Latinx Oregonian Access to Oregon Reproductive Health Program:

A Needs Assessment

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Abstract

Recent data show a decrease in the number of participants in the state-funded Oregon Reproductive Health (RH) Program, including a decrease in participation among Latinx Oregonians. This has happened in spite of provisions made by the Oregon legislature to expand Oregon RH Program services at no additional cost to many Latinx Oregonians through the Reproductive Health Equity Act (RHEA). In partnership with Multnomah County Health Department (MCHD) and Oregon Health Authority (OHA) this needs assessment gathered qualitative data from community partners who work with Latinx Oregonian community members to explore reasons why Oregon RH Program is underutilized and what methods MCHD can do to expand usage. Results show that birth control options, STI care and cervical cytology testing are of most interest to the Latinx community and that outreach and bilingual/bicultural services were most important to improve access. Further qualitative research with Latinx community members who are eligible for RH services are suggested to validate these results and guide program planning.

Introduction

Established reproductive health (RH) for all individuals of a community benefits the entire community as a whole. Essential components of comprehensive RH and family planning include contraception, abortion care, maternal and newborn health, infertility, screening for reproductive cancers, screening for partner violence, and STI screening and treatment (Keller & Sonfield, 2019). Unrestricted access to RH care addresses disparities by allowing women to space out pregnancies and reduce the rate of infant mortality, reduce the rate of STIs and infertility, increase educational and career opportunities, and promote financial sustainability (Healthy People 2020, 2019; Hinchcliffe, 2017). Access to RH care and contraceptive counseling is key to attaining equity and fulfilling reproductive rights of the community.

Unfortunately, access to the essential components of RH in the United States is not equitable. Inadequate RH care results in greater infant and maternal mortality rates, poor fertility rates, low birthweights, and rising STI and HIV rates (WHO, 2016). Factors that affect access to RH care include racism, gender inequality, gender identity, immigration status, housing, food insecurity, income, health care access, insurance status, policy, provider bias, and health system resource distribution (Horwitz, Pace & Ross-Degnan, 2018). Membership to any racial or ethnic minority group is associated with lower use of effective contraceptive methods (Horwitz et al., 2018) that may be a result of poor access to quality, affordable and evidence-based RH care. The driving forces behind these disparities are multifaceted and worth further investigation, in particular how race defines access to RH care.

RH disparities among racial groups and STI rates in the greater Portland area are notable. In the greater Portland, OR area the rates of syphilis, gonorrhea, chlamydia, and HIV have increased over the last several years (OHA, 2015). In Oregon, the Latinx population comprises

12% of the state population, but the Latinx community has greater rates of HIV/AIDS, gonorrhea, chlamydia, and syphilis compared to White counterparts (CDC, 2018; OHA, 2019). Latinx Oregonian (Hispanic) women have higher rates of cervical cancer and are more likely to die from cervical cancer compared to their White counterparts (US Department of Health and Human Services [DHHS], 2018). The majority of Latinx Oregonians are of reproductive age and will require RH care during their lifetime. However, increasing access to RH care among the Latinx community proves challenging.

In spite of recent state-wide efforts to decrease barriers to RH care, the state-funded Oregon RH Program is underutilized. Data from 2017 to 2018 show a decrease in total enrollment in the Oregon RH Program in Multnomah County by 17%, where among the Latinx community the decrease is by 18% (OHA, 2019b). At the time of this research project, 2019 data for Oregon RH Program enrollment was not available. Although it is uncertain what is causing this decrease in enrollment, possible reasons include impacts on Latinx communities regarding recent federal policy, such as the national discussion of public-charge and immigration enforcement resulting in community-wide vigilance and need for privacy to protect the family. Language barriers and poor advertising of the RH program may also pose barriers to access. This needs assessment will explore access to RH services among the Latinx community of the greater Portland area as they are offered through the Oregon RH Program.

Literature review/Available knowledge

Search Strategy

A literature review was conducted using PubMed and CINHAL using “full text,” “English language,” “Academic Journals,” “best match.” Search terms included “reproductive health,” “sexual health,” “reproductive justice,” “health disparities,” “Latinos,” “Hispanic,”

"Latinx," "immigrant," "access to health care," "rates of STIs." The range of dates for the literature review was January 1, 2015 to December 31, 2019. Articles were excluded if they were in a language other than English and if "full text" was not available. This search found over 500 results on PubMed and 12 results on CINHAL. A total of 21 journal articles were reviewed for this paper. Barrier to care themes identified include access to health insurance, racism, immigration status, location and socioeconomic position, language and cultural barriers, and reproductive health status. Twelve references were obtained from the Centers for Disease Control and Prevention (CDC), Oregon Health Authority (OHA), World Health Organization (WHO) and US Census Bureau.

