Barriers to Prenatal Care for Hispanic Immigrants in Utah County

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ABSTRACT

BARRIERS TO PRENATAL CARE FOR HISPANIC IMMIGRANTS IN UTAH COUNTY

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This thesis examines four barriers that may inhibit Hispanic immigrant women from receiving care in Utah County, including language, insurance, documentation, and education. Six clinics in Utah County were contacted to determine how the services they provide account for these barriers. Nine Hispanic women were then interviewed about their experience with prenatal care in Utah County with respect to the four barriers. Interpretation services were offered by each clinic, though none of the women interviewed used professional interpretation—either their husbands translated, or they met with a Spanish-speaking doctor. Every clinic accepted insurance and Medicaid, while one clinic had a flexible payment plan, and none of the clinics required proof of documentation. Three of the women used Medicaid to pay for their prenatal care, and in every case, insurance was a deciding factor in choosing a healthcare provider. Only one prenatal class was found to be offered in Spanish and each of the nine women expressed that they wished they had known more about prenatal care or the healthcare system before pregnancy. Further research needs to be conducted, and Utah policy makers and health care providers should prioritize overcoming these barriers.
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Introduction

Over the past few decades, large numbers of Hispanic immigrants have moved to the United States. According to census data analyzed by the Pew Research Center, Hispanic people made up 17.6% of the United States population in 2015, whereas in 1990 they made up only 8.8%. In 1990, Pew estimated that 14.0 million U.S-born Hispanics lived in the States, along with 7.8 million who were foreign born. Both of those numbers have grown, so that in 2015, 37.1 million Americans identified as Hispanic, and 19.4 million immigrants to the United States came from Hispanic countries (Pew Research Center, 2017). According to the U.S. Census Bureau, Hispanics comprise 14.2% of the population of Utah (U.S. Census Bureau, 2019).

From this data, we can see that Hispanics are the most abundant minority in the United States, as well as in Utah specifically. To further understand this growing population, I focus my research in the state of Utah, specifically in Utah County. Data from the U.S. Census Bureau indicate that in 2019 the population of Utah County was 12.0% Hispanic. With a population of 516,564 people in 2019, this would mean that nearly 62,000 Hispanic people live in Utah County, making it one of the counties with the highest number of Hispanic inhabitants in the state, second only to Salt Lake County (U.S. Census Bureau, 2019).

It is important to consider that the experience of an immigrant differs from that of a U.S-born Hispanic citizen. Pew estimated that out of the Hispanic population born in the States, 89.7% of them speak English at an advanced level. This is starkly different from foreign-born Hispanic immigrants, where only 34.6% of them speak English very well (Pew Research Center, 2017). This data shows that when we consider the
experiences of Hispanics overall, it is necessary to differentiate between foreign-born and U.S-born. Foreign-born immigrants come to the United States from diverse backgrounds and unique circumstances; however, similarities exist in their experience as immigrants to the U.S. Many studies have tried to determine what that experience is like by focusing on specific aspects of it, such as healthcare. As researchers have studied Hispanic women, children, and the Hispanic population at large, they have found that Hispanic immigrants do not always receive the healthcare that they need (Bromley et al., 2011; Huang et al., 2006; Rodriguez, 2005).

Several factors create barriers to healthcare for the Hispanic population. Cristancho and colleagues (2008) define the term “barriers” as “individual, societal, organizational, structural, and/or provider-based factors that preclude a certain population from fully utilizing health care and health promotion interventions.” They identified many potential barriers that could inhibit a Hispanic immigrant from receiving care, such as the lack of health insurance, costs of healthcare, language ability, the lack of medical interpretation, documentation status discrimination, and transportation, among others. In my research, I seek to better understand how providers of prenatal care address these barriers in the Utah County, and how the barriers affect the personal experiences of Hispanic immigrants. I focus on four specific barriers that could inhibit Hispanic mothers from receiving prenatal care: interpretation services, insurance availability, documentation status, and educational resources.

**Background**

*Language Barriers*
Within the current body of literature on this topic, almost every study mentions the importance of interpretation for patients who speak primarily Spanish. Language concerns are one of the major barriers to receiving quality healthcare (Bauer et al., 2000; Cristancho et al., 2008). When immigrants face illness, they are much more likely to seek healthcare and rate it as a good experience when they can understand the doctor (Chiauzzi et al., 2010). Multiple studies agree that when Hispanic immigrants with low English proficiency are unable to access translation services, the likelihood that they will remain in good health decreases (Cristancho et al., 2008; Timmons, 2002). This may be caused by the fact that they do not visit a physician regularly (Nandi et al., 2008; Timmons, 2002). Even if they do see the doctor, the language becomes a barrier to understanding. The quality of their visit decreases, because they do not understand what the doctor is recommending, or what exactly is wrong with them (Bauer et al., 2000; Cristancho et al., 2008).

