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Sexual and Reproductive Health Care Access and Utilization by Mexican Immigrant Women in New York City – A Descriptive Study

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Background

This report uses data collected by Planned Parenthood of New York City (PPNYC) as part of a larger sexual and reproductive health (SRH) needs assessment. We analyzed various demographic factors and barriers to describe SRH access and utilization of services among Mexican immigrant women residing in New York City (NYC). We purposely sampled 151 adult women seeking assistance from the Mexican Consulate of New York City and other community-based organizations (CBOs). Women choosing to participate were administered an anonymous survey. Data collected included age at time of survey completion, Mexican State of origin, length of time in the United States, borough of residence, insurance status, history of SRH service utilization in NYC, and current contraceptive use. Participants were also asked a series of questions to assess barriers to obtaining SRH services.

While barriers to health care access and low utilization of services by immigrant populations in New York City (NYC) have been documented, relatively little research has examined specific Latino immigrant subgroups (i.e. by country of origin), women, and sexual and reproductive health (SHR) care. Mexican women in particular have one of the highest birth rates in the United States and have disproportionately high rates of cervical cancer.¹ These rates indicate a need for reproductive health care information and services not currently being met in Mexican communities.²

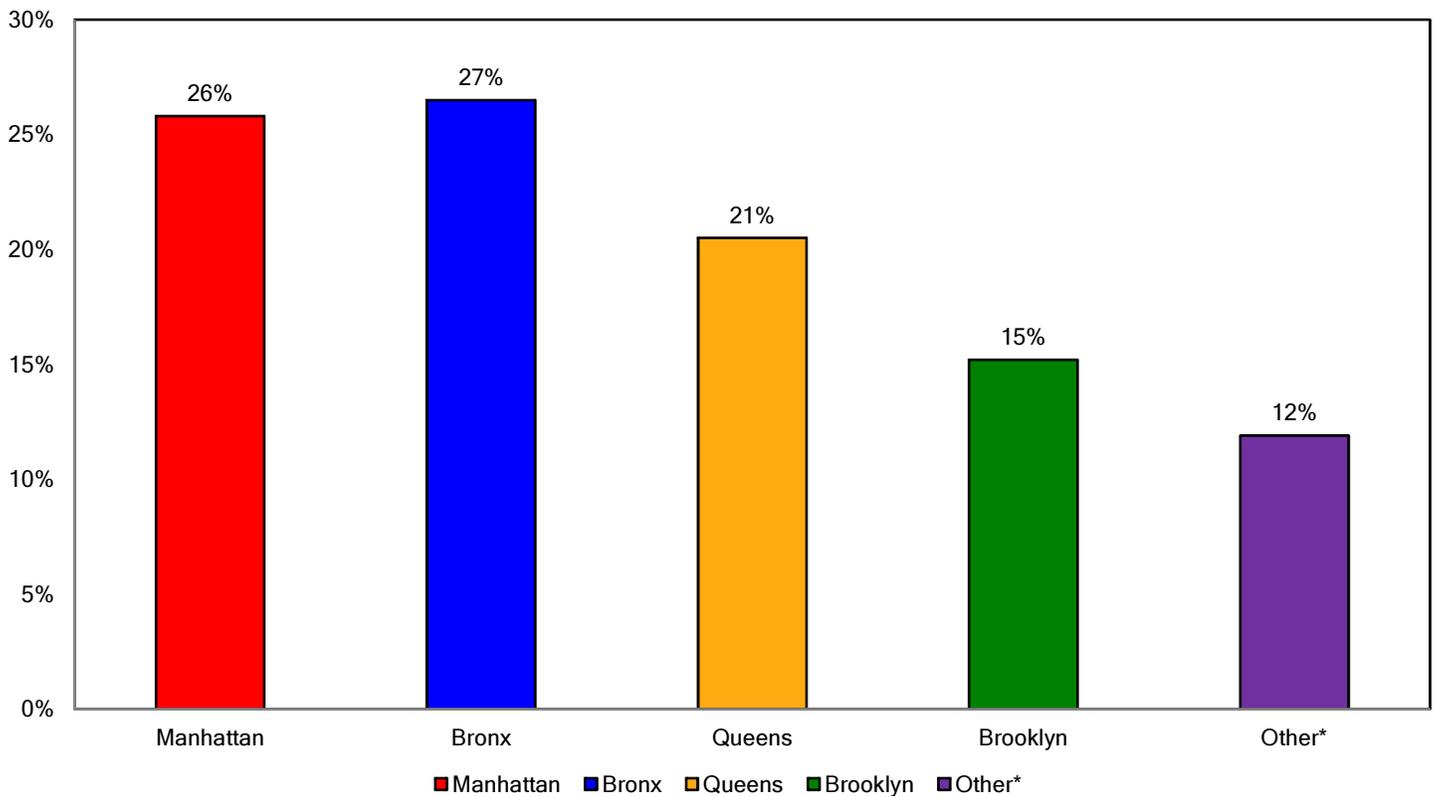
Developing knowledge and conducting research in this area is critical, as (1) Mexican immigration to New York City is relatively recent, and from different regions compared to more established immigration patterns of Mexicans in the West and Southwest of the United States (US); (2) the majority of Mexican immigrant women in NYC are within their reproductive years; and (3) Mexican immigrants in NYC often have low socioeconomic status (SES), limited educational attainment and employment. According to recent data, the median inflation-adjusted household income for Mexican residents is \$40,000, and for females in particular, it is \$30,100.³ Sixty-three percent of Mexican female residents did not graduate from high school, and only 5.8% received a Bachelor of Arts degree or higher.³ When compared to other foreign-born Latino nationalities residing in NYC, Mexican immigrants have poorer educational outcomes and employment outcomes as well, particularly for females. For example, 56% of Mexicans do not graduate from high school, compared to 44% of Dominicans, 43% of Ecuadorians, and 24% of Colombians⁴. When compared to other foreign-born Latinas in the workforce, 48% of female Mexicans are out of the work force, compared to 28% of female Colombians, 34% of female Ecuadorians, and 34% of female Dominicans⁴. These demographic statistics indicate that Mexican female immigrants are a vulnerable and disenfranchised group.

