title VI of the Civil Rights Act. In terms of enforcing Title VI, one provider offers:

"And unless there are State mandates to put all signs in English and Spanish, then companies, hospitals, offices won't do it. So just by inaction, there can be a hindrance because of the lack of information. If I've come here from another country, it takes you awhile to learn to speak that language. And, unless you see a

few familiar words here and there, you're sort of out of luck." (Health Service Provider)

Providers express frustration at the fact that they know about organizations that receive public funding and are therefore bound by the Title VI language access mandates, and yet these organization are either unaware or choose not to implement language access policies and practices.

> *"Again, I think language access policy does not adequately support, and definitely does hinder. What policies are on the books are weakly enforced, and a lot of advocacy has gone into keeping weak policies in place, rather than improving those policies and making them more effective and stronger. In terms of language access, there's some contradictory policies out there. A lot of institutions that receive state funds have chosen to implement state and federal funds, will implement English only policies, not realizing that they are in violation of Title VI, the Civil Right Act. But, again, it takes somebody understanding the law, and is able and willing to advocate for those things to change. So it's overwhelming, in terms of the places." (Social Service Provider)*

Another provider believes there is a problem in communicating the policies from the state level to the local level.

> *"The federal government already said, 'Okay if you receive federal dollars you have to provide interpreting services.' Because that's the main barrier there is the language and the money's given to the state, the state says, 'Okay yes we'll do what you say from the federal government,' but it's trickle down, okay. So somewhere in the middle the message getting across needs to be emphasized again." (Health Services Provider, Latina)*

A policy professional explains that she's aware of people being turned away from public services because they do not speak English:

> *"it happens more often than not that people are turned away because 'I can't understand you. Come back when you can find somebody to translate.' That is not the way you deliver service to people." (Policy Professional)*

This statement supports informal community leaders experiences and perceptions that persons who do not speak English are made to wait longer than others or simply not

attended at service agencies. It also provides an example of what Title VI was intended to prevent: discrimination and differential treatment based on nationality or language. Another provider is also aware of this situation occurring:

> *"Here, if you don't have an interpreter, they put you in the back of the line. That's how it is. They make you wait. Patients wait forever just because they don't speak English." (Health Service Provider, Latina)*

One of the challenges with Title VI is the fact that it is an unfunded mandate. It applies to any agency that receives public funds, so private providers who do not take public funds in the form of Medicaid or SCHIP or Medicare, are not bound by this policy. Many providers claim they simply cannot afford to provide language access, yet a few providers in the Louisville area have managed to implement language access policies through hiring of bilingual staff and use of the telephone language line. Some providers are concerned that even when organizations have language access policies, some providers simply don't understand the importance of using an interpreter or do not know how to use an interpreter properly.

> *"…so we have a lot of places providing services that don't know how to use interpreters, they don't have translated documents." (Health Service Provider)*

6. The potential impact of the Affordable Care Act on foreign-born Latina immigrants' access to and perceptions of access to family planning services and information.

a. Providers feel generally ambivalent about the ACA in regards to its potential direct impact on immigrants due to the exclusion of undocumented immigrants and the five-year wait for documented immigrants. Providers are hopeful that by covering

more of the general population, they can refocus available resources to better serve undocumented immigrants and others who will fall through the cracks after ACA is fully implemented.

> *"You know, I'm not really sure how it will affect women because it's my understanding that woman that are undocumented may not be able to benefit from those anyway." (Policy Professional, Latina)*

Overall, providers seem unsure as to what impact, if any, the Affordable Care Act will have on their ability to serve Latina immigrants. All providers have heard of the ACA but most are unclear as to the details. Health service providers knew more about ACA and some were concerned that they were unprepared for its full implementation, as they believe it might increase their patient loads dramatically.

Social service providers were less familiar with the ACA but generally felt that it would not likely affect their ability to serve Latinas or affect Latina immigrants very much as many of their clients are undocumented. Some providers were aware of the five-year waiting period for documented immigrants and were frustrated that the ACA did not waive that wait period in order to provide coverage for those documented immigrants.

> *"It's not going to affect undocumented people. I mean they made it really clear that health insurance should not go to people who are here illegally so I don't think that'll make a difference. Now the people that have papers and now from what I remember, if you're like a resident or alien, you have to wait several years to get it anyways." (Health Service Provider)*

While providers were not deeply knowledgeable of the ACA provisions, many did know that the ACA "excludes undocumented immigrants from all of its programs aimed at helping the uninsured gain coverage."[151]

Another health provider discusses that without changes to the immigration system, immigrants will continue to fall through the cracks of the health system.

> *"I mean, they have to fix the immigration problem issue too. I mean people are marginalized when they don't have documentation but they've been living here for 15, 20 years." (Health Service Provider, Latina)*

This provider goes on to say that she is skeptical of what effect it can have on immigrants, as she said so many of the undocumented tend to "stay under the radar" (Health Service Provider, Latina) to avoid trouble. This sentiment is echoed in an October 2011 article by Zuckerman et al that states that "health insurance problems and the access barriers they pose will not be solved without broader reform of immigration policy."[152]

All types of providers expressed hope that the ACA may indirectly help them better serve Latina immigrants, particularly the undocumented, by diminishing the pool of uninsured. Some spoke of re-routing funds currently used for the uninsured to provide more language access, more outreach, and more services that Latina immigrants desire but cannot access due to lack of insurance (IUDs were given as an example).

> *"It should improve our abilities because if we have fewer uninsured, that we're using our grant dollars to offset, then we use out grant dollars to provider better services to the people...So maybe we could afford 20 IUDs instead of two, or hire two more practitioners so we can provide better access." (Health Service Provider)*

Zuckerman et al present a similar viewpoint in stating that the larger insured base promised by the ACA could help safety-net providers "cross-subsidize care for the uninsured" as well as provide support for caring for undocumented immigrants

through "increased funding for community health centers; and more options for using Emergency Medicaid to pay for care to the uninsured."[153,154]

Only one provider specifically referred to the preventive service provision of the ACA, stating that she saw the ACA as boosting their ability to provide family planning services since some of the services would be covered without co-payments.

b. Foreign-born immigrant Latinas were generally unaware of the passage of the ACA or felt it might have a negative impact on undocumented immigrants.

The majority of the informal community leaders had not heard about the ACA. Those who had, had very little information about it, with some believing it would actually harm undocumented immigrants.

> *"Mala. Les va a afectar también sobre todo a la gente indocumentada. Si, bueno, lo que yo he escuchado hasta ahorita, lo que yo he escuchado sobre la reforma de salud, la reforma de salud es para todos, pero no creo que estén incluidos la gente que no tenga papeles." (Bad. It's going to especially affect undocumented people. Well, yes, what I have heard so far, what I have heard about the health reform, the health reform is for everyone, but I don't think that people without papers are included. Mexico, 38 years old, 10 years in Kentucky)*

When asked if she thought the ACA would affect Latina immigrants, an informal community leader stated:

> *"Pues mucho, porque si no consiguen los métodos o todo el... entonces va a ser difícil para ellos poder planificar así solos." (Well, a lot, because if they can't get the methods and all that...well, it's going to be difficult for them to plan like that alone. Mexico, 38 years old, 10 years in Kentucky)*

If this study sample is any indication of the overall immigrant Latina awareness regarding ACA, then there is very little knowledge as to its existence, provisions, or potential impact in the immigrant Latina population. The overall U.S. population has

also generally been uninformed or misinformed about the ACA. An August 2011, Kaiser Family Foundation conducted a poll on how the overall uninsured population views and understands ACA. Among the uninsured, close to half of persons polled believe that the ACA will have "little impact on them personally".[155] An equal proportion of the uninsured are unaware of some of the key provisions of the ACA, and approximately 14 percent believe the provisions may have a negative impact on their situation.[156] While this current study does not provide percentages of the population due to the small sample size and methodology, it would seem that the Latina immigrants interviewed were less aware and had more negative impressions of the ACA than the general population.

The fear that the ACA might have negative effect on undocumented immigrants may have to do as much with fear that undocumented immigrants will have access to less care as much as with potential negative perceptions of undocumented immigrants. As the pool of uninsured shrinks with the full, anticipated effect of ACA, undocumented immigrants will become a more significant proportion of the uninsured population.[157] This effect could increase negative perceptions and attitude towards undocumented immigrants (and immigrants in general) as communities struggle to provide care for the remaining uninsured.

As most informal community leaders had not heard about ACA, they were asked what they would want to see happen if there was a health reform. The majority talked about increased access to health services for the undocumented. Specifically, women spoke of the need for more hours of service for those who work; more options for

paying for those who do not have insurance; and being treated with more respect by service agencies. Women articulated, in their own terms, a human rights approach to health services, where no one is denied care that is needed and all persons are treated with dignity and respect.

> *"Por tu condición de inmigrante no tiene los mismos accesos; entonces en esa reforma seria importante cuando realmente tienes un problema de salud, que realmente lo necesitas que te hagan la cirugía, y yo se que nada debe ser completamente gratuito, pero, que te den opciones, planes de pago, pero a veces se hace difícil." (Because of being an immigrant one doesn't have the same access; so with this reform it would be important that when you really have a health problem, that you really need it, that they perform the surgery, and I know that nothing should be completely free, but, they should give you options, payment plans, but sometimes it gets very difficult. Mexico, 43 years old, 15 years in Kentucky)*

Structural Determinants of Reproductive Health: Developing A Framework for Understanding Immigrant Latinas' Access and Perceptions of Access to Reproductive Health Services and Information

One of the proposed goals of this study is the development of the structural determinants of reproductive health framework as a way to support policy-development from a holistic, "as it happens in people's lives" approach rather than a single-issue, silo manner that excludes the contextual realities that create the conditions that bring about health behaviors and conditions. The structural determinants of reproductive health framework is informed by the reproductive justice and the social determinants of health frameworks. This framework was to be fleshed out iteratively through the rich data collected in this study. The original study proposal relied on Photovoice as the primary data collection method, and key informant interviews as a secondary source of data. Due to institutional concerns, however, the

original Photovoice methodology was not approved by the IRB, and key informant interviews was the principal and sole source of participant data collection. While the data collected provides clear insights into Latina immigrants' access to family planning, it does not provide the depth and richness of data anticipated through Photovoice. Therefore, while the groundwork for this framework is laid out in this report, a full development of this concept will require further research through participatory methods.

Building a Framework

The structural determinants of reproductive health lays its foundations on the concepts and approaches of the reproductive justice and social determinants of health frameworks. The evolving concept of perceptions of access is also integral to the framework's infrastructure. The findings of this study provide key components for this framework and begin to illustrate a visual and conceptual mechanism for understanding the multiple and interactive elements that contribute to access and perceptions of access to family planning for Latina immigrants in new settlement states. This framework could be adapted to address other reproductive health issues and other contexts (i.e. beyond new settlement states).

I begin the exploration of the structural determinants of reproductive health by revisiting these three contributing concepts, followed by a description of what this study's process and findings have added to this evolving framework.

Reproductive justice places gender, race, class, culture, sexuality, age, and geography at the forefront of reproductive issues and policies and addresses the whole

person through a holistic, multi-disciplinary, inclusive approach to protecting and strengthening reproductive rights and health. The concept of self-determination is central to reproductive justice as it refocuses the community from an object to be acted upon to a self-directing actor.

Reproductive justice recognizes the need for an intersectional analysis, where the interactions of the social, economic, biological, and political realms are determinant of the options and exposures and, in turn, outcomes that are most accessible and likely to individuals and communities. Intersectionality also refers to the multiple identities that individuals experience at once (i.e. gender, race, class, immigration status, social class, etc.) and the need to consider all these multiple identities, realities, and roles. Reproductive justice has grown to include immigration policy as a significant factor in immigrant women's reproductive health.

Similarly, the social determinants of health (SDOH) are defined as the "social conditions in which people are born, live, grow, work and age, including the health system" and are informed by a "growing understanding of the remarkable sensitivity of health to the social environment."[158,159] Inherent in this approach is government's responsibility to implement and enforce policies that promote and protect health equity.

Like reproductive justice, the social determinants of health similarly takes a holistic, ecological approach in explaining the socio-political conditions that predispose health options, and hence health conditions. The SDOH framework pushes us to look beyond the health care and public health sectors of services and policies and to view health outcomes as a result of multiple (and inequitable) exposures and opportunities

at various levels of society and in realms not traditionally included in health analysis. For both reproductive justice and social determinants of health, the importance and necessity of the participation of the community, as individuals and a collective, is implicit.

