Increasing Family Planning Utilization among Latinas: Opportunities and Challenges

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Introduction

Low rates of contraceptive use and consistency among Hispanics, as well as high rates of teen and unintended pregnancy in this population, are of particular concern because Hispanics represent the largest minority group and are one of the fastest growing populations in the U.S (Pew Hispanic Center, 2008). Among Hispanics, immigrants have especially low levels of contraceptive use and high rates of teen pregnancy (Franzetta, Schelar, & Manlove, 2007; Martin et al., 2007; Ventura & Bachrach, 2000).

The nation's Title X programs as well as other state and local programs are designed to provide services to help women and couples avoid unintended pregnancy. However, the high unmet need for family planning services—represented by high rates of unintended pregnancies and sexually transmitted diseases (STDs) as well as the ineffective and nonuse of contraception among sexually active teens and young adults suggests that some of those in greatest need of services are not accessing family planning clinics or programs (Guttmacher Institute, 2006). In particular, a continued challenge among family planning programs is getting the highest-risk populations to come to clinics, as well as ensuring that those who have come in the past continue to receive services and use methods correctly and consistently.

A better understanding of the family planning service needs among Hispanic women (including immigrants), as well as of their perceived barriers and motivators to use services, is needed to help improve outreach efforts to engage and better serve these populations. This study is based on a series of focus groups conducted in multiple cities across the country with Hispanic women and providers to examine the barriers and facilitators to accessing reproductive health services. We explore structural and cultural barriers and facilitators as well as community context and the role that policy at the national, state and local levels shapes Hispanic women's perceptions, awareness, use or nonuse of reproductive health services in their communities. We also examine the interplay between policy, community, strucutural barriers and culture and how together they help to shape the women's access to and experiences with reproductive health services.

Data and Methods

Sample

The study is based on focus groups conducted with Hispanic women and service providers. A total of 11 focus groups were conducted with young adult Hispanic women in three large metropolitan cities across the United States with high concentrations of Hispanics: Washington, DC, Los Angeles, and San Antonio. Of the 11 groups of young women, six groups were conducted in English and five were conducted in Spanish. One focus group per city (for a total of 3 groups) was conducted with service providers from various programs and clinics that served the local Hispanic community. Using purposive sampling techniques, the young women sample was segmented by characteristics that prior research has shown to play an important role in shaping behavior, such as nativity status (born in the U.S. or abroad), education and language (unilingual Spanish speakers and bilinguals). Service providers included direct service providers (e.g., nurses or doctors), case workers, program/clinic directors, front-line staff, community liaisons and advocates. While the majority of participants in the service provider groups provided reproductive health care services, some worked in social, legal, and mental health services.

Our target population included Hispanic women who were: 1) between ages 18-24, 2) married or single, and 3) not planning pregnancy within the following year. Young women participants were recruited from clinics and community programs and through newspaper/website ads and flyers posted in strategic public locations throughout each city (e.g. bus stops, malls, and stores serving the Hispanic population). Service providers were recruited through clinics and community programs that agreed to assist in the recruitment of the young women and from referrals; no program provided more than one service provider to attend a focus group. Interested participants were asked to call into the study center to establish study eligibility through a short screener interviewer. The screener interview also allowed us

to track the sample's characteristics across key variables of interests such as family income, age, and nativity status. Focus groups were conducted in clinics and community programs that were readily accessible and that agreed to provide accommodations. In order to access different components of the local Hispanic community, groups were held in different locations in each city.

The study included a total of 95 young Hispanic women across the 11 focus groups. Approximately one-half of the sample (n = 49) was foreign-born. Sixty-three percent (n = 60) of the women were bilingual while a little more than a third of the sample was unilingual (Spanish only, n = 27; English only n = 6). Over one-half of the sample (n = 56) were never married, 16% (n = 15) were currently married, 23% (n = 22) were cohabiting, and two women were separated or divorced. Roughly one-third of the sample (n= 29) had a high school diploma or did not finish high school. Women were largely low-income, 62% (n = 59) had a yearly family income of less than $25, 000.