Demographic Characteristics

All participants were women born in Mexico, primarily in the central to southern regions, from Mexico City to Oaxaca, and currently living in the New York City area. The highest percentage of participants reported residing in Manhattan and the Bronx (26% respectively for both); followed by Queens (21%) and Brooklyn (12%). Twelve percent reported living in Staten Island or just outside the city limits north of The Bronx and east of Brooklyn/Queens on Long Island. (See Figure 1). The distribution of our participants does not accurately represent the general distribution of Mexican immigrant women residing in the 5 boroughs of New York City, and may be influenced by the location of NYC's Mexican Consulate (in Manhattan), the site where the most participants were recruited. As of 2009, 31% of Mexicans resided in Brooklyn, followed by 26% in Queens, 24% in The Bronx, 14% in Manhattan, and 5% in Staten Island.³

Participants ranged in age between 18 and 63, with an average age of 31 years. On average, women reported living in the United States for about 9 years. Twenty-one percent had some form of health insurance.

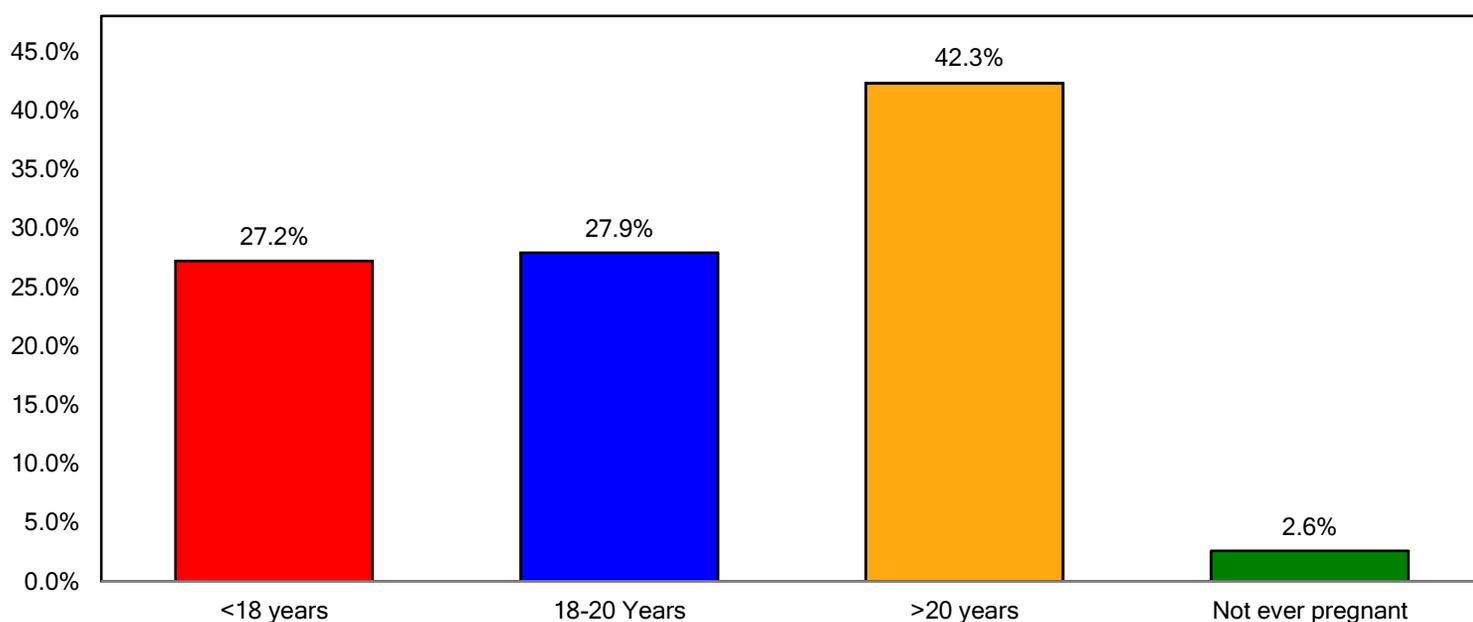
Figure 1: Participant Borough of Residence
(% of total participants, N=51)



Reproductive Health History - Pregnancy

We asked women if they have ever been pregnant and the age of their first pregnancy. We also asked about past terminations of pregnancy. The majority of the women surveyed had children (97%), with an average of 2.5 children. The average age of first pregnancy was 21 years, and the majority had their first pregnancy by the age of 20 (See Figure 2). Eighteen percent of women reported having had an abortion.

Figure 2: Age of First Pregnancy
(in % of total participants, N=151)



Use of Reproductive Health Care

The majority of our participants had been to a hospital, due primarily to childbirth; while far less had been to a health center or doctor's office for reproductive health care. Some women said they used home remedies and/or *botanicas* for reproductive health, as well as products from Mexico, regardless of whether or not they visited medical professionals in NYC. (Figure 3). In terms of services received, most had received some form of prenatal care in NYC (88%), but many said they had never been to a doctor's office or health center for routine reproductive health care (e.g., PAP smears or testing for sexually transmitted infections) nor obtained birth control methods when not pregnant (32%). This is also reflected in the number of women who had received prenatal care services, with fewer receiving routine reproductive health care (i.e., non-pregnancy related gynecological exams, STI testing, and mammograms). (See Figure 4).

Figure 3: Sources of SRH Care
(% of total participants, N=151)