The government issued a mandate in 2000 that federal services reevaluate their efforts to provide for the needs of those with “Limited English Proficiency (LEP),” however, this is not always reflected in healthcare (Cristancho et al., 2008, LEP.gov). Consequently, studies have shown that 60% of LEP Hispanic patients have English-speaking family members do the translation. While this can be convenient and a better alternative to having no interpretation at all, experts have stated that this can actually create further problems (Chiauzzi et al., 2010). Studies show that the untrained incorrectly interpret half of the providers’ communications to their patients (Cristancho et al., 2008). It can also add legal complications, as doctors are required to not reveal personal information to people other than the patient. This evidence further solidifies the
need for clinics to provide professional translation services to Hispanic patients who need it.

Having Spanish language training is also beneficial to the provider. Past research has found that physicians are more likely to consider cultural beliefs of patients during treatment when they have a better understanding of Spanish language and culture (Chiauzzi et al., 2010). Unfortunately, the same study found that only 26% of medical schools in the U.S. and Canada provide training on Latino culture, let alone the Spanish language. The need to account for language barriers when treating Hispanic immigrants cannot be overstated. Without proper interpretation, the amount of care received and the quality of care suffers.

**Insurance Barriers**

Another roadblock to receiving proper healthcare for Hispanic immigrants is access to insurance. Paying for healthcare of any kind can be difficult in the United States, particularly for immigrants who are more likely to be in a lower socioeconomic class. Research on the subject has found that many Hispanic immigrants lack insurance, particularly non-citizens (Cristancho et al., 2008; Ku et al., 2001). Employers provide health insurance to immigrants less frequently relative to citizens (Huang et al., 2006). If or when it is required, the insurance may be limited. One study found that among employed immigrants who received health insurance from an employer, frequently the insurance was only for the employee, leaving an unemployed spouse and children without coverage (Cristancho et al., 2008). Clearly, Hispanic immigrants face barriers financially that limit access to insurance and healthcare, and this has consequences.
One study observed that almost half a million Mexican immigrants living close to the border traveled to Mexico to receive care when needed, due to a lack of insurance (Wallace et al., 2009). This is not, however, an option for most Hispanic immigrants living in the U.S. In fact, one study found insurance status to be the strongest predictor of access to healthcare for the Hispanic population (Hubbell et al., 1991). Lack of insurance correlates strongly with not receiving needed care, particularly for women needing mammograms, and children facing health risks (Huang et al., 2006; Hubbell et al., 1991; Rodriguez, 2005).

**Documentation Barriers**

A similar risk factor is the status of the immigrant’s legality. Pew Research Center estimates that as of 2017 there were 10.5 million undocumented immigrants, with about 4.9 million from Mexico (Radford & Noe-Bustamante, 2020). Though they indicate that this number has been declining in the past fifteen years, it certainly remains a large population. Unfortunately, undocumented immigrants are at a higher risk of not receiving care, and studies have determined that various factors affect this. Most notably, illegal immigrants frequently do not possess health insurance, showing an important overlap between two of the barriers considered in this study (Hubbell et al., 1991; Ku et al., 2001). Two separate studies found that the longer immigrants live in the United States, the more likely they are to have insurance and receive healthcare (Hubbell et al., 1991; Ortega, 2007). This is a favorable trend; however, it also means that recent undocumented immigrants are at a higher risk. Another complicating factor is that accessing services like Medicaid or coverage through the Affordable Care Act becomes increasingly difficult for non-residents (Salami, 2017).
Another aspect that contributes to undocumented immigrants’ lack of healthcare is the fear of deportation. While this is hard to test, many researchers believe this influences whether or not immigrants are comfortable seeking medical care (Bauer et al., 2000; Huang et al., 2006; Hubbell et al., 1991; Nandi et al., 2008). Disclosing personal and sensitive information, such as that which is required by healthcare providers, is likely frightening for immigrants in this situation, further deterring them from seeking the care that they need.