While the concept of access is an "ill-defined term", in public health, the notion of access has generally been expanded beyond traditional markers of access such as insurance coverage, health care utilization, affordability, and a usual source of care.[160] Although there isn't a single public health definition of access, some definitions are broad and entail "factors which influence entry or use...viewed as a concept that's somehow related to consumers' ability or willingness to enter into the health care system".[161] Broader definitions includes things such as transportation, hours of operation, location of health care service, proximity or accessibility by public transportation, and may even include childcare, language access, and cultural competence.

Although the broad application of the term access entails numerous important elements, it is limited to factors characteristic of the health care system itself or of a "fit" between the health care system and the individual or group.[162]

The concept of perceptions of access acknowledges that factors outside of the health care system affect individuals' and groups' perception of accessibility and that experiences with or knowledge of others' experiences with instrumental access shape beliefs about the possibility of accessing services. The concept of perceptions of access also introduces psychosocial dimensions to access. Perceptions of access are fed by

individual-, community-, and societal-level factors. For example, in this study, personal experiences, knowledge of experiences of others in the Latino community in Kentucky, and information heard through media regarding immigration policies, all affected informal community leaders' perceptions of access. Importantly, perceptions of access result from multiple factors interacting, rather than any one factor alone. In this study, Latina immigrants' cultural beliefs and comfort with sexuality and reproductive topics combined with a sense of lack of entitlement to health services, a fear of deportation, and more instrumental access concerns such as language access and transportation to create a co-ocurring interest in and limited access to family planning services and information.

Policies (and how they are communicated) set the tone on how groups are perceived, valued, and how that group believes the "system" or community as a whole perceives them. While policies are developed to address single issues and with input from few or singular sectors, they affect access and outcomes in sectors beyond their originating field. Policies, in effect, contribute to perceptions of accessibility and may act as a barrier that precedes the instrumental aspects of access.

This framework recognizes the role that political philosophies and interests as well as social values and norms play in the types of policies that are developed and how they are implemented. In the case of the U.S., both domestic and international policies are relevant as U.S. policies have broad repercussions throughout the globe. The U.S. emphasis on individualism and the growing push towards limited government role

contribute to the types of policies that are developed and affect every layer of the diagram.

Communities perceive and value immigrants based on a number of markers, including race and ethnicity, ability to speak English, socio-economic status—including educational level, occupation, and rural versus urban origins. While immigration status contributes to how communities view and value immigrants, this is reportedly assumed from other information, such as race/ethnicity, language, and socio-economic status. These community perceptions and attitudes interact with the overall social context and contribute to immigrant Latinas' perceptions of access.

Contributors to perceptions of access include cultural attitudes of the community where immigrants come from and where they currently live. For example, in this study, Latina immigrants discussed how the values and beliefs they were raised with affect their attitude and comfort with family planning. The political context of immigrants' home country also contributes to their expectations of government's role in health and their sense of trust in the government. In terms of their current home, Latina immigrants and some providers reported racism and discrimination against immigrants. Providers also reported a resistance to change and lack of experience and exposure to immigrants and non-English speakers by the general population in Kentucky. These internalized and external contextual realities contribute to immigrants' experience of fear, isolation, and rejection, which describes how immigrant Latinas experienced perceptions of access in this study.

Perceptions of access are an important component to the structural determinants of reproductive health as it is a product of the various factors from multiple sectors and levels of society that directly and indirectly affect health.

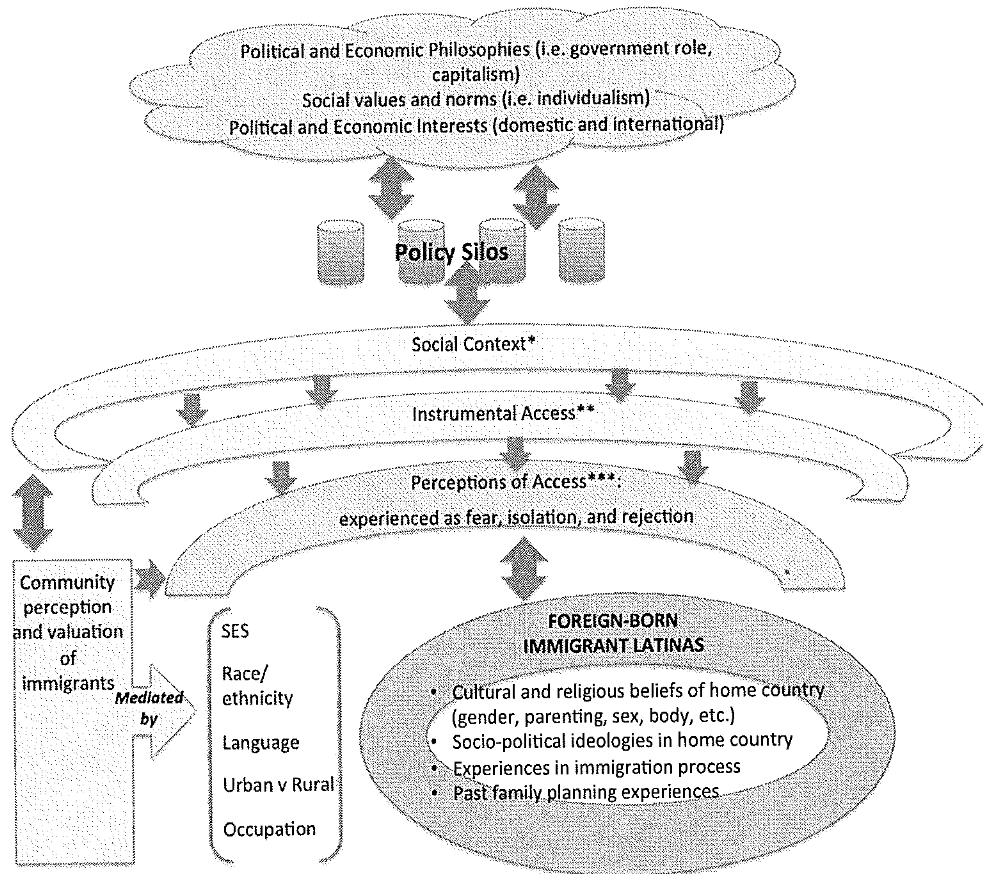
From the two above-described frameworks and the concept of perceptions of access, the idea of structural determinants of reproductive health arises. This concept includes various socio-economic, cultural, and political factors, such as gender, race, socio-economic status, ethnicity, immigration status, rural-urban location, religion, sexual identity and orientation, and parenthood. An important aspect of this worldview is that none of these factors can be disentangled from others, and therefore it is the interaction of various factors with varying degrees of influence on each individual that create specific and unique experiences and social position.

The diagram below lays out the initial thinking around the structural determinants of reproductive health and illustrates the description provided above. It considers the case of immigrant Latinas in a new settlement state as a vehicle for exploring this framework. It is important to note that the levels illustrated below are porous, so the influence of a level "higher up" in the diagram permeates through to all the levels below, both directly and indirectly.

The scope of terms used in the diagram is presented on the following page and are based on findings from this study. While it is assumed that factors such as sexual identity and orientation would play a role in this framework, this issue was not addressed or identified in this study and is therefore not presented in the diagram. The exclusion of important identity or social context factors is not a statement of their

relevance but rather is limited by the current study's findings. Further research will contribute to the completion of this framework.

Structural Determinants of Reproductive Health : An Evolving Framework (M.G. Alcalde)



*_Social Context_: Political messages and actions; anti-choice rhetoric; economic health; political voice of immigrants; cultural openness to change; post-welfare reform messaging; cohesiveness of Latino community; general attitude towards immigrants; general gender attitudes and dynamics; experience with immigrants.

** *Instrumental Access*: Transportation; language access; cost; insurance coverage; program eligibility; cultural competence; hours of operation; waiting times to and at appointments; intimate partner violence; partner support in family planning decisions; information and services by religious entities; availability of all contraceptive methods; awareness and knowledge of family planning services.

****Perceptions of Access*: Fear of being arrested for driving without a license; fear of being deported while accessing services; fear of being mistreated for "looking Latino"; fear of not understanding/being understood due to lack of language access; fear of partner in abusive relationships; fear of contraceptive side-effects; fear of not having a right to services due to being undocumented; fear of not being able to pay for services; shame in discussin family planning; fear of losing cultural identity; not realizing importance of family planning to achieving goals as individual and parent; feeling of isolation and being alone; experience and fear of being rejected.

CHAPTER V
DISCUSSION

This study provides a glimpse into the experiences and perceptions of foreign-born Latina immigrants in regards to family planning in a new Latino settlement state. Given the rapid and significant growth of the Latino population in states such as Kentucky, the existing reproductive health challenges that Latinas face, and the heightened national tension around immigration, this study provides a timely contribution to current knowledge and dialogue. Through the study findings and recommendations, possible paths for further exploration as well as approaches to increasing access to family planning for Latina immigrants are laid out.

The current study sought to expand upon the existing literature on Latina immigrants in the United States and their perceptions of access to family planning, particularly in new settlement states. While existing knowledge provides a foundation for building a more in-depth understanding of Latina immigrants' access to and use of contraceptive methods and family planning, existing literature in this area is very limited.

Existing Knowledge

Prior research has identified that Latinas tend to overstate the risks of using hormonal contraceptives, with studies identifying a widespread lack of knowledge

regarding contraceptive method safety and product side-effects.[163,164,165] Latinas are also more likely to report less knowledge of the reproductive system and functions overall.[166,167]

This knowledge barrier co-exists with low contraceptive use, with Latinas less likely to use contraception than white or African American women.[168] Latinas are also more likely to experience inconsistent use of contraception and contraceptive failure.[169,170] When compared to non-Hispanic women, Latinas are more likely to rely on sterilization and long-acting hormonal methods than on the birth control pill or condoms.[171]

Just as in the current study, researchers have explored how cultural norms and practices play a role in women's decisions regarding family planning. Some prior findings indicate an association between traditional gender roles' and decreased power within intimate relationships effects and a woman's ability to negotiate contraceptive use, number of children, and child-spacing.[172] Despite the centrality of religion in many Latin American cultures, researchers have found no correlation between religiosity and contraceptive beliefs.[173] In terms of gender roles' influence on family planning, Latinas report lower levels of comfort in talking to a partner about sex or condom use.[174] This is significant as women who speak to their partners about contraception and make decisions together about family planning are more likely to use and stay on contraceptives.[175,176]

Researchers have also identified language access as a barrier to family planning use for Latina immigrants. In studies looking at English-speaking and Spanish-speaking

Latinas, a difference was identified in the two population's comfort and proficiency in family planning use, knowledge, and attitudes.[177] Similar findings were identified in studies that compared foreign-born and U.S.-born Latinas.[178]

Although not directly focused on Latina immigrants, research into intimate partner violence has identified contraceptive sabotage as a common tool used by perpetrators of abuse within the context of intimate relationships.[179] Researchers have found that women who are victims of intimate partner abuse are much more likely to experience unintended pregnancy, sexually transmitted diseases (including HIV and AIDS), and state that they do not have control over the number or spacing of their children.[180,181] Studies also report both forced continuation of an unwanted pregnancy and forced termination of a desired pregnancy to be common in abusive relationships.[182]

Studies have also identified program eligibility requirements, hostility towards immigrants, and clinic practices to be barriers to Latina "women from accessing reproductive health care services available in their community."[183]

Overall, the literature addressing the family planning experiences, beliefs, and knowledge of foreign-born Latinas is limited. Knowledge is particularly limited in regards to new Latino settlement states, such as Kentucky. Due to the fact that most research comes from states with established Latino populations, studies tend not to differentiate or combine foreign-born and U.S.-born Latinas, despite the fact that significant socio-economic differences exist between these two groups. In new settlement states, the Latino population is predominantly foreign-born. Much of the

current knowledge about Latinas and family planning is focused on adolescents or very young adults and is based on populations identified through health care services use. As Latinas have a high-uninsured rate and have less access to health care services, by selecting a study population from those accessing health care, the results can be skewed.

Existing literature is primarily focused on individual determinants, and less so on structural or environmental determinants as factors in family planning or contraceptive use, knowledge, or access. A limited analysis of the broader social context within which Latina immigrants live is prevalent and few studies provide a voice to Latinas.

Limitations of this Study

The data acquired through this study provided the necessary information to answer the research questions and gain initial insights into the concepts of perceptions of access and the structural determinants of reproductive health. The data also allowed for the discovery of several relevant findings. However, this study should be viewed within the context of its inherent limitations.