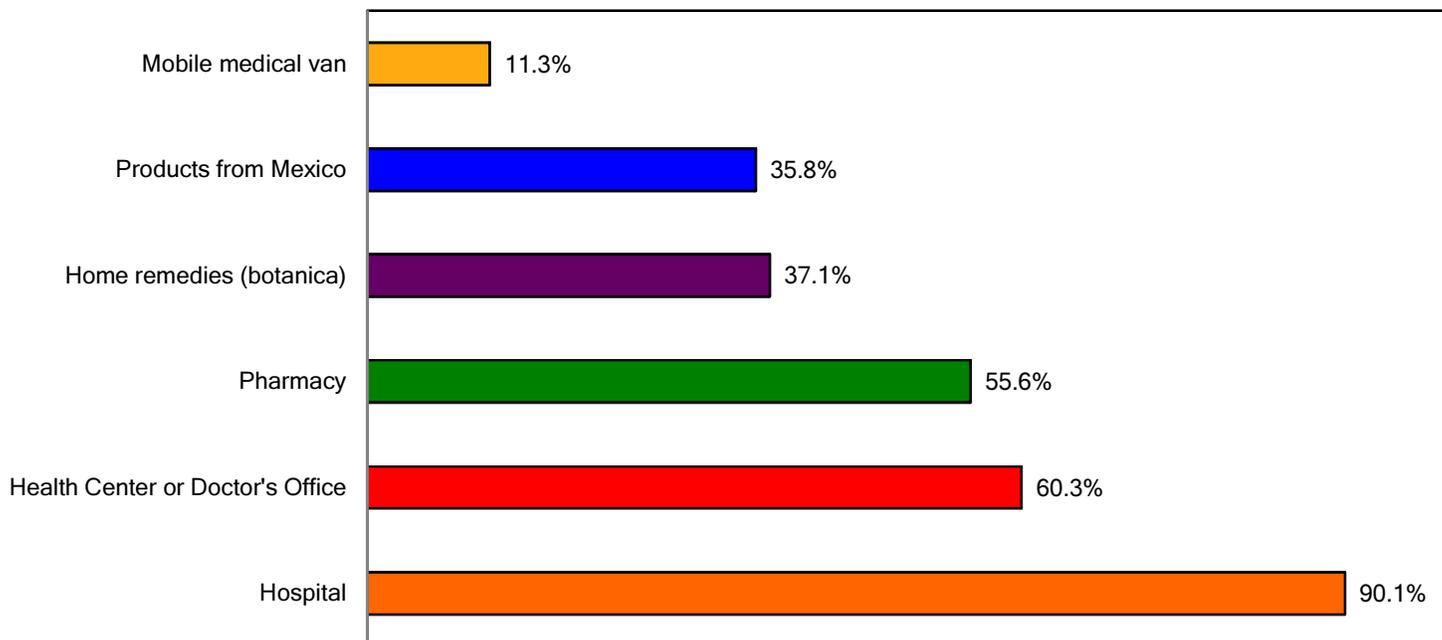
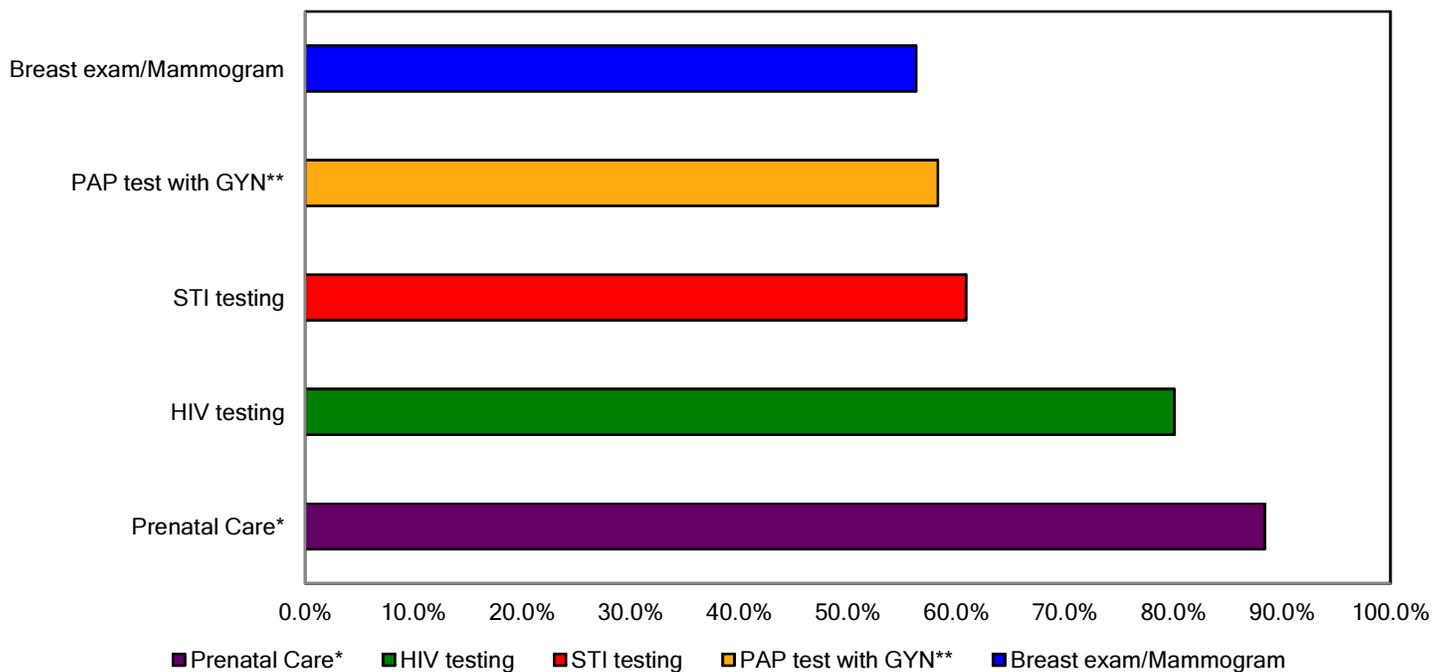