**Educational Barriers**

The last factor that I consider is the availability of programs and health education that cater to the Hispanic population. Not as much research has been done on the effects of such programs in terms of healthcare. One study looked at the misconceptions that Hispanic immigrants have about origins and treatments for upper respiratory tract infections. The researchers showed that educational opportunities to teach about such infections would have increased the willingness of immigrants to seek care and understand treatments (Larson et al., 2008). Another study examined the public’s understanding of the use of antibiotics and found that “Hispanics surveyed in Spanish, compared with non-Hispanic whites, had significantly lower knowledge about antibiotics for colds” (Corbett et al., 2005). Pew Research Center indicates that among foreign born Hispanics in the U.S, aged 25 and older, 71% had a high school education or less (Noe-Bustamante Flores, 2019). A population that is more likely to be low-income and less likely to have secondary education may be at higher risk for misconceptions regarding healthcare, and this may extend into prenatal care.
Drawing upon this research, I examine healthcare availability and experiences for women in Utah County, with a focus on prenatal care. It is clear that the increasing Hispanic immigration since 1990 has also led to increased research on Hispanic immigrant healthcare, but little attention has been given to prenatal care. Utah County has a population of nearly 62,000 Hispanic people, yet there are no studies that examine the barriers to prenatal care for Hispanic women in this county (U.S. Census Bureau, 2019). With this in mind, to further understanding of barriers to prenatal care for Hispanic immigrant women, I investigate prenatal healthcare in Utah County using qualitative methods.

**Methods**

First, I focus my study on four specific barriers to healthcare based on the review of the literature: interpretation availability, access to health insurance, documentation status, and health education resources. In order to understand the services available to Hispanic women in Utah County, as well as their individual experiences, I used two different approaches to collect information regarding barriers to healthcare.

**Healthcare Services**

To understand the availability of these services to Hispanic women in Utah County, I first surveyed local clinics for information regarding the services they provide. Following an Internet search of clinics offering prenatal care, I identified six clinics in Utah County that I could contact about their services in regard to these barriers.

I visited clinics in person or called a reception desk. Most often I spoke with a receptionist, though at one clinic the receptionist referred me to a nurse. I asked four
open-ended questions, developed to learn more about how each clinic addressed the four main barriers. These are the questions I asked:

- What resources do you have for women who speak primarily Spanish and come for care?
- If someone comes requesting care but does not have insurance, what happens then?
- If a Hispanic immigrant comes for care and she is undocumented, how would that affect her experience?
- Do you have any educational programs for prenatal care? Are those programs available in Spanish?

Aside from the clinics, I also consulted three other local resources. I contacted a community agency that provides support for the local Hispanic population to learn where they refer expecting mothers who are seeking prenatal care. I also reached out to a program called “Welcome, Baby” which provides classes and activities for new and expecting parents to help them learn parenting skills. Finally, I consulted a website put together with the help of Utah doctors that provides information about pregnancy and childbirth and where to look for help.

*Individual Healthcare Experience*

In order to gain a better understanding of the prenatal care experience of Hispanic immigrants, I interviewed Hispanic women living in Utah County directly. Prior to interviewing, I received approval from the Internal Review Board at Brigham Young University. Each woman was provided with a consent form approved by the Internal Review Board, explaining the purpose of the study and their role and rights as
participants. A local professional translator agreed to translate the consent form and interview questions into Spanish. The consent form in both languages can be found in the Appendix.

I found women to interview through my personal connections and word of mouth, using a snowball sampling technique. Qualifications to be interviewed were as follows: (1) immigrated to the United States from a Spanish-speaking country, (2) pregnant in Utah within the past 5 years, and (3) not pregnant at the time of the interview. The third qualification was set in place in accordance with IRB restrictions against studies involving pregnant women.

Interviews were conducted over the phone and recorded. In order to receive consent from each participant, I emailed each woman a copy of the consent form to review. After reading the document, they provided written consent via email that they agreed to participate. Recordings were then transcribed and analyzed, and the original recordings were destroyed. This was done to protect the identity of the participants according to IRB requirements. With the same four barriers in mind, I developed the following questions to guide my interviews:

Where are you from & how long have you been in the US?

Did you receive regular prenatal care during your pregnancy, and if so where?

How did you choose your healthcare provider?

Please describe your experience with prenatal care.

What were you hoping to gain from your prenatal care?

How would you change or improve that experience if you could?

Have you had another child in a different location other than Utah?
If so, how did that experience compare?

How did you first learn about what to expect from prenatal care?

Did you take any classes?

Did you have or request an interpreter when seeking healthcare?

What payment options did you have for care received?

Is there anything that you would change in the future for your prenatal care?

Do you think your experience was influenced at all by your being a Hispanic immigrant and, if so, how?

Responses to these questions were analyzed for patterns and examined within the context of services offered at local clinics. I interviewed nine Hispanic women who had been pregnant in Utah and met the qualifications to be included in the sample. Three of the women were from Guatemala, two from Peru, one from El Salvador, one from Bolivia, one from Panama, and one from Chile. The time that each of them had spent in the states ranged from five years to 22 years. One of the women had only one child, and the others had between two and five children. Each of the women’s identities has been kept confidential, and whenever they are referred to individually in this study, they have been given alternate names.