Methods

Exploratory focus groups were conducted and participants were guided through open-ended questions, which also contained targeted probes designed to gather insights about why women did or did not access services and how to best draw Hispanic populations into family planning clinics and programs. More specifically, group discussion centered around 4 topics: 1) Women's knowledge and knowledge acquisition about reproductive health and family planning including sources of knowledge and misperceptions; 2) Access and awareness of community reproductive health care services including recent experiences accessing services, perceptions of clinic accessibility (e.g., who clinics serve, services provide, hours of operations, etc) and "openness" towards Hispanics, and general perceptions of free- and reduced-price clinics; 3) Main barriers to accessing and using reproductive health services among Hispanic women including individual, family and cultural perceptions of family planning; and 4) Recommendations for increasing and improving service utilization among Hispanic women. At the end of each focus group, demographic information was obtained through a questionnaire that contained close-ended questions. Each focus group was audio recorded and detailed notes were taken. The young women's focus groups were about 2 hours long while service providers groups lasted about 3 hours. Young women received $50 and service providers received $250 at the end of the focus group. IRB approval was obtained for all study procedures and materials.

Analysis. Upon the completion of each focus group, a brief summary of the discussions was drafted and audio recordings were transcribed and, if necessary, translated into English. Data were analyzed using an inductive approach. Additionally, throughout the field period a series of debriefing sessions were held with study team members to carefully review group summaries and notes to identify themes generated in the group discussions. Initial debriefings helped identify unanticipated themes that could be followed-up on in subsequent focus groups. The debriefings also served to identify themes from which an initial coding scheme was developed. The coding scheme was continually updated and refined using an iterative approach as described by Krueger and Casey (Krueger & Casey, 2000). The data were coded and analyzed using NVIVO 8, a qualitative software package which allow users to store, code, manage and explore the data. Data were also analyzed to compare and contrast findings from the Spanish and English groups and groups across the three cities.

Preliminary Findings

In general, we found multiple barriers that created conditions which hampered the accessibility and attractiveness of reproductive health services. Some barriers arose from multiple sources, such as policies from funding sources, policies within community clinics, and from the cultural beliefs and practices that exist within the Hispanic community. We also found that the role of cultural norms, values and expectations play an important role in women's willingness to access reproductive health care services. We also highlight examples of interaction between policy, community context, structural issues, and cultural beliefs and practices that together may exacerbate barriers. Below we highlight three examples based on our preliminary analysis.

Necessity is the Mother of all Inventions: Bypassing the medical establishment to access reproductive care.

Across each city and in each of the women groups, we found evidence that some Hispanic women were bypassing the traditional medical community to access birth control. Women purchased birth control and obtained reproductive

health services from "bodegas", "botanicas", "flea markets," "swap meets," or by sharing birth control prescriptions of friends whom prescriptions were covered by health insurance. Women in San Antonio and Los Angeles also reported that Hispanic women cross the U.S./Mexico border to obtain reproductive health care services, such as birth control and yearly exams. Additionally, women in all three cities reported that women also send for birth control from their country. Findings from the service providers groups paralleled women's reports of accessing reproductive health care outside of doctors and pharmacies. The following quote from a provider's group illustrates the practice of using alternative means to obtain birth control:

R: They [grocery stores] have the little pharmaceutical section, but then they have that [birth control] under the table.

M: Why do they do this [women accessing birth control in groceries]?

R: Because it's familiar…It's where they come from.

R: They have a quick solution…I don't have to prove anything…I just pay $10 and they'll give me whatever they think I need.