In this paper the term "Latinx" will be used in lieu of "Hispanic" in an effort to support a societal transition to using Latinx terminology in future scholarly works, data output, and publications. Occasionally "Hispanic" will be used when referencing statistics that refer to the "Hispanic" population.

Access to health insurance

Multiple articles show access to health insurance coverage as a critical barrier to RH care among women and families. Cost of health care and lack of health insurance are factors that decrease access to care for many families with another immigration status (AIS) (without legal documentation to live and work in the US) (Keller & Sonfield, 2019; Raymond-Flesch et al., 2014). People with AIS are not eligible for government benefits such as Medicaid, even though they pay more in taxes than they receive in government services (National Immigration Forum, 2018). Among the US population, 20% of the Latinx population under the age of 65 is uninsured, which is nearly three times the rate of uninsured compared to White non-Hispanic people under age 65 at 7.4% (Centers for Disease Control & Prevention [CDC], 2017; CDC, 2017a). Among

women, 32% of non-citizen women ages 15-44 were uninsured compared to 9% US born women of the same age (Keller & Sonfield, 2019). Latinx women delay RH services well past the recommended intervals for screening due to cost and not having health insurance (Sandstrom et al., 2019). For some people, even if they have insurance, the copay itself may pose an insurmountable barrier to RH care (Raymond-Flesch et al., 2014). Latinx women, especially those with AIS, who carry the responsibility of contraceptive care, face undue hardships to secure equitable access to RH care secondary to poor insurance access.

Racism

Gendered-racism, the ongoing discrimination and stereotype-threat rooted in historical stereotypes about sexuality and motherhood among women of color, exacerbates RH disparities among Latinx women. Latinx women experience greater infant mortality rates, greater HIV and STI rates, lower uptake of HPV vaccination, and resultant increased cervical cancer rates compared to their White counterparts (Rosenthal & Lobel, 2018; Sundstrom et al., 2019). Some Latinx people express concern that health care providers discriminate against them based on the color of their skin, perceived for actual low-income status and documentation status (Raymond-Flesch et al., 2014). The implications of racism on access to RH care are profound and call for continual determined efforts to break down these barriers.

Immigration Status

Research shows that state and federal legislation have a significant impact on immigration status resulting in discrimination of groups of people based on their country of origin. Policies that reinforce anti-immigrant sentiments maintain the status quo of marginalization by perpetuating poor access to educational opportunities, employment exploitation via low-wage jobs without options for employer-based insurance, and lack of

affordable housing, all of which affect access to RH care (Coleman-Minahan, 2017). Current immigration policy impacts Latinx communities given the persistent threat of immigration raids (North, 2019). Fears of arrest and deportation based on immigration status among members of the migrant community and established Latinx communities impacts access to reproductive health as many immigrant patients are unwilling to leave their homes to travel to a clinic (Downey & Gomez, 2018; Fleming et al., 2018). Immigration status is a unique barrier to care among Latinx communities that demands policy changes to ensure equitable access to RH care.

Location and Socioeconomic Position

For Latinx people of lower socioeconomic position, the barriers to care increase. Lower socioeconomic position (SEP) results in lower uptake of preventative care measures such as HPV vaccination and cervical cancer screening (Sundstrom et al., 2019). Fewer health care facilities and limited proximity to these facilities in rural areas automatically predisposes patients to poor access to care (Lammers et al., 2017). With limitations in transportation ,migrant Latinx women often must rely on male social networks for transportation and interpretive services, in which they cannot discuss contraceptive services due to need for privacy (White, Ocampo & Scarinci, 2016). Latinx women who live in rural areas will likely face greater disparities compared to their urban counterparts, given these differences in access.

Language and cultural barriers

Face to face communication in Spanish with patients is an important factor in satisfaction with health care services among the Latinx community. Sundstrom et al. (2019) note that lack of effective communication, which may be related to language barriers, results in poor initiation and completion of the HPV vaccine among Latinx patients. Another study shows that language barriers were less likely to impact access to reproductive health care since many clinics offer

interpretive services (White, Ocampo & Scarinci, 2016). Regardless of interpretive service, it is suggested that when health care providers speak Spanish it can increase trust and adherence to medical advice (Peterson-Burch et al., 2018). Usage of language interpreters and the impact of potential language barriers may depend on how large the local Latinx population is in the area and whether clinics have made accommodations to meet the unique needs of this group.