Results

Language Barriers

The first barrier considered was interpretation availability. Every clinic had some sort of solution to help overcome this barrier. Three of the clinics provided on-site interpretation that a patient could schedule in advance. One clinic estimated that 70-80% of the staff spoke Spanish fluently, and consequently they did not lack for interpretation.
This clinic was the best equipped to handle an abundance of Spanish-speakers and was also the least expensive. Three of the women interviewed took advantage of this service. Another clinic used an iPad to connect with an off-site interpreter for visits and calls. The least equipped of the six clinics was relatively small and had only one nurse that spoke Spanish out of all the staff with no other possibilities for interpretation. The receptionist did mention that they could use an interpretation hotline if necessary, but I did not inquire further about that option. At varying levels of efficiency and availability, each clinic had an answer to my question.

None of the women interviewed expressed any issues with communication when it came to a Spanish-English language barrier. The majority of them spoke English well enough to feel fairly confident in the healthcare setting. Those who did not speak English confidently interacted with medical personnel who spoke Spanish or were accompanied by their family members who spoke English. None of them specifically requested professional interpretation services. Two of the women consistently brought their husbands with them, who provided translation or clarification whenever necessary.

However not every woman had this option. For example, for her first pregnancy in Utah County, Laura lived with her husband who was pursuing a master’s degree in business. She explained, “My English at that time was very bad… My husband didn’t have time to accompany me to the doctor. I had to go by myself” (translated from Spanish). Fortunately, a friend of Laura’s recommended a particular clinic because of their Spanish-speaking staff, so she was still able to receive care in her native language. An instructive comparison can be made to Carmen, who moved to the United States as a high schooler and therefore had a better mastery of English. She felt that language did not
get in the way of her receiving care and expressed that she felt she was at an advantage compared to other immigrant women for that reason. As a fairly fluent English speaker, Carmen could have chosen any clinic within the scope of her insurance, whereas Laura’s options were comparably limited.

*Insurance Barriers*

The second barrier was lack of insurance. In response to my question, all of the clinics responded that without insurance the patient would be considered “self-pay.” All but one accepted Medicaid; the rest explained that they inform the patient about Medicaid and how to apply. When I spoke to the community agency, the representative stated that they refer mothers with no insurance to the cheapest clinic in the area. At this clinic, they work with each individual family without insurance to determine how much they can pay. A package that includes all prenatal care visits and delivery could cost from $700-$3000, depending on the situation of the mother or family.

Economic level and insurance status varied among the nine women interviewed, however all of them were able to find a way to pay for the medical expenses, using either insurance or Medicaid, or a combination of the two. Three of the women specifically mentioned seeking care from the least expensive clinic so they could take advantage of the payment plans provided there.

In speaking to each woman, it became clear that insurance was one of the most influential factors in deciding where they received care, and not every woman had access to insurance. On one extreme was Carmen’s experience. When she was pregnant with her third child, her husband left her, and she was in no financial state to pay for prenatal care. She was able to apply for Medicaid and was accepted. The other two women who also
lacked insurance successfully received help from Medicaid, so none of the women had to pay out of pocket. Laura, for example, was covered by her husband’s student health insurance, but with a deductible of over $700. In order to cover that amount, they requested Medicaid. It is fortunate to see that, in the cases of these women, finances did not stop them from receiving prenatal care. However, it certainly did not make the process less complicated. Isabel explained that when she was pregnant, her husband had lost his job. She said, “We applied for government insurance, I think. I still don’t know a lot about that. They took care of us. But I think for the same reason it was difficult to request a private doctor.” Jazmín had similar concerns when she explained how they worked around insurance options so they could receive care from the same Spanish-speaking doctor for all of her pregnancies: “Because we worked with Obamacare, every year we had to update our insurance. So, I would always have to make sure that our insurance would cover [my doctor] … like I had to change insurances twice just so I would be with him.” Navigating insurance for medical care is not simple, but when this overlaps with other barriers such as language restrictions or documentation status it can make the situation more complicated.