While the places and methods that women used to access birth control outside of the medical community varied across the cities, the reasons for doing so were largely the same. When asked the reasons why women access reproductive health care through alternative means, women and service providers stated that cost and convenience played key roles in women resorting to alternative means. As this clinic service provider noted, "*My aunts buy their birth control from Mexico and bring it to the states just because it's cheaper".* Moreover, many of the women and providers noted that the cost to accessing birth control was not limited to the price of birth control but also included the cost to women in time and lost earnings while visiting a clinic due to the long wait lines (in many cases as long as several hours) coupled with the cost of transportation and clinic fees. For those with young children, these costs were further compounded by the cost of child care. Indeed, some women and providers referred to this as the "triple cost of accessing care".

Other women, however, noted that they purchased their birth control through alternate means because they lacked health insurance, did not qualify for free or reduced fee services, or because they lacked documentation needed to prove their income and identification as required by some programs. Additionally, some did not access traditional services because of fears of being reported to immigration authorities; these fears were exacerbated by document requirements of clinics and especially present in localities that had established policies and law enforcement strategies aimed at deterring illegal immigration.

Discussions with Hispanic women and providers also made it clear that culture norms and practices helped to create an "underground" market for birth control and reproductive health care services. In Latin American countries, pharmacists are often consulted to provide medical advice and medicine in many countries is dispensed without prescriptions and often at the costumer's request. Additionally, pharmacies and "drugerias" are prolific in most cities in Latin America and located in places that are easily accessible and convenient. Thus, many Hispanic women have had experience or are comfortable and used to having ready access to medical products without professional supervision.

Our findings suggest that policy (e.g., governing program eligibility) , community environment (e.g., hostility toward immigrants), clinic practices and procedures (e.g, long wait lines, prices, and documentation requirements), and culture each play a role in deterring some women from accessing reproductive health care services available in their community. At the same time these same factors have helped to produce alternative means to birth control in response to women's needs and in keeping with their cultural norms and practices.

Not enough time to build rapport: Cultural norms clash with program's reality and policy. A second key barrier to accessing reproductive health care services was the short duration of appointments and consultation. On the one hand, women in all the groups voiced disappointment at the lack of time they spent actually in front of a doctor. Women also reported feeling frustrated that after what was often a lengthy wait (some women reported up to 6 hours) in the reception area they were rushed when it came to spending time to with the doctor. Some noted that

the short visits (often lasting no more than 10 to 15 minutes) were not long enough to be examined, discuss important issues or for doctor to communicate all the relevant information, as the quote below from a participant of an English-language female focus group illustrates.

R: And there are some doctors that don't tell you all the information because they have to see five patients to get the money so they'll see one and pass the rest to the nurse.

Cultural norms also exacerbated women's discomfort with rushed or short-lasting doctor visits. As is noted below, many women reported that they were not comfortable and felt embarrassed having physical and gynecological exams as sexual activity among women - in particular among unmarried women - was frowned upon in the Latino culture. Additionally, Hispanic's 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 about asking potential sensitive or embarrassing questions. Indeed, as illustrated by the quote below, some women withheld information from their doctors because they didn't feel comfortable talking with them. "*I felt kind of scared talking to my doctor about anything because she was very judgmental. I never told her I was having a certain kind of pain… so I think it also has to do with, like I guess the doctor or the doctor visits itself and you know caring for the patient and how they feel."*

Other women avoided certain clinics in their neighborhood or reported traveling longer distances in order to receive services from doctors and clinics where they perceived they were being cared for and not being rushed, as illustrated by the quotes below.

R: Where we went before no matter what you were going for, I didn't feel like I was treated as a person. It was just someone would come and that's it. No one would treat you like a person.

R: Also, there is another place close to us, but we also prefer to go to this one [clinic long distance from R's home] for the same reason that they are very nice there. They talk well; they always remember me and ask me how I am. And over there you see the nurse and the doctor. The [wait time] is faster also.

Service providers also reported feeling frustrated by the lack of direct time with patients. However, they noted that the length of patient visits was dictated by funding. Clinic received funding based on the number of patients served and the kind of care they were providing. As such, scheduling patients back-to-back is often necessary to obtain sufficient funding. Additionally, providers noted that funding policy also dictated which types of services were covered and which were not. As illustrated by the quote below, some noted more difficulty, for example, finding funding for follow-up.