Figure 4: Types of SRH Care (total percentages among participants, N=151)



Contraceptive Use

Seventeen percent of women in our sample reported currently using male condoms alone, and an additional 3% are using condoms along with another method of birth control. Close to 15% reported using a form of non-IUD, hormonal contraceptive such as oral contraceptive pills (about 50%), Depo-Provera, or Nuva-Ring. Thirteen percent have had a tubal ligation, or a partner with a vasectomy. Almost 8% of the sample is using an IUD. Forty-one percent of women reported not using any contraceptive method currently. (See Figure 5) When compared to the general female population in the United States aged 15-44 years, the percentage of our sample reporting non-use of a current contraceptive method is slightly higher, while use of female sterilization and oral contraceptives is lower, and use of condoms is about double.⁵ (See Figure 6) However, inferences cannot be made from these comparisons, as survey participants were not sampled randomly, our sample size is small, and the age restrictions of the study design do not correlate with the US data.

Figure 5: Current birth control method (in percentage of total participants, N=151)

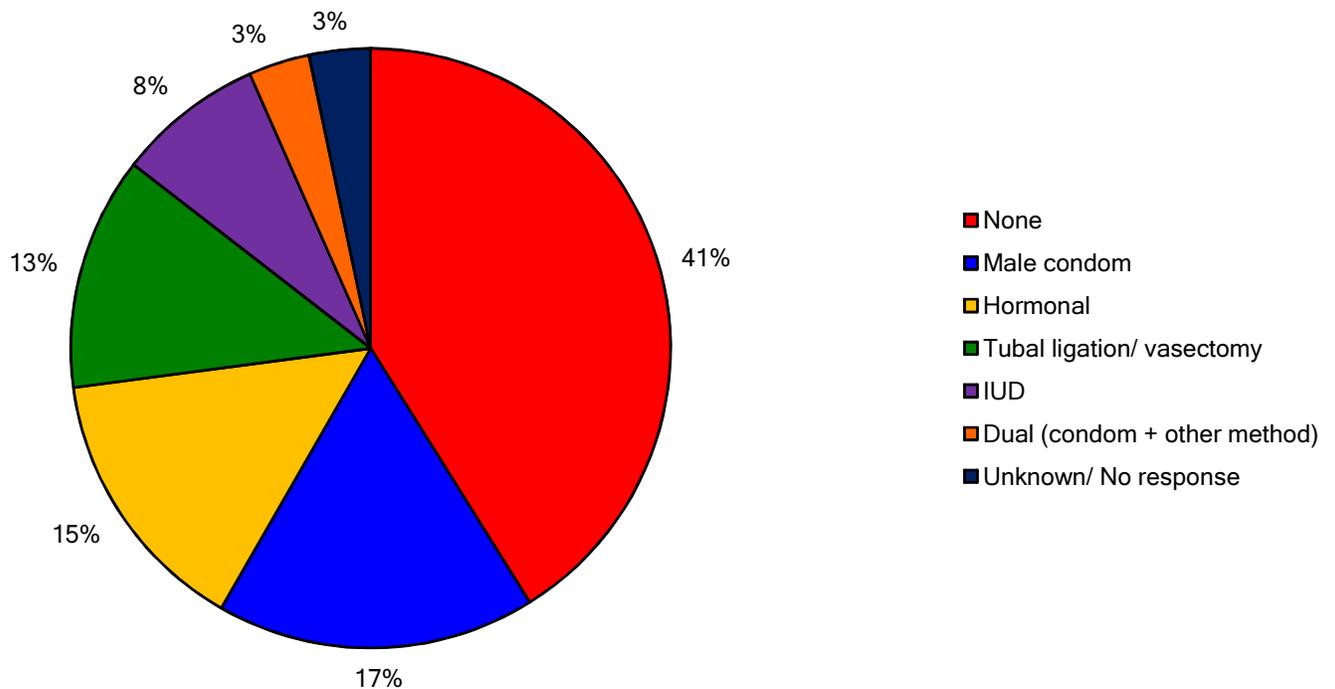
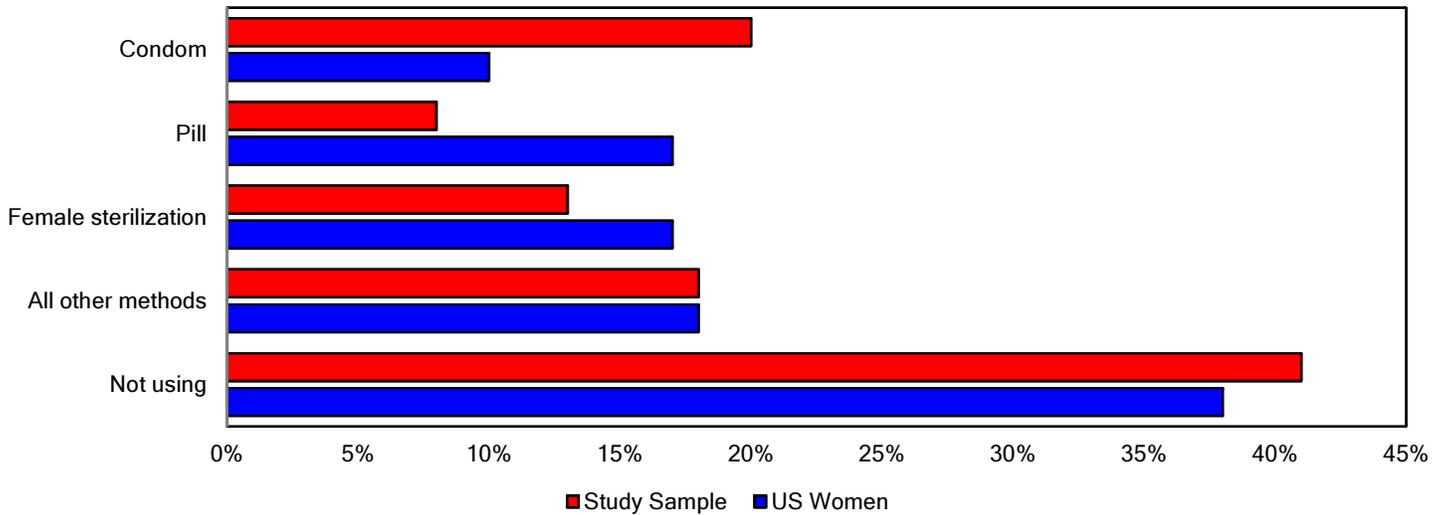


Figure 6: Percent Distribution of Women by Current Contraceptive Method: Study Sample and United States Women (aged 15-44 years, 2006-2008)*