Documentation Barriers

When asked how being undocumented would affect the experience of the patient, all of the clinics said that it would not affect her experience. Two clinics ask for social security numbers upon check-in, however one receptionist explained that if they do not have one, they are simply marked as non-citizens. The other four clinics only required a form of ID, and even a foreign ID would suffice.
As mentioned earlier in this report, there was not a specific question in the interviews about the legal status of the women. Jazmín did mention how going into her first pregnancy as a non-resident and non-citizen was difficult. Her application papers for residency had been sent in, and she was in the United States on a visa, but that was the extent of her status. She and her husband had to seek specific guidance on how to proceed, particularly in the case of insurance. When Laura needed help from Medicaid to pay for prenatal care, because she was not a citizen, she applied specifically for Emergency Medicaid. The National Conference for State Legislatures organization website explains that “Unauthorized immigrants are not eligible for federal health insurance programs and are only eligible for more discrete programs like emergency medical assistance under Medicaid, services in federally qualified health centers and certain public health programs” (Salami, 2017). This shows again how each of these barriers overlap, with legal status perhaps a risk factor for all the rest. As all the women did receive regular prenatal care during their pregnancies, we can see that their legal status at least did not stop them from seeking care. Whether it was a cause of worry cannot be fully determined due to the lack of inquiry on the subject.

**Educational Barriers**

The last barrier I considered was educational resources. While I asked this question of every clinic I visited, it did not apply to each of them. Only two of the clinics offered classes for prenatal patients. At one of these clinics, classes are not offered in Spanish. At the least expensive clinic, however, a monthly class is offered with two instructors, one of which is fluent in Spanish. Consequently, the class is offered in both languages. The other community resources I examined became relevant when
considering this barrier. When I spoke to a representative for Welcome, Baby—the program designed to teach parents important skills—she informed me that while they had some Spanish-speaking volunteers, none of their services were available specifically in Spanish. The website providing educational information on pregnancy and care contained a Spanish option. The majority of the website was available in Spanish with only some portions of it not yet translated.

Only two of the women interviewed had specifically taken a class about pregnancy, though one of them took the class in relation to her second pregnancy, not her first. Each of the nine women expressed that they did not feel well-equipped with information going into their first pregnancy in Utah. That is not to say that they did not look for and find information, but they did not have a straightforward way to learn about prenatal care and the healthcare system. Carmen was the only one to mention taking advantage of “Baby Your Baby,” a local service, and in her estimation, it was a useful source of information. Another learning resource came in the form of an app that Sofia used to track her pregnancy, keeping her updated on the tests that she could expect each week. These women were not cut off from information, but in many cases, they indicated that they wished they had known more. Daniela explained, “since I didn’t know anything about prenatal care or anything, I think I would have liked an orientation or something at the beginning, like something that tells you, okay, these are the appointments that you are going to have.” After conducting all of the interviews, it seems that each of the women would agree with Daniela on this point. Daniela also made an important counterpoint in her interview, explaining that if there had been a class available, which there may have been, she was not sure that she would have had time to attend.
When Jimena was asked what she would change about her experience, she said she would gather more information about how to eat, because during her first pregnancy she was diagnosed with gestational diabetes and was unsure how she needed to manage that condition. In the case of Elena as well, she felt that her first pregnancy would have gone differently if she had known more. When I asked her how she knew what to expect from prenatal care when she was first pregnant, this was her response: “I didn’t know anything. I didn’t know what to expect because I had no idea about what was going on... I Googled everything, because I was the first to get pregnant from my friends and my family. So, I had to learn by myself, because if I couldn’t do it, no one was going to tell me what to do, where to go. I had to look for an Ob/Gyn because I didn’t have one. I’m not from here, so I didn’t know where the hospital was or where the Ob/Gyn was or what to do. I had no idea of everything, I had to look for it.” She did manage to find access to prenatal care, but her experience did not get easier. During her first pregnancy she suffered from a cervical insufficiency, something she was completely ignorant about, and which ultimately led to a miscarriage. After learning more about the condition after her miscarriage, she believes that the doctors could have done more to save her baby, but because she did not know anything at the time, she was unable to advocate for a different course of action.

Being able to advocate for oneself based on greater knowledge was a sentiment felt by Rosa and Isabel as well. Rosa explains her experience with her first pregnancy as follows: “I wanted to understand what was happening, but mostly I just went with whatever the doctor said. With the other two I had more of a say, and I kind of pushed what I wanted more.” In fact, she would have requested a midwife for all three of her
pregnancies, instead of only her third one, but she did not know enough about midwifery services at the time. Through exposure to healthcare resources, she was also able to question her previous opinion that formula was akin to “poison,” a belief that she attributes to her culture. Like Rosa, Isabel learned about prenatal care simply from the experience of her first pregnancy. She learned afterward that for her second child she could ask more questions and for specific treatments.