R: Now we can't bring them [patients] back on Family PACT [Reproductive health care for low-income persons]… just for results. It's not acceptable…most funding sources will not pay for that. And so in the way the system is designed, it does not facilitate it [follow-up care] by reimbursing you. It doesn't reimburse you for it unless there is pathology and you can justifiably bill for it…

This example illustrate how funding affects how clinics are able to serve their clients which in turn may produce less than positive results in particular when it clashes against the cultural norms and practices of the Hispanic community.

Multiple Functions of Cultural Beliefs, Norms, and Values: Findings indicated that culture functions in multiple ways as a barrier to accessing reproductive health care. This originates from the cultural belief of "Marianismo" versus "Machismo," a set of values that define gender roles within the Hispanic culture. Marianismo refers to the expectation that women should remain virgins until marriage and be passive sexual partners. As such, under these beliefs, Hispanic unmarried women do not feel comfortable accessing reproductive health care because it provides "incriminating" evidence of their sexual activity. There was a strong consensus across the women's groups that they did not feel comfortable accessing services because they felt embarrassed that they were going against the cultural norm of being sexually active and expressed concerns about family members and neighbors finding out of their

sexual activity if seen at a clinic. Thus, their cultural values and expectations preclude women from accessing reproductive services as illustrated by this quote from a young woman attending an English speaking group.

> *R: So I went with him [to the clinic], filled out the paperwork, we gave fake information. That's the way I found out where to get the birth control, Plan B, condoms and all of that. And I was like, this is something I never knew. This is something my parents would never tell me because my parents are Mexicans so they tried to convince me… I don't know the word. You know like wait until marriage. That's what they wanted, but later on I heard more people talking about Planned Parenthood and I started to pay more attention. And that's the way I found out. Other than that, my parents, no...*

Another way in which Marianismo functions as a barrier to Hispanic women is access to reproductive health care services comes from the cultural belief that women should sacrifice their needs for the welfare of the family and should always put family first. This notion stems from religious beliefs that the Virgin Mary sacrificed herself for her son and as such, all women should also do so as well. Service providers across the three groups reported that Hispanic women do not access services because they would rather spend the limited funds and time to the needs of their children and family as illustrated by this quote from a service provider.

> *R: The woman's needs are always at the bottom of the pile. Um…and whether mother or young woman or whatever, we just traditionally everybody has always put the woman's needs, health needs at the bottom.*

These findings provide further evidence that cultural values shape women's behaviors regarding reproductive health. Cultural beliefs, values, and norms function in various ways to serve as barriers for Hispanic women to access reproductive health care.

Discussion and Next Steps

The results of the preliminary analysis reveal that Hispanic women's access to reproductive health care is a complex issue. Policy influences clinic practices which in turn interact with women's cultural beliefs, customs, and norms. Our next steps will include a final analysis of the data and identification of policy and program implications that emerge from our findings. Our preliminary analysis suggests several policy and program recommendations. First, policy makers and program providers should consider the cultural implications of their policies and programs in order to improve access of care to Hispanic women. Increased awareness and sensitivity to these issues is a critical first step. Second, our finding that underground markets have developed in many communities to serve the Hispanic community is troubling but also can be used as a learning opportunity. Partnerships with local bodegas and botanicas can be used to promote awareness of services and to help combat misperceptions about programs or family planning in general. These local storefronts may play a critical role in the community akin to what barbershops and hair salons do for the African American community. Third, discussions with providers indicate the importance of strong and extensive ties to the community for outreach and establishing legitimacy and presence. Likewise, partnerships across programs within communities are useful in identifying clients and in ensuring continuity of care across health domains. Our findings suggest that the complexity and effectiveness of these partnerships vary by the city's immigration history and composition.

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