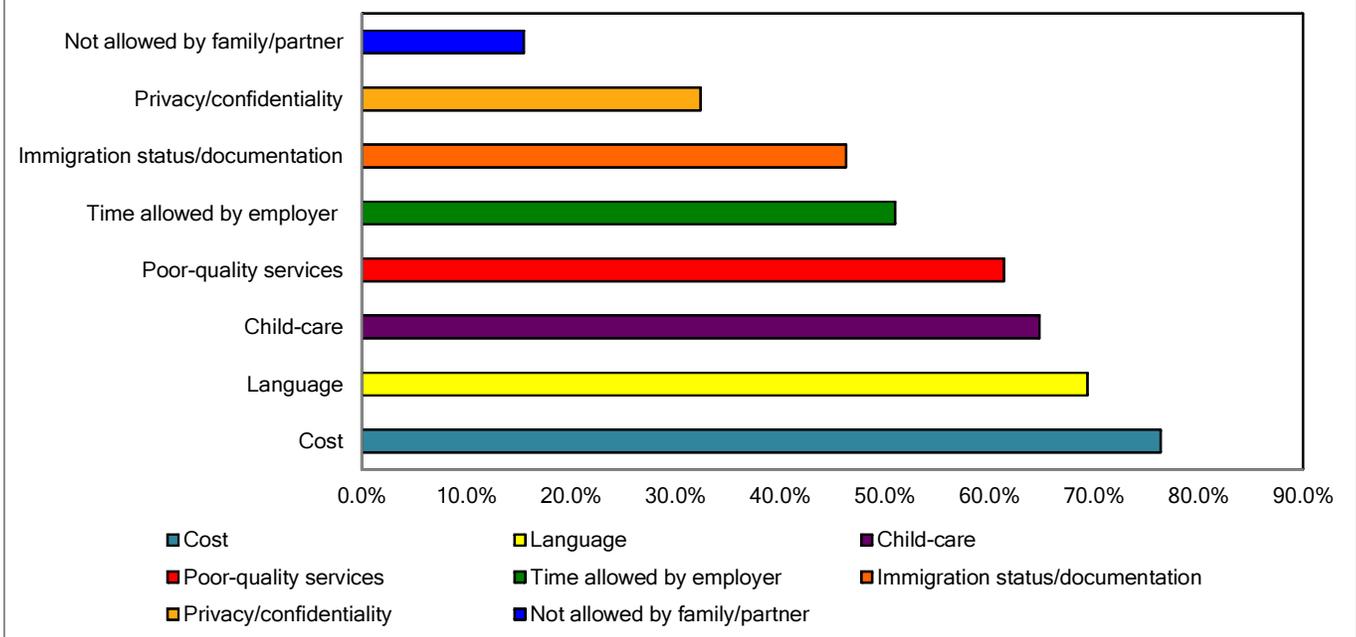


- Data source: Mosher WD and Jones J, Use of contraception in the United States: 1982-2008, *Vital and Health Statistics*, 2010, Series 23, No. 29.

Barriers to accessing care

Of the 8 different barriers that were asked about on the survey, the highest rated barriers were not being able to pay for services (76%), provider not speaking Spanish (69%), difficulty finding child care in order to go to an appointment (65%), and fear of receiving poor quality services (65%). (See Figure 7).

Figure 7: Barriers to accessing SRH care (total percentages among participants, N=151)



Discussion

In general, women in our study had been residing in one of the 5 New York City boroughs for almost a decade. They were relatively young, and parenting on average at least two children. Their first pregnancies were also experienced while they were young.

The majority were uninsured. Although most had received some form of prenatal care, it is disconcerting that approximately 12% of the sample had not. Furthermore, the majority of our sample reported a history of receiving limited SRH care during their time residing in NYC. Participants indicated several barriers to accessing reproductive health care services and reported limited regular gynecological care, leaving them at risk for preventable deleterious health outcomes, including STIs/HIV and unintended pregnancy.

The findings show that there is a need for affordable, comprehensive, and linguistically-appropriate sexual and reproductive health care among Mexican immigrant women. It is possible that child-friendly environments (where women can come with children to the appointment in the case that other forms of child-care are not available) may further facilitate access to SRH services. The findings of this study should be interpreted with caution, as this is a relatively small sample size, and cannot be generalized to the larger Mexican female immigrant community of New York City. However, as a descriptive study, it supports evidence that there are serious gaps in health care access for young Mexican immigrants, and that they are not receiving optimal SRH care. Although NYC has several options for free or low-cost SRH services, women may not know about sources of care, or be able to access them due to insurance/documentation status and/or financial constraints.

There is limited research that explores the variability of service utilization by various Latino immigrant sub-groups in New York City, and the contexts that may explain observed differences. However, there is evidence suggesting that Mexican immigrant females may be less knowledgeable of the services and resources available to them regardless of immigration status when compared to more established Latino immigrant populations in New York City, such as female Dominicans.⁶⁻⁸ Furthermore, past experiences with authority entities (i.e. the government, police force, etc) and the health care, domestic violence, and child welfare systems vary not only by individual but by country of origin and may influence current behavior in accessing care⁹⁻¹⁰. When compared to Latina immigrants from other countries, Mexican women in particular may look upon the forces and systems that are supposed to care for and protect them warily and with skepticism, due to past negative experiences in Mexico.¹⁰

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