The women’s lack of information was not solely with regards to pregnancy; a few also explained that they did not know much about the healthcare system itself. Coming back to Daniela’s experience, she explained: “I never needed to go to the doctor before this, so I wasn’t familiar about how the healthcare system works. I didn’t know that you deliver in one room and then they move you to another room after the baby is born. I just didn’t know. I think it was the first time that I was inside a hospital here in the U.S… I was kind of lost.” In Isabel’s case, she was used to a different situation in her country. In her own words, “in my country you are very scared of the doctors” (translated from Spanish). She had to learn that in the United States, she could feel comfortable talking to the healthcare professionals. Laura was also used to a different health care system, though in this case a superior system in Chile, by her estimation. She was used to having many more ultrasounds for her first two pregnancies in Chile and coming to Utah she needed to adjust to a healthcare system that offered ultrasounds less frequently and would not begin setting appointments for her until she was at least 8 weeks along.
Discussion

Previous studies mention language interpretation as one of the most common barriers to receiving health care. In a population where the largest minority is Hispanic, many of them foreign-born, it is incumbent on all healthcare providers to account for this barrier. In an ideal community, all prenatal care providers would have professional medical interpretation readily available. While there is room for some improvement, overall it is clear the prenatal care providers in Utah County are taking language barrier into account and striving to overcome it. The body of research on medical interpretation for Hispanic immigrants considers it a predominant inhibitor to receiving care and recommends professional language services as the best way to overcome this barrier.

In Utah County, steps are being made in the right direction, and must continue to improve. Each of the women interviewed seemed fairly comfortable working out interpretation if it was something that they felt that they needed, though an argument could be made that the responsibility falls on the healthcare provider and not the patient herself. It is fortunate to have access to family members that can provide interpretation; however, as I mentioned earlier, research indicates that amateur interpretation by family members can be problematic (Chiauzzi et al., 2010). It is also important to remember that not everyone has the same resources, both in personal and family language ability.

Clear communication is a key factor in a woman’s healthcare experience, and resources that stop language barriers from inhibiting that communication will never lose relevance as our community becomes increasingly diverse. The clinic with the most Spanish-speaking staff is a great example to other healthcare providers. While we cannot expect every clinic to hire only Spanish-speaking staff, any measures that are taken to
make women who rely on interpretation feel more comfortable and confident in receiving care, as we saw in Laura’s experience, have an important impact. Each woman seeking care will require different levels of language resources, but the most disadvantaged should be able to find what they need.

Another barrier that varies a lot in each case is financial situation and access to insurance. In the United States, immigrants are more likely to be in a lower socioeconomic status, and some researchers consider this to be the largest barrier to receiving care (Hubbell et al., 1991). Due to the fact that both healthcare and health insurance are expensive, Hispanic mothers may not seek care because they cannot afford it. Extenuating circumstances like those experienced by the women interviewed, such as divorce or unemployment, will only complicate matters further. Ideally, community prenatal care clinics would provide affordable care despite lack of insurance.

When looking at how the clinics account for this barrier, there were only a few solutions for Hispanic immigrant mothers. The best that most clinics offered was an acceptance of Medicaid. Medicaid is a valuable resource for low-income families, so it is positive to see that it be mostly accepted, and that it was an option for some of the women interviewed. However, not every low-income immigrant family may qualify for Medicaid, and the process to apply takes over a month. The flexibility of payment options allows for Hispanic women from all kinds of backgrounds and different means to receive the care that they need as expecting mothers. The clinic that offers the different payment plans depending on circumstance again sets an example for others to follow. If similar plans were available from more than just one location, this could lead to more women accessing care without the stress of insurance or government aid. As mentioned earlier,
insurance was almost always the deciding factor when the women were choosing their prenatal care provider. Their experience would only improve if there were a variety of easier and cheaper options.

The barrier of legal status overlaps significantly with financial barriers when it comes to receiving needed care in an insurance-based healthcare system. However, there is more to the healthcare experience of an undocumented immigrant than just a lack of access to insurance or Medicaid. Particularly when we consider U.S. immigration policies and today’s political climate, any immigrant who is here illegally may face a fear of deportation that inhibits them from seeking medical care. Requiring personal information is sensitive for someone who is undocumented, especially young, expectant mothers. However, this does not mean that they should not seek care. Ideally, undocumented immigrant women would face no discrimination or risk when seeking prenatal care.

After posing my question about immigrants’ experiences to these six clinics, it appears that there are not many risks for someone who is in the country illegally. As they did require some form of identification, it is still understandable that a woman in that situation would be nervous; however, logistically there is no reason that she should be. A better understanding of whether or not undocumented Hispanic mothers in Utah County are comfortable seeking care requires future research. In addition, as an undocumented immigrant, interpretation may become more necessary and navigating insurance and Medicaid becomes significantly more complicated. This was evident in Jazmín’s account, as she and her husband tried to find insurance when she was not yet a resident. Further research should be conducted in a sensitive manner, to investigate how to help this
population feel comfortable enough to seek necessary care without putting them at further risk.