Limitations to this study include lack of generalizability as the experiences, perspectives, and beliefs expressed by key informant interview participants can only be assigned to those individuals, in their specific temporal, socio-cultural, political, geographic, and economic realities. Further, the current socio-economic (economic recession), political realities (national anti-immigrant sentiment and current backlash towards reproductive health services and policies) also affect the experiences and perspectives of the participants. While participants spoke of the changes over the past

decade or more in Louisville and Kentucky, they provided this long-view from their personal perspective. Further, interviews were conducted once and therefore the data represent the participants' views at one point in time.

While this study's findings may be relevant to other states with recent Latin American immigrant settlements, the experiences of Latina immigrants in Kentucky may be unique and not as transferable to experiences in other states. Further, although the scope of this study is Kentucky, the area from which key informants will be sampled is the largest urban center of this largely rural state. In this way, this study may not be applicable to all localities in Kentucky, but rather more salient to urban centers in Kentucky.

While the investigator made every effort to assure that the participants chosen would provide a good sample of representativeness in both the provider and informal community leader populations, the participants were chosen as a result of the investigator's knowledge of those working with Latinos, with the guidance of a handful of providers in Louisville and at the state level on the appropriateness of the list of potential participants. Participants for the informal community leaders were chosen from a network of women's support groups. While there are 12 groups throughout the city, the groups' membership is not encompassing of all Latina immigrants in Louisville and other informal community leaders exist who do not associate with the Latina Women's Movement. Overall, there is limited generalizability of the findings due to the study's methods and delimitations.

Latinas represent multiple countries of origin, urban and rural roots, varied socio-economic and educational levels, diverse racial identities, and other dimensions of diversity within this very heterogeneous group. Within the broader sample of key informants, this study looks at a non-representative sample of Latina community advocates and leaders and their experiences, perceptions, and opinions cannot necessarily be generalized to all other Latinas due to the wide diversity within the category of "Latina."

The P.I.'s identity as a Latin American immigrant also inserts bias into the study. At the same time that the P.I.'s identity inserts bias, it also allows for a translation of information that may not be possible for a researcher not a member of the general Latin American cultural or immigrant category. It is also important to note that while the P.I. is also a Latin American immigrant who considers Spanish her native language, she is also different than much of the Latino immigrant population in Kentucky in terms of immigration status, educational opportunities and attainment, and current socio-economic status.

The Current Study's Contributions

This current study's findings both concur and expand upon existing literature on foreign-born Latina immigrants' access to family planning. Further, the explicit focus on perceptions of access in this study expands our understanding of how social context and policies are experienced by Latina immigrants and the role those experiences and perceptions play in instrumental access. This study provides insights into Latina immigrants' experiences and perceptions at a time when immigration and reproductive

health are highly politicized, particularly in Southern states such as Kentucky. The findings also contribute to the limited information on Latina immigrants' awareness and understanding of the Affordable Care Act.

Key findings of this study include the centrality and interaction of immigration, transportation, and language access policies in both the perceptions of access and instrumental access to family planning for foreign-born Latina immigrants. Some findings apply specifically to new settlement states, including the perceived sense of transition from a predominantly white state to an increasingly linguistically- and ethnically-diverse state. The realities of Kentucky, as a poor, predominantly white state with reported cultural resistance to change and inconsistent political messages and actions, while specific to the state, may mirror some of the circumstances of other new Latino settlement states, particularly in the South.

The influence of culture in Latinas' family planning decisions has been studied before, yet the added dimension of the convergence of post-welfare reform rhetoric with vocal anti-choice presence, provides a more complete and complex picture of the cultural context that Latina immigrants must navigate to access family planning. This finding is particularly salient when considering the reported central role that religion plays in many Latinas upbringing and the role that the church plays in providing support and basic services for low-income immigrants in the community.

While findings of language access as a barrier have been presented before, linking these existing community deficits with Latina immigrants' experience of isolation, rejection, and fear provide a more complete picture of barriers to access by

layering perceptions of access in the Latina community atop the known instrumental access barriers of language and information access. Similarly, previous findings of program eligibility as a barrier to access is complemented with this study's findings of perceptions of not having a right to access services due to immigration status and persistent fear in the community that accessing health or social services may result in arrest or deportation.

This study's findings that Latina immigrants describe family planning as a multifaceted, complex and highly valued concept, with a strong focus on children and ability to parent has implications for programmatic as well as research efforts. Participants' entry into discussions about family planning was almost exclusively through conversations about children and parenting. Programs and research that focus on contraception, rather than family planning, may miss the opportunity to tap into Latina immigrants' motivation and context for valuing and seeking family planning. This finding also underlines the need to more effectively incorporate the disease-prevention role of contraception with Latina immigrants.

While this study's findings confirm a reported lack of comfort and knowledge of family planning, contraceptive methods, and reproductive and sexual matters in general, it also provides a strong message from Latina immigrants of their keen interest in learning more about all contraceptive methods. Previously identified mistrust of hormonal methods was also identified in this study, although participants' emphatically expressed importance of receiving complete information about all methods could

indicate that lack of trust in hormonal methods is a condition of lack of knowledge and information about such methods.

This study also provides insight into the multiple factors affecting unwanted pregnancies in Latina immigrants. While lack of access to contraception is reported as a definite factor, informal community leaders presented a complex web of factors that led them to unwanted pregnancies, including especially intimate partner violence, lack of awareness and understanding of family planning as a concept, and lack of negotiating power in the relationship with a sexual partner.

An important, and prevalent, finding is the importance of confianza (trust) in perceptions of access. The concept of trust has been studied in other contexts, and may be particularly relevant to this topic from studies of social capital. The specific meaning of confianza in terms of Latina immigrants' experiences with reproductive health in a new settlement state will need to be further explored. This study's findings clearly indicate that experiencing confianza increases Latina immigrants' perception of access to a specific organization and provider. Providers spoke of being sought out by Latina immigrants because of the existence of a relationship of confianza.

The theme of confianza also abound in discussions of the centrality of women's groups as a source of information and support. While linguistically- and culturally-appropriate family planning information and education from providers was presented as desirable, the importance of peer-to-peer learning was evident in every interview with informal community leaders and with providers involved with or with experience with the women's groups.

Key elements of the women's groups include the nonhierarchical nature, the long-term commitment, the coverage of numerous and varied topics, and presentation of family planning within a broader context and as related to parenting. The women's groups also reportedly address both issues and context of issues. For example, addressing concerns over gender roles and relationships when discussing family planning. The women's groups all occur in Spanish-only and are located throughout the city to allow women in various neighborhoods to attend. Some of the groups are located in churches, although the content of the group discussions are defined and led by participant women with support from the facilitating organization, La Casita Center. The stated acceptance and trust in family planning information received through such groups is an important finding given the existing lack of knowledge and misinformation about contraception and reproductive health issues in general among Latina immigrants.

Another key finding of this study is the reported importance of the role of men in family planning. Both informal community members and providers identified the need to involve men in family planning education and decision-making. Given prior research findings of the important role that gender roles play in family planning, and Latino men's perception that family planning is a woman's issue, this finding of Latina's desire for men to become better educated and involved in family planning provides further support for the development of culturally- and linguistically-appropriate family planning education efforts with Latino men.

Overall, providers and informal community leaders asserted the interaction of a wide range of social policies with family planning without much prompting. The lived experiences of the informal community leaders and the knowledge and perspective gained by providers who work very closely with Latina community members (and are often Latina themselves) provides a natural vehicle to understanding access through a structural determinants of health framework, where various factors at the personal, community, and societal levels interact.

While policymakers, and often public health professionals, may not immediately see the connection between immigration or transportation and family planning, Latina immigrant informal community leaders, as well as providers working very closely with the Latina community, easily see that changes in immigration and transportation policy impact their ability to seek family planning information and services.

This study's findings reiterate the importance of facilitating a real voice to the community affected by the issue being studied in research and policy development. Without the voices and perspectives of Latina immigrants, key findings and connections in this study would have been missed. Key to their experiences coming through in the research is the study's focus on perceptions of access, which allow participants a chance to share information that goes beyond the instrumental. The ongoing development of the structural determinants of reproductive health will further contribute to more grounded and holistic approaches to policy development, while integrating the experiences and perceptions of Latina immigrants as integral to understanding and addressing access to family planning.

While this study's findings provide an impetus for action by public health professionals and researchers on specific programmatic, policy, and leadership items, it most importantly calls for a transformation in the conception of policy development. Specifically, this study's findings support the need for an intersectoral, multi-level and multi-disciplinary approach to policy development based on the emerging structural determinants of reproductive health framework.

Through it's findings and recommendations, this project contributes to the conversation around how to apply the social justice, social determinants of health concepts that underpin public health. Finally, because there is currently such a dearth of information and understanding of the realities of Latina immigrants in new Latino settlement states such as Kentucky, this study and its products contribute to a small but increasingly relevant body of literature.

Recommendations for Future Study

This study points to several opportunities for further research in terms of methods and focus of study. In terms of methods, the ability to collect information over time may enhance the completeness of the evolving understanding of perceptions of access and contribute to the full development of the structural determinants of reproductive health. A series of interviews over time, rather than single, one-time interviews would allow a richer and more dimensional representation of Latina immigrant informal community leaders' experiences and perceptions. The use of CBPR methods would enhance the informal community leaders' evolving role in the Latina community and serve as a venue for capacity-building and leadership-development.

CBPR methods would also allow for researchers to capture richer and more nuanced information about perceptions of access and the conceptualization of family planning. Specifically, in order to fully develop the structural determinants of reproductive health framework, further participatory research in this area is necessary.

This study identifies several areas for future research. Principally, future research should consider the role of immigration, transportation, and language access policies on access to family planning, or other reproductive health services and information. Within this general theme, research should be conducted to elucidate the potential health impact of state laws that limit undocumented immigrants from accessing driver's licenses. Similarly, research should be conducted to ascertain potential health impact on Latina immigrants in communities that have adopted the Secure Communities agreement and the 287(g) program. Studies could compare reported perceptions and experiences of access by Latina immigrants in communities that have and have not adopted the policies listed above.

Given the high proportion of providers and policy professionals who are Latina among the participants of this study, it would be interesting to study the role of Latina providers in providing access to family planning for other Latina immigrants in new settlement states and locations with limited immigrant-friendly infrastructure. Also at the organizational level, research is needed to evaluate the effect that organizations that implement CLAS may have on access to family planning for Latina immigrants.

This study indicates a strong interest by Latina immigrants and providers to engage male Latino immigrants in family planning efforts. Research is needed to

identify the approaches being taken with Latino men as well as evaluations of such approaches.

An unexpected finding was the central role that women's groups play as channels for trusted family planning information for Latina immigrants. Research should explore peer-to-peer, Latino-led efforts' role and success in increasing awareness, knowledge, use, and dissemination of knowledge (through community-based leadership) of family planning.

In regards to the ACA findings and some providers ideas that they would be able to focus existing funding streams on outreach and services to undocumented immigrants as ACA would increase coverage for others who are currently uninsured, it will be interesting to see how organizations who serve undocumented Latinas adapt their outreach and services as ACA increases coverage for others in the community. In terms of perceptions of access, assessing Latina immigrants' knowledge of and perspectives on ACA over time would merit future inquiries.

This study also indicates that the study of the perceptions of access can provide a valuable added dimension of understanding to the concept of access. Perceptions of access may be particularly relevant in studies dealing with marginalized communities. Further research is needed to fully develop the concept of perceptions of access and operationalize it in a way that it can be applied more broadly.

More generally, further research is needed to elucidate the mechanisms for successfully implementing a comprehensive, intersectoral policy-development approach that incorporates the structural determinants of reproductive health

framework and includes meaningful community participation that allows for context-specific adaptations.

CHAPTER VI
RECOMMENDATIONS, POLICY, AND LEADERSHIP IMPLICATIONS

Based on the Findings described in the prior chapter, the second and final research questions are answered through the development of recommendations and a discussion of policy and leadership implications. The recommendations are intended to address the challenges identified by both providers and Latina immigrant informal community leaders, building upon the ideas provided by the study participants.

In order to answer the final research questions, How can public health advocates more effectively use community-based approaches to influence reproductive health policy initiatives targeting Latina immigrants in Kentucky?, the policy process and approach, rather than specific policies, will be explored. These processes and approaches would facilitate the implementation of the recommendations laid out in this section.

Recommendations: What is necessary to improve access to family planning services and information by Latina immigrants in Kentucky?