Cultural differences among the Latinx community affects access to RH care. Latinx Americans are culturally diverse on multiple levels from the country of origin to regional origin to education attainment to duration of time living in the United States (Hasstedt, Desia & Ansari-Thomas, 2018). Cultural differences related to gender inequality and sexual expectation are shown to impact the reproductive health of Mexican-origin young women (Coleman-Minahan, 2017). As a group, the Mexican born population in the US are more economically disadvantaged than other Latinx groups in the US and they bear the brunt of US anti-immigrant policies that restrict access to economic resources and result in employment exploitation (Coleman-Minahan, 2017). Recognition of these differences may help guide RH care and services.

Reproductive health status

Reproductive health status of a patient may either support or limit access to reproductive health services. Pregnancy status is a facilitator to access RH care that often ends postnatally (Sundstrom et al., 2019). Pregnancy status and subsequent prenatal care increases uptake of cervical cytology testing among migrant women possibly due in part to emergency/pregnancy insurance coverage (Guerrero et al., 2016). Although RHEA narrows the gap in reproductive health coverage for many Latinx Oregonians, it is limited by not offering RH services women who are not able to reproduce (OHA, 2018a). Theoretically, this means that a 35-year-old with a hysterectomy or a tubal ligation does not qualify for RHEA through Oregon's RH program and

will have to find a clinic that offers sliding fee services so she can pay out of pocket for RH care. This barrier to care is further impacted if she lives in a rural area, does not have transportation, does not speak English, fears for her safety due to immigration status, or must choose between RH services and paying bills to keep her family safe.

Policy Issues

New federal legislation will impact Latinx access to not only RH care, but all types of health care. Under the new public charge rule, immigrants who rely on public benefits, including those they qualify for, will be used as evidence to deny them visas or other legal permission to enter the country (Immigrant Legal Resource Center, 2019). This rule will affect approximately one million US citizens who will opt to become uninsured in fear of limiting immigration options for themselves and their family members (Perreira et al., 2018). RH care is further impacted by policy changes to the Federal Title X program. The current administration reinstated the Title X rule, also referred to as a "gag rule" that prevents health care providers from providing complete information to patients regarding health care options and giving appropriate referrals if they receive Title X funding dollars (American Medical Association, 2019). Instead of complying with the restrictive policies of the Title X rule, the state of Oregon stopped accepting Title X dollars and devised an alternative way to fund RH clinics across the state.

On August 15, 2017 Governor Kate Brown and the Oregon legislature set out to continue funding Oregon clinics and RH care providers, in spite of the gag rule reenacted by the current administration, by passing HB 3391: Reproductive Health Equity Act (RHEA). The passage of RHEA "ensures that Oregonians have access to comprehensive RH care regardless of their income, citizenship or immigration status, gender identity, or insurance coverage" by expanding RH coverage for some uninsured individuals, providing RH services with no cost sharing or

copays, keeping abortion legal, and banning discrimination while delivering RH services (Oregon Health Authority [OHA], 2018a). RHEA improves access to the Oregon RH Program for immigrants, approximately 75% of whom are at higher risk for unintended pregnancy, low income, and have inadequate or no health insurance (OHA, 2018). To comply with receiving RHEA funding, each county must demonstrate how they ensure access to RH services to community members by submitting their proposed strategies via the Program Elements (PE) 46 form. The objective is to increase access to the Oregon RH Program to reduce disparities such as rates of unintended pregnancy, poor maternal and birth outcomes, STI and cervical cancer rates.

Framework

Reproductive justice is a framework developed by SisterSong, a coalition of Black women, who define an alternative approach to the dominant discourse of previous feminist theories about reproductive rights. It is grounded in the recognition of the intersectionality of marginalized people living in a nation defined by a history of racialized slave economy, within a patriarchal structure, with a profound impact on a woman's reproductive rights (Ross, 2017). Although Latinx people do not share the history of a racialized slave economy with Black Americans, they do share minority status, targeted racism and marginalization as a population that is underrepresented and largely left out of dominant discourse on health and equity. Therefore, it is reasonable to apply the framework of reproductive justice to the needs assessment of the Latinx community in the greater Portland area to guide assumptions, support predictions and inform outcomes.