With regards to the last barrier I studied, ideally educational resources would exist for immigrants to access and understand easily. Only one provider surveyed had a class that served this population specifically. While it is good that the government-sponsored website was also in Spanish, only immigrants with access to the internet would be able to use it. Researchers have found that without proper educational resources, misconceptions about healthcare will exist, such as Rosa’s negative impression of formula (Larson et al., 2008). Therefore, it is problematic if there are no other resources for Hispanic immigrants to learn about what they can expect from prenatal care. Each one of the women interviewed would have benefitted from some sort of program or class that taught them what they would experience, the tests that they would receive, and what to do if potential complications arise. While learning through direct experience eventually teaches women what they need to do during pregnancy, it should not be the primary way to find information.

Immigrants who have not lived in the United States for very long are also unfamiliar with the healthcare system. When they have not required any healthcare services before and when they are having their first child, these women are at a disadvantage to receiving or understanding the care they need. More classes or programs that advise women on how to navigate the healthcare system and how to access insurance or Medicaid could allow for immigrants to overcome the other three barriers as well. If a woman is more informed on language interpretation services, she may be more likely to use them. If there were a way for immigrants to learn about the process in advance,
finding insurance would become less daunting. Even simply a better overall understanding of the healthcare system may make seeking care seem less threatening to those who are undocumented.

When considering how to provide educational services to Hispanic immigrant women, it is important to remember Daniela’s comment that she would not have had time to take a class. These women often need to work, attend school, or take care of their families while being pregnant, and so classes or programs would need to cater specifically to their needs and family/work life. Educational resources of various length and commitment level could be available to help women in any situation.

**Conclusion**

After analyzing the prenatal care services and experiences in Utah County, it is clear that prenatal care providers in the county are doing moderately well at considering the needs of the immigrant population. It is important to recognize that the clinics are taking measures to help these women have a good prenatal care experience by providing interpretation options and by not asking about legal status. The experiences of the women interviewed were for the most part positive. However, we should not stop considering what more can be done to help Hispanic immigrant women access prenatal care. I conclude with four policy or research implications of this study.

First, having professional interpreters that are trained to translate medical terms is crucial, and ensuring that interpretation services are uncomplicated and well-advertised can help immigrant women feel more confident receiving care.

Second, the fact that there is only one provider that allows for personalized payment plans is problematic in that immigrants in difficult financial situations have only
one option. The existence of more clinics with flexible payment plans would improve the experience of many immigrants by giving them more choices for prenatal care.

Third, further research should be done to understand the concerns of undocumented immigrant women that may stop them from seeking prenatal care. With a greater awareness of their perspectives, policy makers and healthcare providers can find ways to encourage women to access care and to help them feel safe in doing so.

Finally, Hispanic immigrants need better opportunities to learn about the prenatal care they need. Based on my survey of clinics, just one class for Spanish-speakers in the whole community is insufficient. These classes or programs need to be in Spanish for immigrants who do not speak English fluently, and they also need to be advertised and easily accessible to the Hispanic community. Knowledge about prenatal care will empower immigrant women, giving them the ability to navigate a complicated system and find the services that cater best to their personal needs during pregnancy.

It is necessary to acknowledge that there are limitations to this study. The women interviewed came from a variety of Central and South American countries, and while there certainly exist similarities in culture among those countries, we cannot consider them to be identical. Country of origin may have influenced the experience that these women had in their prenatal care, but that was not taken into account or controlled for in this study. In addition, there was no question regarding legal status in the interview guide, even though that is one of the barriers considered. This was a deliberate decision due to the sensitive nature of that question and to not place undocumented immigrant women in a vulnerable position.
Another important point is that while the majority of interviews were conducted in English, two were in Spanish. As an intermediate Spanish speaker, I felt comfortable enough to conduct those interviews personally, acknowledging my ability to the interviewee at the beginning of our conversation. However, my Spanish abilities are certainly not perfect, and while I hope that it did not affect the interview, it should still be acknowledged. Lastly, no results can be generalized to all Hispanic women in Utah County. That being said, I still consider the research conducted and the conclusions drawn to be a valuable look at the experience of women in this situation.