1) Culturally- and linguistically-appropriate outreach and education at the community level:

a. Support current grassroots, Latino-led, peer-to-peer groups and workshops for women and create or expand similar efforts for men addressing immigrants' rights, cultural beliefs around gender and sexuality, and comprehensive family planning (including parenting): Latina Women's Movement model

The importance of outreach through the use of peer-to-peer models, for example the women's groups of the Latina Women's Movement, was very clear in the findings of this study. These findings indicate that support should be expanded for such groups so more Latina immigrants can benefit from the information-sharing that takes place. Additionally, similar groups developed to meet the cultural needs of male Latino immigrants should be created to complement and support the work of the women's groups. As stated by the participants, family planning can only be fully implemented when both parties involved in the sexual relationship are in agreement and supportive of the decision. In addition to the cultural and linguistic access provided by such groups, literacy and educational level barriers can be addressed through peer-to-peer groups.

Because cultural understanding of gender roles and sexuality were described as central to the work of the groups around family planning, peer-to-peer efforts should explore, and when appropriate, challenge in a culturally-sensitive way, the assumptions around gender and sexuality. Findings also indicate that these groups serve to educate

and empower Latinas in terms of immigrant rights and comfort in communicating with health providers. These topics should be addressed directly through groups for men as well.

The Latina's Women's Movement, facilitated by La Casita Center, can serve as a model for these groups. The groups are located throughout the city, are relatively self-directed, are nonhierarchical, and address a broad array of issues. As indicated by the last recommendation of this study, the women's groups should be evaluated to assess their effectiveness in increasing knowledge, changing behavior, and increasing information-sharing from group members to non-group members, and to gain a deeper understanding of the components that make the groups so appealing to the members.

b. Expand current education efforts for Latina immigrants to include greater information on the importance of family planning for disease-prevention, taking into account the centrality of children's wellbeing as a motivator for family planning

While informal community leaders report having gained in-depth knowledge about family planning through the women's groups and workshops, there was a gap in knowledge in terms of contraception as disease-prevention. Current efforts should expand or emphasize the importance of contraception for disease-prevention within a context that appeals to the women. One possibility is to incorporate the reported desire to take care of personal health to guarantee the woman's ability to take care of and provide for her children.

While it is also important to highlight the importance of self-care and the value of the women themselves, due to the strong external focus in reported health behavior,

it may be culturally-appropriate to initially present disease-prevention as a tool to provide children with the attention, love, and education that women desire for their children.

c. Further develop partnership with churches and other natural community conveners for outreach and education

While it is unclear whether Catholic churches would be open to providing workshops and groups that address family planning and other reproductive health services, other religious congregations may be open to this effort. Further, partnerships with Catholic churches may also serve as a way to establish trust with Latina immigrants and as a desired channel for outreach and education as reported by informal community leaders. La Casita has successfully conducted women's groups at churches where the programming is independent of the church. Such arrangements seem to be the result of long-standing and trust-based relationships between church leaders and nonprofit organization leaders facilitating the groups.

2) Training and establishment of clear policies and procedures for providers, front line staff, and leadership at service agencies

a. Title VI and CLAS[c], IPV and reproductive coercion, program eligibility and identification requirements

[c]CLAS: Culturally and Linguistically Appropriate Services. These are national standards and guidelines targeting health care organizations and providers, developed by the Office of Minority Health. Information available online at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

This study identified significant gaps in the implementation of exiting policies, as well as reported lack of knowledge of such policies by providers. Implementing mandatory and periodic training on existing policies, such as language access, should eliminate some of the apparent confusion and misinformation. Further, clarification of existing policies, or development of policies where they are non existent, regarding culturally- and linguistically-appropriate services (CLAS), program eligibility and requirements, as well as screening and referral for Intimate Partner Violence and reproductive coercion, could expand access to information and services for Latina immigrants. Health care organizations and other health providers should follow national guidelines on CLAS, Title VI, and use best practices in screening for IPV and reproductive coercion.

b. Cross-training of social service staff on family planning

Because family planning is a multifaceted concept for Latina immigrants, providing basic training to social service providers on family planning information and methods could provide another avenue for access for Latina immigrants. If provided in a linguistically- and culturally-appropriate manner, receiving information about family planning from a social service provider could also help dispel misinformation about contraception. Given that such a high percentage of Latina immigrants are uninsured, accessing information about family planning through channels not requiring insurance coverage, such as social service providers, increases the chances of Latina immigrants actually receiving such information.

3) Advocacy and action to change current state laws and policies

a. Driver's license requirements for immigrants

Given the profound effect that the driver's license law has had on undocumented immigrants' mobility and associated fear, organizations and individuals working with the Latino community, as well as public health professionals, should advocate for state legislators to re-evaluate and eliminate this law on the basis of its negative impact on the public's health. Public health professionals should assess the health and safety impact of driver's license laws such as the one in Kentucky. Evaluations should include measures of perceived access, as fear of arrest resulting from this law can inhibit access. Public health organizations should take a position against such legislation as a barrier to public health and safety. Public health advocates should work with state health departments to educate policymakers on the negative public health consequences of such laws.

b. Secure Communities and 287g programs

Hess et al report that implementation of programs such as Secure Communities and 287g Agreements, decrease the immigrant community's trust in law enforcement and foment fear, with particularly negative impact on immigrant women who are victims of abuse.[184] Participants in this study also indicate that undocumented immigrants are likely to forego needed health care, included family planning services, due to fear of being reported to immigration. These policies clearly undermine public health and raise questions about civil and human rights violations given reported racial

profiling and harassment by law enforcement. Public health professionals should support the immigrant and advocacy community in calling for an end to these policies and programs that seek to enforce immigration (a federal duty) at the local and state level. Public health organizations should consider further health assessments of these policies and issue a statement about these programs and policies regarding the potential public health impact on immigrants and the communities they live in.

4) Proactive political messaging at local and state level regarding immigration and immigrants (Mayor, Governor, police departments)

Political will and political commitment are necessary for any policy-level change to occur. Further, as reported by providers in this study, the tone set by political messages at the state and local level have concrete consequences in the community. Whether these consequences are due to perceived access or instrumental access, the effect is similar if immigrants feel unwelcome and curtail help-seeking behavior due to fear.

Political messages from Mayors, the Governor, and police departments regarding the importance of immigration to the local economy, and the importance of treating people with respect, and clear messages about the local law enforcement's policy regarding immigration enforcement, can potentially create a sense of safety and being welcome for immigrants.

Proactive messaging against racial profiling, and messages about the safety of contacting law enforcement when they are needed are also essential to mitigating the possible effects of violence in the home and in the community.

5) Culturally- and linguistically-appropriate services and information around comprehensive family planning in an environment of trust (including all options counseling and screening for IPV)

Culturally- and linguistically-appropriate access to family planning is important as "…contextualizing health within culture, sexuality and a broader political economic framework is essential and too often left out of the public health equation."[185]

While this recommendation entails changing to funding, training, and service provision, some smaller steps can be taken in this direction by organizations without significant structural changes. First, following the fourteen (14) National Standards on Culturally- and Linguistically Appropriate Services (CLAS) should be set as a priority for all health care organizations providing family planning services. Further, some of the IOM Recommendations regarding the ACA might help to fill the gaps (for those who have private or public insurance) in Latina's access and use of family planning services and information identified in this study, such as 1) Annual counseling on sexually transmitted infections for all sexually active women; 2) Counseling and screening for human immunodeficiency virus infection on an annual basis for sexually active women; 3) The full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity; and 4) Screening and counseling for interpersonal and domestic violence…in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.[186]

6) Further examination of feasibility and potential outcomes of making contraceptives available over the counter

A recent study of Mexican women who crossed the U.S.-Mexico border to attain over-the-counter birth control pills, The Border Contraceptive Access Study, found that women who acquired the pills over the counter were more like to continue pill use than women who relied on prescriptions for birth control pills.[187] These researchers also found that women would likely use the birth control pill if it was available over the counter.[188] During the same study, researchers also found, however, that women who received their birth control pills over the counter were more likely to have counter-indications for pill use, raising concerns about the safety of birth control pill use without medical counseling.[189] Further research is needed into the possibility of providing birth control pills (and other contraceptive methods currently requiring a prescription) over the counter. Looking at the possibility of pharmacists providing counseling and standard screening for pill use; making only pills with the least contraindications available over-the-counter (i.e. progestin-only pills); or making birth control pills available at non-urgent care centers (such as the Walgreens clinics) where no appointments are necessary, should all be explored as ways to decrease barriers to access for Latina immigrants and other low-income women.

7) Increased communication and coordination among Title X providers, with monitoring of wait times for new patients and appointments

a.	Increased accessibility to IUD

Statements by providers in this study point to a lack of coordination and communication among Title X recipients in Louisville, Kentucky. Greater communication and some level of coordination could lead to shortened wait times for new patients; streamlined paperwork; possible integration of family planning services into other clinic services; and better data to assess the effectiveness and efficiency of the program. A provider also commented that new guidelines on family planning were released for Title X providers periodically. Keeping up to date on these guidelines was reported to be a challenge. An annual meeting of Title X providers, plus the establishment of some form of communication and tracking of wait times for new patients should be developed to assess how well these services are serving the community and formulate solutions when necessary.

Efforts should also be made to increase access to the IUD for Title X providers to better serve the contraceptive needs of immigrant Latinas, who reportedly have difficulty accessing this preferred method due to cost.

8) <u>Greater clarity about the impact of ACA on immigrant access to health services, and more community-level education on ACA in a linguistically accessible format</u>

Much like general population in national polls, local providers lacked clarity and detail on the components and potential impact of the ACA. Further, most Latina immigrant informal community leaders had not heard of the ACA and the few that had, regarded it in a negative light. Efforts to educate providers on ACA should be made at the national level, possibly through national health care organizations and associations. National organizations should also develop simple materials for the lay community

describing the basic components of the ACA, identifying specifically how these will affect immigrants. These materials should be available in various languages and written at literacy level that will allow the greatest informational access. These materials should then be distributed through local service and advocacy organizations, churches, and other faith-based organizations that provide services to immigrants and low-income populations.

9) <u>Dialogue with funders to re-evaluate the usefulness of short-term measurable outcomes as markers of success for programs that aim to create cultural changes</u>

Providers working with the women's groups express frustration in trying to find adequate funders for their women's groups work. The tendency for funders to target specific, narrow topics, and to look for traditional (and often quantitative) markers of short-term success, limits the ability to implement long-term, broad programming that aims to create cultural changes through the development of trust. It is important to note that the women's groups did not address family planning, or other sensitive topics, exclusively or right away. Women attend groups for topics such as cooking, parenting, diabetes care, workers' rights and immigrants' rights, and other less intimate topics before addressing topics such as sexuality, gender roles, and family planning. There is a significant time investment in developing sufficient trust and rapport before sensitive topics can be addressed with the groups. Providers working with the groups talk about different stages of "readiness" in terms of what topics each group addresses. Groups also weave in sessions on music and dancing, craft making, and cooking.

Funders interested in creating the long-term cultural changes necessary to enable changes in reproductive health seeking behavior, should consider the multifaceted, socio-ecological understanding of family planning for Latina immigrants.

If organizations are to adopt approaches that take into account social determinants of health, they will need the support of funders in addressing the underlying, root causes of inequity. For example, informal community leaders indicate that learning about immigrant rights (such as language access) and challenging gender roles (machismo) are important steps in identifying family planning as valuable and taking necessary steps to access such services. Along with funders, evaluators will need to develop new ways of capturing this more long-term and diffuse form of change, and redefine markers of success to better capture the social change necessary for true, sustainable interventions at the social determinant level.

Policy and Leadership Implications: How can public health advocates more effectively use community-based approaches to influence reproductive health policy initiatives targeting Latina immigrants in Kentucky?

First, in order to answer this last research question, we should identify who constitutes a public health advocate. In this study, public health advocate includes all public health professionals, who by the nature of their work in the field should embrace the advocacy role in public health. As stated in the Principles of the Ethical Practice of Public Health "[P]ublic health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all."[190] This principle applies very well

to public health professionals working on issues that affect immigrant communities, particularly the undocumented, who are certainly disenfranchised and encounter many challenges in meeting the "basic resources and conditions necessary for health". The category of public health advocate includes governmental, nonprofit, for-profit, and independent professionals.

The political nature of immigration and reproductive health, particularly in states like Kentucky, require that public health advocates concerned with family planning, and general health, of Latino immigrants embrace the political nature of public health and advocate for the community's well-being through work at the policy, programmatic, and community-level. Professional circumstances can limit public health professionals from taking what could be construed as partisan positions in their work and from engaging in lobbying. However, recognizing the political nature of public health issues, and the central role that education and advocacy play in public health, public health professionals must find a way to work within professional constraints while being effective champions for the community's public health interest.