A reproductive justice approach grounds this study in implementation of culturally-appropriate inquiry that examines the intersectionality of Latinx Oregonians and whether/how they utilize RH services offered through the Oregon RH Program. Findings from this needs

assessment will shed light on potential solutions to barriers to RH care to ensure better access to care for communities traditionally underrepresented and underserved by federal and state policies. This needs assessment uses qualitative methods to gather data from Latinx community partners to determine barriers to care, gaps in care, and needs of the Latinx community to access RH services. It will provide possible explanations for the decline in the RH Program enrollment as well as provide documentation for the PE 46 evaluation as required by the OHA.

Method

COVID-19 Pandemic Implications

On March 23, 2020, approximately one week prior to the commencement of data collection for this project (via listening sessions), the spread of novel coronavirus, COVID-19, resulted in a pandemic leading to drastic measures carried out by Governor of Oregon, Kate Brown, who prohibited any social gathering. These orders prevented the original methodology of data collection for this project, given we could not meet face to face with members of the Latinx community. However, the process of locating an established group of Latinx women for the initial listening session led to an organic network of community partners and their contact information. Therefore, in lieu of collecting data directly from Latinx women, a new pivot project was quickly refocused to collect data from local community partners via an online survey.

Setting

This needs assessment was a collaboration with Multnomah County Health Department (MCHD) to gain a better understanding of the barriers to access the Oregon RH Program among Latinx Oregonians in Multnomah County. This needs assessment completed the intervention among the Latinx community who live in the Portland area and who qualify for RH services.

Portland is largely within Multnomah County; however, portions of the city are also located in Washington and Clackamas Counties. Clackamas County borders Multnomah County to the south and Washington County borders Multnomah County to the southwest. Multnomah County is Oregon's most populous county with over 800,000 residents. According to the US Census Bureau (2019) the percent of persons who identify as Latinx in 2019 for Multnomah County is 11.7%, Clackamas County is 8.9% and Washington County is 17.0%. This area was chosen as the focus for this project given the sizable community of Latinx patients and the network of community partners who organize events in this area.

This investigator acknowledges that her status as a person who is not a member of the Latinx community has the potential to be a barrier to data collection by affecting the outcomes of this study. Although efforts were made to limit this impact, results may reflect the unequal relationship of researcher versus participant. Advice and input were collected regarding drafts of the survey as a pretest of the survey. This project was supported by community partners, Multnomah County Health Department, and OHA, whose purpose is to improve community awareness and health while protecting equality and human rights.

Participants

A list of community partner names and emails from Multnomah, Clackamas and Washington County networks was collected from October 19, 2019 to March 1, 2020 while establishing a group for the originally planned listening session. This list of contacts comprises the convenience sample and includes community partners associated with the Sexual Reproductive Health (SRH) Coalition in Clackamas County as well as several community partners in Multnomah County including: MCHD Community Health Workers (CHW), Rosewood Initiative, El Programa, Familias en Accion, Oregon Latino Health Coalition,

Bienestar de la Familia, Project Access, Northwest Family Services, Portland State University, Mexican Consulate, Women Infants and Children (WIC) for MCHD, and Wallace Medical Concern. It is possible that some snowball sampling occurred as the link was sharable and at least two community partners reported sharing the link. OHSU Institutional Review Board (IRB) was consulted and determined the original project was not human research and therefore exempt from IRB oversight. Modifications due to COVID-19 were not significant and did not require IRB resubmission. MCHD Project Review Team was consulted and approved original project. Project modifications due to COVID-19 precluded patient contact, therefore voiding the need for resubmission to MCHD Project Review Team.

Intervention

This study gathered data via a Google Forms survey that was emailed to community partners. The survey was based on outcomes from similar previous research regarding Latinx Oregonian access to RH care conducted by Western States Center (2018). The survey comprised of 19 questions. Questions included five multiple choice, five select all that apply, eight free text, and one Likert scale question. In addition to questions that gathered demographic data about respondents and their clients, the survey primarily focused on gleaning information regarding challenges or barriers to care among women who do, and women who do not access RH care. The survey also inquired on needed RH services and how reproductive status may impact access to RH care. See Appendix A. Answers to the survey were not linked with emails or names of participants to allow for greater freedom in responses. The survey was available to respondents for eleven days. An email with the link was sent on day one and again on day seven as a reminder.