Given these limitations, this study underscores the importance of overcoming barriers to prenatal care in Hispanic immigrant communities. As we consider the ways that clinics already eliminate barriers, and as we hear the positive accounts from immigrant women, we have reason to hope. However, we cannot stop improving. Moving forward, Utah policy makers and healthcare providers should recognize how the barriers of language, insurance, documentation and education impact this population, and work to overcome those barriers.
References


Appendix 1

Consent to be a Research Subject

Introduction
This research study is being conducted by Maren Monson and Renata Forste at Brigham Young University to understand the barriers to prenatal care faced by Hispanic immigrants in Utah County. You were invited to participate because you are a Hispanic immigrant who has given birth in Utah County within the past 5 years.

If you agree to participate in this research study, the following will occur:
- you will be interviewed for approximately ten (10) to twenty (20) minutes about your experience with prenatal care during your recent pregnancy
- the interview will be audio recorded and notes taken to ensure accuracy in reporting your statements
- the interview will take place at a time and location convenient for you
- total time commitment will be less than 60 minutes

Risks/Discomforts
With this research, there may be a possibility of some emotional discomfort or embarrassment. Feel free to answer questions to whatever extent you are comfortable with to minimize this discomfort. If you become uncomfortable we can stop the interview at any time.

Benefits
You will receive a $10 Amazon gift card to thank you for your participation.

Confidentiality
To protect your identity and maintain anonymity, you will be assigned a unique number ID. The research data will be kept on password protected computer and only the researcher will have access to the data. In presentations concerning research, you will be referred to only as “participant #” and age. At the end of the study, all identifying information will be removed and the data will be kept in the researcher’s locked office. By the end of the year, all recordings or transcripts will be destroyed.

Participation
Participation in this research study is voluntary. You may withdraw at any time or refuse to participate entirely without any negative consequences.

Questions about the Research
If you have questions regarding this study, you may contact Renata Forste, 801-422-3146 or email renata_forste@byu.edu .

Questions about Your Rights as Research Participants
If you have questions regarding your rights as a research participant contact IRB Administrator at (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu.

Statement of Consent
I have read, understood, and received a copy of the above consent and desire of my own free will to participate in this study.

Name (Printed): __________________________ Signature __________________________ Date: __________________________

Ver. 12/12
Consentimiento para ser sujeto de estudio

Introducción
Este estudio es realizado por Maren Monson y Renata Forste, de la Universidad de Brigham Young, con la finalidad de comprender las barreras del cuidado prenatal que enfrentan los inmigrantes hispanos del Condado de Utah. Usted ha sido invitada a participar porque usted es una inmigrante hispana que ha dado a luz en el Condado de Utah en los últimos 5 años.

Si usted accede a participar en este estudio sucederá lo siguiente:

- usted será entrevistada por aproximadamente diez (10) a veinte (20) minutos en cuanto a su experiencia con el cuidado prenatal durante su reciente embarazo.
- la entrevista será grabada en audio y se tomarán notas para asegurar la exactitud del reporte de sus comentarios.
- la entrevista se realizará en el lugar y a la hora más conveniente para usted.
- este compromiso no será por más de treinta minutos.

Riesgos/incomodidad
Con este estudio, existe la posibilidad de que usted sienta alguna incomodidad emocional o vergüenza. Por favor, siéntase con la libertad de contestar hasta donde usted se sienta cómoda para minimizar cualquier incomodidad. Si se siente incómoda podemos terminar la entrevista en cualquier momento.

Beneficios
Usted recibirá una tarjeta de regalo de Amazon de $10 como agradecimiento por su participación.

Confidencialidad
Para proteger su identidad y mantener anónimo, se le asignará un número único de identificación. La información del estudio se mantendrá en una computadora con una clave protegida y solo el investigador tendrá acceso a la información. En presentaciones concernientes a este estudio, se referirá a usted solo como “participante #” y su edad. Al final del estudio, todos sus datos de identificación serán eliminados y la información se mantendrá bajo llave en la oficina de investigación. Al final del año, todas las grabaciones y transcripciones de las mismas serán destruidas.

Participación
La participación en este estudio es voluntaria. Usted puede retirarse o negarse a participar en cualquier momento sin ninguna consecuencia negativa.

Preguntas respecto al estudio
Si tiene preguntas con respecto a este estudio, puede contactar a Renata Forste, 801-422-3146 o al correo electrónico renata_forste@byu.edu.

Preguntas respecto a sus derechos como participante de la investigación
Si tiene preguntas respecto a sus derechos como participante de la investigación contactar a la Administración IRB (801) 422-1461; A-285 ASB, Universidad de Brigham Young, Provo, UT 84602; irb@byu.edu.

Declaración de consentimiento
He leído, entendido y recibido una copia del consentimiento anterior, y deseo participar en este estudio por voluntad propia.

Nombre (escrito):_________________________ Firma __________________________ Fecha: ____________________________

Ver. 12/12