Policy Implications

Policy, just like health, does not develop in a vacuum, but rather is the result of context-specific interactions of multiple variables. It is the result of the specific historical, political, and socio-economic stage and place whence it is developed. In other words, "[p]ublic health policies do not arise autonomously but instead partly from the broader political and economic forces."[191] The multiple ways in which policies

affect both instrumental access and perceptions of access are vividly conveyed through the stories that informal community leaders and providers share in this study.

A Lived-Experience Perspective of Policies

Adding to policy-driven external factors affecting access, are the internal factors that immigrant women bring with them from their own countries. Behind the stories, experiences, and perceptions of study participants are years of exposure to specific political ideologies and policies that created the world they've lived in. These personal experiences of socio-economic, political, and cultural forces are manifest in the family planning decision-making *vis-a-vis* perceived and instrumental access. Cultural norms and practices regarding comfort of speaking about sexual and reproductive matters and women driving combine with lack of language access and transportation barriers; entrenched racism and classism experienced in Latin America (particularly for women of indigenous, low-educational attainment, and/or low-income backgrounds) combine with immigration policies that criminalize and devalue undocumented immigrants. Understanding the lens and context through which policies are experienced and understood can provide public health professionals with a more complete understanding of policy-impact. Policies can have unintended but significant effects on portions of the population, and it is through lived-experience accounts from community members that we can incorporate this unintended impact into how we evaluate policies.

This community-level view of policies can also give guidance to policy-development approaches that take into account the multiple ways that policies can affect health access and health outcomes. The continued development of the structural

determinants of reproductive health should contribute to this lived-experience and integrated view of policy development.

A Development Approach

Along with a better understanding of Latina immigrants' understanding and experience of policies that affect health access, this study provides some insight into community-level efforts aimed at increasing and improving access to family planning for Latina immigrants. During interviews with providers, it becomes apparent that the work of the grassroots organizations supporting Latina immigrants is very akin to development work conducted internationally. Similarly, public health work has been associated with development work.[192] Indeed, the understanding of the social determinants of health necessitates a focus on development approaches. However, development has generally been conceptualized through a Western (primarily U.S.) lens and served to (possibly inadvertently) continue to undervalue and stigmatize indigenous, nonwestern identities and practices.

Many of the home countries of the Latina immigrants in Kentucky have been recipients of both international and domestic development work. In the interviews, women stated experiencing conflict between the affection and safety they feel in having been raised in a large, multigenerational family and the messages they received in their home countries about smaller families being preferable. Whether the reasons for wanting larger families were addressed or not, the small family was presented as the ideal of a more modern, educated, and Western person. Indeed, it is through reliance on a powerful Latin American bias of the superiority of European-origins over

indigenous-origins, that development messages are often relayed. In effect, development is often an external pressure with goals defined by international organizations or domestic organizations with urban roots. Immigrant women experience local development efforts somewhat differently as they are surrounded by a new social reality where development work is often aimed at assisting them and supporting them in making sense of the new world they have entered rather than changing the way the interact with a familiar world.

Given that much of the work being done with Latina immigrants in Kentucky is similar to development work, can development be a concept developed within each community? Can public health advocates work locally to identify ways to support healthier communities through local development efforts that empower new immigrants and facilitate Latina-driven transformation and community leadership? Policies and programs that enable culturally- and linguistically-appropriate efforts may require redefining funding and evaluation frameworks, and may broaden the parameter of issues that public health professionals are currently tackling. Key to a context-specific approach is recognizing the stage of readiness of a community. Programs and policies cannot simply be imported from other countries, states, or even localities. The specific socio-economic, cultural, and "readiness" point of each community will need to be taken into account as public health professionals work with communities to inform policies that affect health. These are important elements for public health advocates to consider as they work to support the rights and wellbeing of immigrants.

The Politics and Science of Public Health in Policy Development

Despite the U.S. public health profession's discomfort with political activism, public health does indeed play a role in politics, and politics of the day affect public health policies. It is important to be aware of this, from a historical perspective, and be cognizant of its possible manifestations in the present public health policies that exist and are absent.

Indeed, while public health has attempted to present itself as a science-based field, it is much affected and guided by political philosophies and economic interests and frameworks. The difference in how public health has evolved in the U.S. from other countries, in Europe as well as in Latin America for example, is in part a result of the U.S. emphasis on individualism, and the belief that free-trade and corporate autonomy (as it stands in contrast to strong government regulation) are best for its strand of democracy and freedom. Cultural (and political philosophical) values guide public health policies as much as current scientific knowledge does. In fundamental ways, core values of U.S. social and political philosophy stand in contrast to the collectivism and necessity of government action of public health values. It is essential that we raise a critical lens to the way we embrace or reject public health approaches, to understand the political trends and interest that may be fueling such patterns.

Another level of political awareness necessary for U.S. public health professionals (and the field as a whole) is the influence that U.S. policies have on other nations. Because of the global economic and political influence that the U.S. wields, public health professionals should ponder the ethical implications of both domestic and

international policies. For example, U.S. foreign-trade policies and neoliberal strategies that pressured developing nations to shift from public provision of basic needs to a more privatized approach of health care, have contributed to out-migration flows and decreased access to public health benefits in developing nations. Indeed, aspects of U.S. foreign policy have contributed directly to the high immigration flow into the U.S. from Latin America and the current challenges localities and states face in addressing the growing immigrant populations.

The role of politics needs to also be recognized in the role of the community in policy development. Without political voice and power, community participation remains at a low level and devoid of true empowerment. It can be argued that the political disenfranchisement experienced by some communities, foreign-born Latina immigrants in this case, represents a structural determinant of health. In this study, many providers and policy professionals identified the lack of political voice of Latinos in Kentucky as a limiting factor in Latinas' access to family planning and other health services. Latina informal community leaders communicated a widespread sense of limited rights by the immigrant Latino community. Only through meaningful community participation in policy development and elevated political voice and power, can sustainable community transformation take place. The role of political philosophy and interests in considered in the structural determinants of reproductive health and as such can play a role in integrating political contexts and factors in issue assessments and policy development.

Community Participation in Policy Development

As an example of the need to raise a critical eye to public health efforts, community participation is slowly becoming a powerful tool in public health endeavors as a way to engage, educate, and empower communities. This study, in fact, contends that community participation is essential to increasing access and improving public health conditions for Latina immigrants in new settlement states. Further, this study posits that policy-development can be enhanced through community participation. The WHO Commission on Social Determinants of Health (CSDH) defines participatory approaches as "'political processes that self-consciously and directly engage the people interested in and affected by [policy] choices', as well as the officials charged with making and carrying out policy."[193]

In view of the potentially powerful role that participatory approaches can play in policy development, it is crucial for public health advocates to recognize that community participatory approaches can be used in ways to further political philosophies. For example, Whitfield et al discuss the use of community participation as a tool in establishing and supporting decentralization of health systems in Latin America, a very U.S.-based approach.[194] Indeed, in the 1980s and 1990s, the U.S. played an active role in health care reforms in Latin America that moved health care provision from a "social right" to a "market commodity".[195] Despite the rhetoric, and well-intentioned commitment, of community participation towards community empowerment and autonomous transformation, community participation can be both coercive and paternalistic, particularly when it is lead by persons of differing cultural,

socio-economic, and/or ideological context as the community they are working with. Given these conditions, public health advocates must be aware of their own biases and power as they work with disenfranchised or marginalized communities.

Community participation can convey a lived-experience lens to policy development that is otherwise missing. Without community participation, policy development remains linear and insular in addressing issues as isolated and separate. Communities, on the other hand, experience issues as they overlap and interact, in direct and indirect ways. This community perspective approximates the social determinants of health framework as it connects multiple levels and sectors of society in experiences and perceptions. The CSDH states "the participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health…is justified on ethical and human rights grounds, but also pragmatically."[196]

At a minimum, public health professionals must raise awareness of the socio-cultural and political foundations of policies that affect health. More specifically, the findings of this project call for public health professionals, and others concerned with the health of immigrant communities, to move beyond issue-specific efforts and embrace a more complete understanding of what creates the conditions for people to be healthy. In addition to the recognition of non-health policies' impact on health, public health advocates will gain new insights into what factors affect health through careful and ethical community participation. Community participation in policy development can help to bridge the apparent disconnection between politically-driven

policies and the daily experiences of vulnerable populations. Public health professionals will need to work with government entities to create the space and processes necessary for immigrant communities to participate safely and meaningfully.

Multi-disciplinary and Intersectoral Approach

It is clear from this study, as in extensive social determinants of health literature, that factors outside the health sector affect access to health information and services as well as health outcomes. Addressing access and perceptions of access to family planning by Latina immigrants will require a multi-disciplinary approach that engages actors from various sectors, such as health, transportation, housing, education, social services, law enforcement, immigration, and others. Public health's multi-disciplinary nature should lend itself well to putting intersectoral collaboration and coordination into effect. The World Health Organization's Commission on Social Determinants of Health refers to intersectoral action as that which entails a "recognized relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes in a way that is more effective, efficient or sustainable...".[197] This study argues for intersectoral collaboration in reaching reproductive health goals for marginalized populations. However, it seems politically limiting to make specific health outcomes the common goal of the collaboration. Intersectoral partners will need to identify goals that serve all of their missions in order to make sustained partnerships politically feasible. Indeed, collaborative action by multiple sectors should lead to improved processes and outcomes in all of participating sectors, not just health.

Public Health's Seat at the Policy Table

Policy development is key to public health. While health is affected by virtually any social policy created, public health knowledge and approaches are seldom applied outside of (narrowly-defined) health arenas. Public health must capitalize on its multi-disciplinary nature to embark upon an expansion of public health expertise and authority in policy development. Some efforts in this direction have been made with the development of health impact assessments (HIA).[198] However, the political hurdles that will need to be overcome to raise public health, collectivist concerns above individualistic and free-market interests driving policies, are significant and will require concerted effort by the public health field working in concert with other sectors.

In a country so currently divided by extreme political views and bipartisan configurations, it is challenging to present a rational approach to policy development. The political process is inherently blind to its historical context, as it often views itself as progressing and moving towards something better than before. The cyclical nature of some problems, or indeed the stagnation of novel approaches to certain pervasive health and social problems seems to escape policymakers. Although public health is limited by its weak political position in the U.S., and its thwarted stature next to corporate interests, public health possesses many insights and perspectives that can assist the overall policy-development process in the U.S. in providing a more rational and context-appropriate policy development and implementation process.

One of the greatest challenges of our times facing U.S. public health is the development of its own politically-viable, nonpartisan, authoritative voice in the U.S.

policy discourse while recognizing the political nature of public health challenges and the profoundly political character of policy development. In terms of this study, public health advocates must find their seat at the table of immigration (federal, state, local policies), transportation (laws and infrastructure), language access, and workforce readiness policy and programmatic development if they are to address the social and structural determinants of health for Latina immigrants' access to family planning.

Specifically, public health advocates working with Latina immigrants will need to take an active leadership role in advocacy, programmatic, and policy changes in order to improve access and perceptions of access to family planning. Because of the federalist nature of the U.S. government, public health advocates will have to work at the federal level for rational immigration policy while focusing local efforts to address the dramatic differences experienced by immigrant Latinas as a result of state-to-state variances in policies and policy implementation. In fact, providers in this study stated that while immigration policy should be addressed at the federal level, the state should guide local action through the development of policies, clear communication of policies, and distribution of funding for local action. Providers in this study identified local actors as most apt to respond to the needs of Latina immigrant populations, while agreeing that guidance and enforcement must come from the state level. While, Latina immigrant informal community leaders in this study often named the government as the entity responsible for addressing family planning needs of Latina immigrants, a distinction was not made between federal, state, and local levels, possibly representing their familiarity with more centralized government systems.

As our understanding of health deepens and expands into the realm of social, cultural, and economic factors, so should the practice of public health. While research continues to indicate that in order to address lingering health inequities action is needed at the structural determinant level, most policies and programs continue to act upon "intermediary determinants (decreasing vulnerability and exposure), but interventions at this level frequently target only one determinant, without relation to other intermediary factors or to the deeper structural factors."[199] With policy development as a core public health function, it is imperative to broaden our policy and advocacy horizon in order to deliver effective, ethical, and knowledge-based policies that apply our growing understanding of the roots of health.

Leadership Implications

The policy implications discussed above call for public health advocates to take on active leadership roles. Public health advocates working with Latina immigrants will need to take an active leadership role in advocacy, programmatic, and policy changes in order to improve instrumental access and perceptions of access to family planning. Some of the key leadership elements necessary for a more inclusive and multi-faceted policy-development approach include: advocacy as central to leadership; community-level leadership and community-based participatory approaches as leadership development; organizational leadership in an increasingly multi-cultural society; and shared leadership for a multi-disciplinary approach to public health practice. While an in-depth and detailed discussion of leadership styles and approaches is beyond the

scope of this project, some of the key leadership elements identified through this study are reviewed below.

Advocacy In Leadership

Advocacy is an integral aspect of public health work. According to the Principles of the Ethical Practice of Public Health, "Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all."[200] Further, in order to carry out some of the essential public health core functions, public health professionals must take on an advocacy role.[d]

So what is advocacy? The Merriam-Webster dictionary defines advocacy as "the act of advocating or supporting a cause or proposal." According to London, "[A]dvocacy uses political and social influence to alter attitudes, behaviors, and/or decisions."[201] Public health professionals become advocates as they fulfill their duty to work in the public health interest of a community. The public health interest, as well as the public's interest in key health issues, is often at odds with other existing interests. Even if public health professionals take the position that they represent science-based positions rather than political positions, it requires advocacy to have science-based positions and approaches adopted as policy or practice. By placing a value on the health of the community, public health is advocating for the importance of health. While this may seem obvious and redundant, many policy decisions are made without consideration of

[d] Essential Public Health Services that require advocacy: inform, educate, and empower people about health issues; Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

health implications, or with the knowledge and acceptance of inherent health risks or costs. Public health professionals must become advocates to raise the political position of health itself, and of public health approaches specifically. Public health cannot assume that all stakeholders, or even community members they work with, will prioritize health above other interests.

Advocacy and leadership go hand in hand, according to London, "[A]dvocates become leaders as they communicate a vision, garner support, set strategies, and organize tasks to accomplish their goals." Because of the political nature of immigration and reproductive health, public health professionals will need to engage in advocacy in a way that builds bridges among various interest groups and use public health knowledge to influence action. Advocacy in leadership will also require courage in working for the public's health and wellbeing even as divisive discourse, and at times violent rhetoric, infiltrate the dialogue around immigration and reproductive health. In effect, "[L]eaders as advocates seek social justice, accept social responsibility, and link doing good with doing well."[202]

Organizational Leadership

Assuring a competent public health and personal health care workforce is one of the essential public health services as well as a public health ethical principle.[203] In order to meet this obligation, public health institutions must respond and adapt to an increasingly multi-cultural community with complex and layered needs. As identified in this study, social and health service providers need education and training in terms of providing culturally- and linguistically-appropriate services. Leadership is needed at

both a policy level and an organization level to implement and enforce the existing CLAS standards.

Kotter provides insight into effective organizational leadership through his eight stages of change: 1) establishing a sense of urgency; 2) creating a guiding coalition; 3) developing a vision and strategy; 4) communicating a change vision; 5) empowering employees for broad-based action; 6) generating short-term wins; 7) consolidating gains and producing more change; and 8) anchoring new approaches in the culture.[204] Because of the constant changes in community demographics and needs, it is imperative for organizational leaders to create adaptive organizations capable of responding to the evolving needs of their constituency. Kotter defines an adaptive organization as one that is "externally oriented, empowering, quick to make decisions, open and candid, and more risk tolerant."[205]

Communicating a clear message of cultural sensitivity and humility will be essential for organizational leaders to create compassionate service agencies. Given this study's findings that Latina immigrants experience fear, rejection, and discrimination in the community at large and at service provider organizations, clear communication of a vision that includes compassion and respect for all persons is essential to increasing access.

Shared Leadership

Mobilizing "community partnerships to identify and solve health problems" is an essential public health service.[206] Partnerships and collaborations are also integral to

effective intersectoral policy development. In the context of partnerships or coalitions, shared leadership becomes a necessary and challenging feat.

Yukl describes participative leadership as one in which power is shared and the decision-making process includes many actors. [207] This process provides challenges but it also provides many benefits, including a more complete picture of the issue(s) being addressed as each stakeholder provides information from their own perspective and area of expertise. The process of participative leadership within collaborative efforts should increase the quality and acceptance of the decisions made by the members, leading to a greater chance of success and sustainability.[208] This type of leadership also allows for capacity-building, where all involved can develop skills necessary to identify, assess, and respond to a problem.[209] Participative leadership can be used to include community members as well as organizational representatives.

Within broad coalitions and shared leadership, influence tactics become an important means for sharing information and presenting the public health perspective.

Public health professionals can rely upon what Yukl calls "expert power" and "information power" as public health professionals have access to epidemiological and bio-statistical information not necessarily available to others.[210] This information should be shared in a way to gain influence but not be used in a coercive manner. Further, public health professionals can bring in the social determinants of health framework to coalition work as a way to validate the multiple factors and sectors necessary for a healthy and just community.

Working in coalitions requires that public health professionals understand the role that trust plays in effective collaboration. Because not all partners will enter into a coalition with equal perceived power and influence, a clearly communicated vision and agreement on power-sharing and shared leadership is necessary. A process of trust-building is necessary, particularly when working with marginalized and vulnerable populations. Yukl points to the importance of acknowledging and adapting to the cultural dimensions of all stakeholders in order to succeed in any leadership role.[211] Awareness of cultural dimensions is particularly important when working with immigrant groups. Yukl points to examples of how different cultures value and are comfortable with certain cultural dimensions such as individualism, uncertainty avoidance, gender egalitarianism, and power distance.[212] Similarly, organizations have their own culture and bringing these cultures together into a functional coalition or partnership requires leadership that is both focused and able to share in the decision-making process.

Public health professionals will need to learn about and practice the various shared leadership approaches necessary to successful intersectoral and coalition work in order to develop policies that are contextually- and community-informed.

Community Engagement and Community Leadership

Central to this study is the premise that meaningful community participation is essential to policy development that addresses the root causes of health. Indeed, community partnerships are integral to one of the public health essential services. Community-level leadership can be developed in many ways; in this project the focus is

on the use of participatory research methods and community engagement as facilitators and enablers of community leadership.

The idea of community leadership and community empowerment are rooted in the popular education work of Paulo Freire in Brazil in the 1960s and 1970s. Central to Freire's work is the concept of conscientização, or critical consciousness (also understood by some as consciousness raising). Inherent in conscientização is both the pursuit of a deeper understanding of one's place in the world, as well as the call to take action against the oppressive forces in one's life (individually and collectively). Freire's work also emphasizes co-learning, shared leadership, and transformation.[213] The perspective of the community as expert of their own lives and agents in their own transformation rather than mere subjects under experts' lens, contributed to the development of various community-based participatory research methods (CBPR).

CBPR "is a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being trough taking actions, including social change."[214] Because of the limited understanding regarding perceptions of access to family planning and other health services for foreign-born Latinos in new settlement states, more research is needed. Using CBPR approaches rather than traditional research methods can enhance our understanding and address some of the known underlying barriers to health (political disenfranchisement) by sharing leadership with the community.

Of particular interest in terms of using CBPR to support community leadership and action is the Photovoice method. Photovoice brings the community's voice into the realm of policy-making, thereby "reframing of the problems being investigated."[215] It is an iterative process and one that makes it possible, even necessary, for the researcher to be a participant observer while at the same time letting go of the traditionally paternalistic role of the researcher. Due to the intensity and intimacy of the process, this method allows for a richness and depth that is fitting for complex issues such as reproductive health. This method is also well-suited for the varied, but generally low, literacy level of low-income, foreign-born Latina immigrants. This method has predominantly been used with vulnerable or marginalized populations, with most studies engaging female participants.[216] According to a systematic literature review of Photovoice studies conducted by Catalani and Minkler, the outcomes of the Photovoice projects they studied (total of 37 studies) fell into three broad categories: "(a) enhanced community engagement in action and advocacy, (b) improved understanding of community needs and assets, which in turn could have community or public health benefits, and (c) increased individual empowerment."[217]

Public health professionals will need to increase their knowledge, comfort, and practice of CBPR to support needed community-leadership. CBPR requires relationship- and trust-building with communities and can therefore be time-consuming. CBPR also requires a level of cultural-sensitivity and humility to work effectively with community members in a non-paternalistic way. Public health professionals will need to be aware of the various levels of community participation and work ethically to not exploit the community or involve the community only

superficially. Specifically, in this study, the investigator found that the ability to conduct this research and access the breadth and richness of information through interviews was very much built upon both the existing trust that had developed from her past work with La Casita Center, the women's groups, and the Latina community in general, and facilitated by the investigator's identity as a Spanish-speaking Latina immigrant herself. As findings indicate, those working with the Latina community who were Latina themselves seemed most closely aligned with the experiences and perspectives of the Latina immigrant informal community leaders interviewed for this study.

Participants working with the Latina community who spoke Spanish were also closely aligned with the views and experiences of immigrants. Public health professionals who do not share an ethnic or cultural identity with the community they wish to work with, or who do not speak the language of the community, may experience more difficulty in building the trust necessary to conduct truly participatory research.

Working closely with community organizations that have the trust of the community of interest can assist in building a bridge into the community. Public health professionals interested in CBPR should establish relationships with and consider spending time in such organizations. Public health professionals can do this through participating in events and activities, and volunteering when possible to gain a deeper understanding of the community and to develop genuine relationships of trust with the organization and community members. For the investigator, volunteering and participating in events, workshops, and activities over many years contributed to building trust. Her ongoing support of the organization through collaborations and

advocacy also contributed to establishing trust based on a robust relationship. The opportunity to share meals with community members at organizational events and having her children participate in events with the children of community members served by the organization contributed to a deeper and more personal connection for both the community members and the investigator.

CHAPTER VII
PLAN FOR CHANGE

A primary driver for this research project is the potential utility of the findings and project products for the Latina community in Kentucky, for advocates within and for this community, and for social and health service providers serving the growing Latino community. By creating products based on the findings that are accessible and useful to the community and advocates, the policy-making and implementation process can be influenced in a grassroots approach. Four primary audiences for the research findings exist: Latino community members, advocates and advocacy organizations, service providers, and policymakers. The hope is that the first three groups would use the findings and tools developed through this project to reach and influence the policymakers through formal and informal channels. Additionally, the development of the structural determinants of reproductive health will contribute to the research and academic community's understanding and approach to working with Latina immigrants on reproductive health issues.

Products

The investigator will develop an Executive Summary of this report in lay-person language in English and Spanish. Attention will be paid to develop this product with a literacy level that allows access to the greatest number of people, particularly in terms

of the Latino immigrant community. The investigator will seek input from multiple professionals working with the Latino community in terms of literacy level of the product.

The investigator also plans on developing tailored presentations to various target audiences based on the process, findings, and recommendations of this study. Informal requests for such presentations have already been made by local reproductive health, domestic violence, and Latina advocacy organizations.

Finally, the groundwork for the structural determinants of reproductive health serves as a product in development. The goal is to pursue further research in this are to fully develop the framework and make it an applicable framework for understanding and addressing reproductive health access by Latina immigrants.

Target Audiences

Latino community members: The Spanish-language executive summary will be made available to service and advocacy organizations serving Latinos in Kentucky, members of Latina women's groups, through community centers, and other informal groups for Latinas. Further, a presentation will also be made of this project and its findings to the Latina Women's Movement women's groups through La Casita Center and a brainstorming session will be held to develop ideas of what the groups would like to see happen and how they would like to be involved.

Advocates and Advocacy Organizations: The investigator is the former president of the Hispanic/Latino Coalition of the Louisville and has close ties with this and other

Latino organizations. The executive summary document will be made available to the Coalition in English and Spanish, and it, in turn, can disseminate it through its statewide networks, website, and advocacy committee members. There are other Latino and immigrant advocacy organizations in Kentucky that would be interested in the written document. A list of these organizations is being compiled and each will be contacted and offered executive summaries. The products can also be saved as PDF documents and posted or linked to these organizations' websites.

Some national advocacy organizations may also be interested in this research and its products. All products will be made available to any advocacy organization that expresses interest. As the former Executive Director of the National Latina Institute for Reproductive Health (NLIRH) is on the dissertation committee for this project, the investigator will seek guidance from Ms. Henriquez in this endeavor.

Service Providers: Service providers, both health and social services, could benefit from the project findings. The written document will be offered to all key informant interview participants. Safety net providers will also be offered copies of the written document in English and Spanish. The investigator is positioned to contact various providers, from health care to mental health and domestic violence to education and public health, through professional networks and positions on boards (such as the Louisville Metro Board of Health) and will distribute information about the availability of the written document through these channels. The investigator has also made presentations to both medical and nursing students and practicing providers in the past

and plans on offering presentations using these research findings and products to the same.

Policymakers: The hope is that community members and leaders will be the lead in affecting policymakers. Policymakers can also be reached by the advocates and advocacy organizations targeted with the research products, and finally, providers can be very effective advocates with policymakers and these project findings and products can be used as effective advocacy tools for all three groups to educate and influence policymakers.

Another group that can be reached with the research products are researchers and students in academic centers. The investigator has been and continues to be invited to guest lecture for both undergraduate and graduate classes at a number of state universities and community colleges. Particularly through the University of Louisville Anne Braden Institute for Social Justice Research (the investigator served on its community council for 2 years), the investigator hopes to reach the academic and research community in Louisville and all of Kentucky to present and discuss the findings of the research project and the utility and benefits of using qualitative research methods in exploring issues affecting vulnerable populations and in building more meaningful partnerships with the community. The investigator has contacts within the local school of public health and will share the study findings with faculty there. The investigator also hopes to bring to the fore the importance of leadership and advocacy in the education of future public health professionals.

In terms of a personal plan for change, the process of this study has brought to light some new information and ideas, and expanded the context within which family planning and Latina immigrants' experiences are understood by the investigator. Specifically, the responsibility that research and community engagement bring are both motivating and cause for pause. Engaging communities in research is not to be taken lightly. It requires deep and long-term commitment. The words of the informal community leaders invoking both trust and hope will stay with me and guide my research and community-level work.

> *"Me gustaría que tu investigación tuviera un auge positivo en la comunidad, y que te pudieran escuchar..." (I would like for your research to have a positive impact on the community, and that they could listen to you... Mexico, 30 years old, 6 years in Kentucky)*

By making research more accessible and relevant to communities, research will benefit from the real life experiences and commitment to applicability that community-driven efforts bring. Raising the community's voice in research by including community members as experts in their own lives and experiences creates an opportunity to improve relationships between researchers/academia and communities where research often is conducted. By grounding research in real life experiences, research can gain salience to policy-makers who are more guided by their constituents than research evidence. It also offers the possibility that barriers between community experience and policymaking will be diminished, and that researchers and community members will partner in making the policymaking process more relevant, integrated, and rooted in social justice and equity.

Appendix A. Summary of Literature Review Findings

Title, Author	Year	Source	Study Population and Setting	Key Findings	Limitations
Using Photovoice to Improve Family Planning Services for Immigrant Hispanics, Schwartz L.R. et al	2007	Journal of Health Care for the Poor and Underserved	Foreign-born Latino men and women in Midwestern community (Missouri)	Language barriers; services perceived as not welcoming; perceived lack of explicit family planning information and promotion in community;	Small sample (7); included both men and women together (may have been gender dynamics that limited women from speaking as freely)
Contraceptive Use Among Latina Women: Social, Cultural, and Demographic Correlates, Unger, JB et al	1998	Jacob's Institute of Women's Health, Women's Health Issues	Latina women age 15-50 in Los Angeles clinic waiting room	Low-acculturated Latinas' contraceptive use is associated with perceived social support for use, self-efficacy, and an inverse relationship with acculturation level, and desire for more male children.	Selection bias as participants are already accessing gynecological care; contraceptives types were addressed collectively not individually;
Sexual and Reproductive Health of U.S. Latinas: A Literature Review	2006	Alan Guttmacher report	Latinas in U.S., with some distinction drawn between U.S.-born and foreign-born	Identifies limitations in existing literature/research and areas in need of research	Not a study of participants
Contraceptive knowledge and use among low-income Hispanic immigrant women and non-Hispanic women, Garces-Palacio, I.C. et al	2008	Contraception	Hispanic, non-Hispanic white, and non-Hispanic black women in a federal assistance program office in Tennessee	Latinas had lower knowledge and use of contraception, as well as lower knowledge of reproduction. Knowledge of contraceptives, number of children, and marital status correlation with contraceptive use only for Latinas; non-Latinas' use correlated with education level only.	Small convenience sample; most women were or Mexican origins so generalization to all Latinas is not possible.
Exploring Contraceptive Pill taking Among Hispanic	2003	Health Education and Behavior	Hispanic women sample from the National Survey of	Spanish-speaking Latinas were significantly more likely to experience inconsistent pill use;	Secondary data from national sample survey.

Title, Author	Year	Source	Study Population and Setting	Key Findings	Limitations
Women in the United States, Brown J. W. et al			Family Growth-V	acculturation is correlated with sexual risk behavior.	
Knowledge, Attitudes, and Use of Emergency Contraception Among Hispanic Women of North Carolina, Galvin S.L. et al	2009	Southern Medical Journal	Spanish-speaking Latinas in a clinic in western North Carolina	High number of participants reported inconsistent contraceptive use; less than one-fourth of participants knew about EC; only 15% reported moral objections to EC	Convenience sample of Latinas already accessing health care services.
Concerns about contraceptive side effects among young Latinas: a focus-group approach, Gilliam, M.L. et al	2004	Contraception	Young adult Latinas at a clinic and a day care center in Chicago	Latinas were more concerned about contraceptive side effects than national average; misinformation and miscommunication about contraceptives led to lower use; concerns about future health, desire for children, and side effect play a role in contraceptive use	Population predominantly Mexican origin; young adults may not generalize to adults over age 25; structural barriers such as immigration status not explored.
Knowledge and Beliefs about Contraception in Urban Latina Women, Venkat, P et al	2008	Journal of Community Health	Self-identified Latinas at a New York City hospital	No correlation between religiosity and contraceptive beliefs; higher concerns of risks from hormonal contraceptives; most common beliefs about contraceptive side effects include weight gain, bleeding, difficulty getting pregnant in the future.	Convenience sample creates possible systemic bias; participants already were accessing reproductive health services could present self-selection bias; because majority were low-income, it is possible that low-income rather than ethnicity play a role in contraceptive knowledge and beliefs
The role of misconception on Latino	2003	Contraception	English and Spanish speaking	Fewer Latinas are aware of EC, and Spanish-speaking	Small sample size; causality cannot be

Title, Author	Year	Source	Study Population and Setting	Key Findings	Limitations
women's acceptance of emergency contraceptive pills, Romo, L. F. et al			Latinas age 18-43 at a clinic in southeast Texas	Latinas are less aware than English-speaking Latinas; lack of understanding about reproduction/reproductive cycle; Unwillingness to use EC associated with misinformation about EC mechanism;	presumed: lack of knowledge association with unwillingness to use may be because those willing to use it make an effort to learn more about EC
Factors Associated with Effective Contraceptive Use Among a Sample of Latina Women, Harvey, S.M. et al	2006	Women and Health	18-25 year old Latinas at risk for HIV at a clinic and various community settings in East Los Angeles; male partners invited to participate in study as well	Relationship duration was positively associated with contraceptive use; communication with a partner about contraception is positively correlated with contraceptive use; positive relationship between women's relationship power and safer sex practices	Predominantly U.S.-born Latinas; very young sample; small sample; no structural determinants addressed with participants
Family Planning Attitudes of Medically Underserved Latinas, Rivera, C.P. et al	2007	Journal of Women's Health	Latinas age 18-42 at a federally funded health center in New Jersey	U.S.-born and foreign-born Latinas were less likely to know of oral contraceptive benefits regardless of age, education or marital status; religious and cultural beliefs did not play a significant role in attitudes towards family planning; majority of participants stated wanting to learn about family planning through discussions and videos rather than written materials; question of whether Latinas see early pregnancy and large family size as a problem or not	Convenience sample of women already accessing health care services;
Perceptions of Hormonal Contraceptive Safety and Side	2000	Maternal and Child Health Journal	California English- and Spanish-speaking	Participants lacked knowledge and confidence in hormonal contraceptives.	Focused on California only, which has a history of

Title, Author	Year	Source	Study Population and Setting	Key Findings	Limitations
Effects Among Low-Income Latina and Non-Latina Women, Guendelman, S et al			Latinas, and non-Hispanic whites part of a study on AFDC (welfare), age 21-44	Importance of client-provider relationships, social networks, and access to care highlighted.	Latina immigration and had less restrictive welfare policies for immigrants than other states
Use of Contraception and Use of Family Planning Services in the United States: 1982-2002, Mosher, W.D. et al	2004	Advance Data from Vital and Health Statistics, Centers for Disease Control and Prevention	National sample	Primary contraceptive method in U.S. in 2002 was birth control pill; 98% of all women who were sexually active used contraceptives in 2002; Latinas/Hispanic women less likely to use pill but more likely to use hormonal injectable and also more likely to use female sterilization; condom use was similar by whites, African Americans and Latinos/Hispanics.	National sample, not focused on Latinas or immigrants.
Partner influence on early discontinuation of the pill in a predominantly Hispanic population, Kerns, J. et al	2003	Perspectives on Sexuality and Reproductive Health	In-person and telephone interviews (English and Spanish) with Hispanic clients at urban family planning clinic	Women whose partners did not know of their pill use were more likely to discontinue pill use; contraceptive use is lower when male partner is 5 years or more older; woman's positive attitude towards becoming pregnant and intent to use pill for a year or less also associated with pill discontinuation	Population bias of clinic setting; no differentiation between foreign- and U.S.-born Latinas
Male Hispanic immigrants talk about family planning	2006	Journal of Health Care for the Poor and Underserved	Four focus groups (33 men) of foreign-born Latino men in Midwestern community (Missouri)	Cost of raising children a factor in deciding how many to have and family planning; limited knowledge of contraceptive methods; condom usage was perceived as more appropriate to use with extra-marital relationships but not with wives; stress of immigration and new	Small sample

Title, Author	Year	Source	Study Population and Setting	Key Findings	Limitations
				cultural norms on relationships with partners leading to unstable relationships; loss of authority and power of male in family in U.S.; lack of family unity in U.S. due to both partners working; changing gender roles after immigration	
Latinas and Contraception, National Latinas Institute for Reproductive Health	2004	National Latinas Institute for Reproductive Health Issue Brief	Secondary research data	Not Applicable	Not a study, simply a summary of contraceptive descriptions and issues in the Latina population
Emergency Contraception: An Important Option for Latinas, National Latinas Institute for Reproductive Health	2003	National Latinas Institute for Reproductive Health Fact Sheet	Secondary research data		Not a study, simply a summary of emergency contraceptive description and issues in the Latina population

Appendix B. Welfare Reform, Latinas, and Reproductive Health Literature Review Table

Title	Year	Source	Study Population and Setting	Limitations
Implications for Family Planning of Post-Welfare Reform Insurance Trends	1999	Alan Guttmacher Institute report	General U.S. population, a section on immigrants	Limited focus on immigrants; no focus on Latinas or distinction of foreign-born
Immigrants and Medicaid After Welfare Reform	2003	Alan Guttmacher Institute report	General immigrant population	Broadly defined reproductive health services
The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care	2007	Alan Guttmacher Institute report	General immigrant population	National level; no distinction between foreign- and U.S.-born; primarily maternal and child health services
Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform	1999	Urban Institute report	Male and female refugees, temporary immigrants, naturalized citizens, and documented immigrants at national level	No focus on reproductive health; analysis of Population Survey data; somewhat outdated
The Scope and Impact of Welfare Reform's Immigrant Provisions	2002	Urban Institute report	General immigrant population, with citizen-noncitizen distinction	No focus on reproductive health or foreign-born Latinas
The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care	2007	Alan Guttmacher Institute report	General immigrant population in U.S.	General reproductive health, focus on maternal and child health services; not focused on foreign-born and/or Latinas
Not Working: Latina Immigrants, Low-Wage Jobs, and the Failure of Welfare Reform	2006	Book	Mexican women immigrants in Los Angeles	Focused only in Los Angeles, CA and limited considerations of reproductive health
Public Benefits: Easing Poverty and Ensuring Medical Coverage	2005	Center for Budget and Policy Priorities report	General U.S. population, section addressing immigrants	No focus on reproductive health or foreign-born immigrants/Latinas

Appendix C. Key Informant Interview Guides—Social and Health Service Organization Professionals and Policy Professionals

Topic: Family Planning Experiences and Perceptions of Access: Latina Immigrants in New Settlement States

Purpose:

Thank you for agreeing to participate in this interview. This interview is part of a broader research project looking at the Family Planning Experiences and Perceptions of Access of Foreign-born Latinas in Kentucky. I am a doctoral student at the UNC Chapel Hill Gillings School of Global Public Health and these interviews are part of a dissertation research project. The research project is looking at the lived experiences of Latina immigrants in our state as they relate to family planning. As part of this project, I will also be collecting the experiences, perceptions, attitudes, and beliefs of Latinas in Kentucky.

Little knowledge exists on the reproductive health experiences and perceptions of Latinas in Kentucky. The purpose of the interview portion of the research project is to gain in-depth information from key stakeholders at the local and state level in Kentucky on their knowledge, experience, and beliefs about Latinas and family planning. Interviewees can also provide insights into available programs and services, as well as policies affecting these services, for Latinas.

A total of 20 to 30 persons will take part in these interviews. Ten to fifteen social and health service providers, and persons involved with the policy-making process will be interviewed. Specifically, I am interviewing individuals who serve Latinas in the city of Louisville and with individuals working at the state level on women's health issues. I will also be interviewing ten to fifteen Latina immigrant women in Louisville as part of this study.

The interview should take about 35-40 minutes. The interviews will add to the background information available on Latinos in Kentucky and so primarily the interview data will be presented as summaries with no identifying information, making the interview confidential. Your name will not be connected to your answers in any way in the summaries. The researcher may want to use some quotes in the research, in that case, permission must be obtained from the interviewee. Would you like for your answers to be used only as part of a summary, with no identifying information, or would identifying your field of practice and location in relation to a specific quote or piece of information be alright with you?

Only as part of summaries ____

Use quotes or specific information with ____field of practice (i.e. social service, health service, policy) _____location (i.e. Louisville, or state-level/Frankfort)

With your permission, I would like to audiorecord our interview. Audiorecordings and transcriptions will be destroyed at the end of the research study process.

Are there any questions that you have about the research study or the interview at this time? May I audio-record the interview?

Opening Question

1. Could you tell me a little about your role at your organization and how you interact or are familiar with health issues concerning Latina immigrants?

Please answer the following questions from the perspective of your organization and your role in your organization.

Geographical Context

1. Could you provide a brief description of your hometown Louisville or Kentucky if working at state-level) in terms of size, culture, demographics, political environment, etc.?

2. In a couple of sentences, how would you compare your hometown to the rest of Kentucky? The U.S.?

3. How would you say Latino immigrants are generally received in Louisville (or Kentucky if at state-level)?

General/Background

4. Tell me a little about the Latinas that your organization serves or what you know about the Latina population in (Louisville) (or Kentucky if at state-level))?

5. Can you tell me about the socio-economic, cultural, and political realities of the Latina immigrants in (Louisville) (or Kentucky if at state-level))?

Barriers and Facilitators

6. In your experience at your organization, do Latina immigrants face barriers in accessing family planning information and services in Kentucky?

If yes,

a. What are the barriers to family planning use by low-income foreign-born Latina immigrants in Kentucky?

7. In your experience at this organization, does the service delivery system (clinics, hospitals, private doctor's offices, social service providers) improve or hinder access to family planning services and information for Latina immigrants?

8. In your professional opinion, what role do current state and local policies play in Latina immigrants' ability to access family planning information and services?

a. How do policies support or undermine access to family planning information and services?

b. Are you referring to any specific policies?

Programmatic

9. Are you aware of any programs that target improving family planning information and service access for Latina immigrants?

a. Do you consider that the program was successful?

b. Why or why not?

Policy-making Roles and Responsibilities

10. Who do you/your organization believe should be responsible for addressing access to family planning information and services for Latina immigrants?

11. What do you/your organization believe is the role of local versus state government in addressing access to family planning information and services for Latina immigrants?

12. How do you anticipate the Affordable Care Act will affect Latina immigrants' access to family planning services and information?

a. How will it affect your organization's ability to serve the Latina immigrant community?

Wrap-up and Closing

13. What other factors do you/your organization believe are important to consider when addressing access to family planning information and services for Latina immigrants?

14. Is there anything else you would like to add?

Thank you for taking the time to answer these questions. Your participation in this interview greatly contributes to the research project and to increasing our understanding around the issue of Latina immigrant's reproductive health. Your answers will be compiled with the answers of all other interviewees and identifying information will be removed. If you have any questions about this interview or the broader research project, please feel free to contact me.

Appendix C. (continued) Key Informant Interview Guide—Latina Community Leaders

Topic: Family Planning Experiences and Perceptions of Access: Latina Immigrants in New Settlement States

Purpose:

Thank you for agreeing to participate in this interview. This interview is part of a broader research project looking at the Family Planning Experiences and Perceptions of Access of Foreign-born Latinas in Kentucky. I am a doctoral student at the UNC Chapel Hill Gillings School of Global Public Health and these interviews are part of a dissertation research project. The research project is looking at the experiences of Latina immigrants in our state as they relate to family planning. As part of this project, I will also be collecting the experiences, perceptions, attitudes, and beliefs of social and health providers, advocates, and persons working in policy in Kentucky.

Little knowledge exists on the reproductive health experiences and perceptions of Latinas in Kentucky. The purpose of this interview portion of the research project is to gain in-depth information from Latina community leaders regarding the knowledge, experience, and beliefs about family planning. I will be asking you questions that you can answer from your own experience as well as your knowledge of the experience and beliefs of the Latino community in general.

I will be interviewing 20 to 30 persons in total, with close to half (ten to fifteen) of those being Latina community leaders. Specifically, in addition to speaking with Latina community leaders, I am interviewing individuals who serve Latinas in the city of Louisville and with individuals working at the state level on women's health issues.

The interview should take about 35-40 minutes. The interviews will be presented as summaries with no identifying information, making the interview confidential. Your name will not be connected to your answers in any way in the summaries. Generally, your answers will be presented with other answers from Latina community leaders under the label "Latina community leader" with no further information about your identity. The researcher may want to use some quotes in the research. In that case, permission must be obtained from the interviewee.

Would you like for your answers to be used only as part of a summary, with no identifying information, or could I use quotes from you? If I can use your words as quotes, can I state your country of origin and how many years you've been in Kentucky and the United States with your quote?

Only as part of summaries ____

Use quotes or specific information with ___country of origin ___years in the U.S./Kentucky

With your permission, I would like to audio-record our interview. Audio-recordings and transcriptions will be destroyed at the end of the research study process.

Are there any questions that you have about the research study or the interview at this time? May I audio-record the interview?

Opening Question

1. You have been identified as a community leader in the Latina community. Could you tell me a little about your role in the Latino community and what types of activities or work you've done with other Latina immigrants?

Please answer the following questions from the perspective of your own experiences as well as your experience as a community leader.

Geographical Context

2. How long have you been in Louisville, Kentucky? ______________

3. How long have you been in the United States? ______________

4. Where are you originally from? ________________

5. How would you describe Louisville and Kentucky to someone who's never been here?

General/Background

6. How would you describe the Latina community in Louisville? In Kentucky?

7. How would you say Latino immigrants are generally received in Louisville? In Kentucky?

8. What would you say are the biggest concerns for Latinas in this community?

9. (If health is mentioned, ask to expand on what she means by health and how one can be healthy)

10. (If health is not mentioned): Is health important? What is needed to be healthy?

Understanding of Family Planning, Family Planning Services and Information

11. What does family planning mean to you?

12. What kinds of family planning information and services are you aware of?

13. Is family planning important to you?

a. Why?

14. Tell me about your experiences with family planning services in Louisville? In Kentucky?

Barriers and Facilitators

15. In your experience, personally and as a member of the Latina Women's Movement, would you say that it is easy or difficult to find and get family planning information and services in Kentucky?

16. What kinds of things make it easy? What kinds of things make it hard?

17. In your opinion, how do laws and policies affect Latina immigrants' ability to access family planning information and services?

a. Are there specific policies or laws that you think help or cause problems for Latinas getting family planning services and information?

Programmatic

18. What kind of family planning information or services would you or other Latinas you know be interested in?

19. Are you aware of any programs or places that provide family planning information and service for Latina immigrants?

a. Have you gone there for services?

b. If yes, what was your experience?

c. If not, would you go if you needed them?

i. Why or why not?

20. What would make getting family planning information and services easier for you?

Policy-making Roles and Responsibilities

21. Who do you think should be responsible for providing family planning information and services for the community? For Latina immigrants?

22. If you had questions about family planning, or other reproductive or sexual health issue, where would you go for information?

23. Have you heard about the health reform law that passed in 2010?

a. If yes, how do you think it will affect Latina immigrants' access to health services and information? To family planning?

b. If no, what would you want health reform to do to increase access to health services?

Wrap-up and Closing

24. What other things do you think are important when thinking about family planning and Latina immigrants?

25. Is there anything else you would like to add?

26. Thank you for taking the time to answer these questions. Your participation in this interview greatly contributes to the research project and to increasing our understanding around the issue of Latina immigrant's reproductive health. Your answers will be compiled with the answers of all other interviewees and identifying information will be removed. If you have any questions about this interview or the broader research project, please feel free to contact me.

Appendix D. Latina Women's Movement Description

"Movimiento de Mujeres Latinas/Latina Women's Movement

Recognizing that a safer and healthier community is built one family at a time, the Latina Women's Movement provides a vital space for women to gather, reflect, learn and take action in Louisville, Kentucky.

The Latina Women's Movement includes 10 active grassroots women's groups who are empowered to participate fully in their communities as leaders, role-models and advocates for social justice. Each of the groups focuses on its own goals, through education, engaging in community service and acts of accompaniment and solidarity. Childcare is provided for all meetings as a key support for participating mothers. Because of the unique, grassroots nature of the Latina Women's Movement, The Family Violence Prevention Network has recognized it as the national model for Latina women's empowerment as it is the only one of its kind in Kentucky and the nation.

We hope to grow and sustain this movement by forming more groups and bringing more women into the movement. Your support helps more women become involved and provides for programming on topics related to health, wellness, self-care, nonviolence, art, parenting skills, gardening, and much more."

From www.lacasitacenter.org

Appendix E. Latina Women's Movement Acuerdos (Agreements)

1. Honor each other's stories by being a confidant;
2. Do not to judge myself or others;
3. Mutual respect and support;
4. Act and speak with transparency;
5. Take responsibility for my actions;
6. Speak only for my self;
7. Listen to what others say;
8. Ask questions, don't assume;
9. Be aware of my own limits;
10. Commitment to non-violence; and
11. Solidarity with social justice.

* These agreements are written on pieces of paper that all participants receive and are spoken in Spanish at the beginning of any gathering of the women's groups. Translation by M. Gabriela Alcalde.

Appendix F. Interview Key

#	Date	Time	Approx Duration	Type*	File Number	Location	Transcribed
1	6-7-11	2pm	13 min	PP, L	WS320022.WMA	Statewide	6-13-11
2	6-8-11	9.15am	23 min	PP	WS230023.WMA	Statewide	6-16-11
3	6-8-11	11.40am	19.09 min	SS, L	WS320024.WMA	Louisville	6-16-11
4	6-10-11	12.30pm	32 min	HS, L	WS320025.WMA	Louisville	6-21-11
5	6-13-11	3pm	29.25min	HS	WS320026.WMA	Louisville	6-21-11
6	6-15-11	1.40pm	44.06	SS	WS320027.WMA	Louisville	6-21-11
7	6-20-11	9.30am	30.37	HS	WS320028.WMA	Louisville	6-22-11
8	6-22-11	10am	28.18	HS, L	WS320031.WMA	Louisville	6-28-11
9	6-24-11	12pm	30.55	HS	WS320033.WMA	Louisville	7-18-11
10	6-21-11	4.50pm	44.20	LC	WS320030.WMA	Louisville	6-28-11
11	6-27-11	10.50am	43.23 and 23.25	LC	WS320034.WMA and WS320035.WMA	Louisville	7-5-11
12	6-29-11	6.30pm	42.05	LC	WS320036.WMA	Louisville	7-5-11
13	6-30-11	9.30am	53.22	LC	WS320037.WMA	Louisville	7-5-11
14	7-1-11	10am	38.56	LC	WS320038.WMA	Louisville	7-8-11
15	7-1-11	7pm	22.33	LC	WS320039.WMA	Louisville	7-6-11
16	7-4-11	1pm	23.50 and 25.10 and 4.01	LC	WS320040.WMA and WS320041.WMA and WS320042.WMA	Louisville	7-6-11
17	7-5-11	10am	40.04	PP	WS320043.WMA	Statewide	7-18-11
18	7-6-11	3pm	16.23 and 13.51	LC	WS320044.WMA and WS320045.WMA	Louisville	7-18-11
19	7-8-11	8.50am	40.44	LC	WS320046.WMA	Louisville	7-21-11
20	7-8-11	11.50am	22.06	SS	WS320047.WMA	Louisville	7-18-11

*Type: SS: Professional at Social Service Organization, HS: Professional at Health Service Organization, PP: Policy Professional, LC: Latina informal community leader, L: Latina

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