Data analysis

Free text responses were coded using an open source qualitative coding software, called Taguette. Demographic data collected via the survey was populated into bar charts and pie charts using Google Forms and Excel Spreadsheets. See Figure 1. A detailed approach analyzed each response to identify themes that may explain decreased enrollment in Oregon's RH Program. Every effort was made to be neutral in the collection of data to maintain confirmability of results through guidance by the reproductive justice framework and awareness of potential bias and expectations that may interfere with the project. However, the survey lacks the richness of a traditional listening session and therefore impairs the dependability, transferability and verification of data that underpins a qualitative study. Namely, this is due to typed responses lacking in generous descriptions, inability for the researcher to clarify answers, not having had prolonged time in the field to develop rapport, limitations in triangulating the data, and inadequate collaboration with peers to debrief the data.

The scope of this project was confined to the Portland area previously discussed and pivoted to the survey format to allow for as thorough an investigation as possible given the minimal time frame and that one researcher is conducting the project in its entirety. The cost of this project was minimal, given that Google Forms and Spreadsheets are free and no transportation, office products, or monetary incentives to participate were required.

Findings

Respondents

A total of 97 emails were collected. Five emails were invalid, resulting in 92 total valid email addresses for community partners. Out of the 92 community partners to whom the survey was sent, 18 responded for a 19.6% response rate. The majority of respondents work for Clackamas, Multnomah and Washington counties with minor representation from Marion

County and Clark County, Washington. The professional roles of respondents include community health workers, education outreach coordinators, WIC coordinators, social workers, school-based health center coordinators, and program managers of social services. Primary care providers (PCP) were not queried as the primary goal was to gain insight regarding access to RH care among Latinx participants who currently do not see a PCP. The majority of respondents work directly with Latinx women. One-third of respondents have greater than ten years of experience working directly with Latinx women, and approximately one-third of respondents do not work directly with Latinx women. Approximately two-thirds of Latinx female clients are reported to already access RH services, but the other third reported uncertainty whether Latinx clients access RH care.

Clients

As shown in Figure 1, approximately one third of respondents report that a majority of their clients have another immigration status. Most clients are reported to find out about RH services from the respondents themselves, the clinic where they receive care, friends, health fairs, and word of mouth or flyers posted at community centers. Respondents report the majority of clients who do access RH services are reported to receive these services from primarily county clinics, followed by mobile/free clinics, and private clinics.

Needed services

As shown in Figure 2, RH services that are deemed more helpful or important for this community by the respondents include the following from highest importance to lowest importance using a summated rating scale: access to birth control, access to cervical cytology testing, STD care, vasectomy services, abortion care, and transgender care. Additional services that are suggested as needed within the community include information about healthy

relationships and sexual coercion, healthy pregnancy and breast feeding, improved access to comprehensive and culturally appropriate care for positive results in cancer screening and STI results, and mammograms. Although the majority of respondents report they know that MCHD offers RH services free of charge to most women, they suggest improvements in outreach to encourage participation in programs such as Oregon RH Program.

Access and gestational status

Access to RH care after childbirth was uncertain, with mixed responses. Twenty-eight percent said care was reduced postnatally, 16.7% said care remained the same, 5.6% said care improved, and just over 60% of respondents were either not sure or declined to answer. These findings suggest further investigation is necessary to determine how gestational status affects access to RH care and what clinics currently to maintain patient access to RH care.

Barriers to RH care

Free text answers to three open-ended questions on the survey were instrumental in revealing potential barriers to RH care. Several barriers were identified that were similar among clients who do and do not access RH care. The more frequently mentioned barriers to accessing RH care were 1) knowledge about RH care offerings and inadequate health literacy, 2) lack of transportation to health care facilities that offer RH care, 3) lack of childcare, 4) concerns about implications of immigration status, 5) lack of culturally accessible care, 6) lack of finances and inadequate health insurance coverage, and 7) inconvenient clinic hours and lack of available appointments. Facilitators to RH care include reputable clinics that offer culturally responsive care and where patients feel heard and valued.

Discussion and recommendations

The findings from this survey identified a number of barriers to access RH care among Latinx women in the greater Portland area. These barriers may help explain the decrease in enrollment in the Oregon RH Program. Some of the findings align with what were found in the literature and include inadequate insurance coverage and concerns about cost of services, immigration status and the implications of being labeled a public charge under the current administration, inadequate transportation, and language/cultural barriers. Although racism was not called out in the survey explicitly, there is evidence that it may play a role in access to care as some respondents report that Latinx women will avoid clinics with a history of offering poor health care services to Latinx patients. In addition to the findings that are supported by the literature, additional barriers were uncovered that were not discussed in the literature. These include inadequate outreach, few bilingual/bicultural staff to support patient access to services, and structural changes such as more accessible appointment times and childcare.

Improving outreach

Inadequate knowledge about RH services was identified by many respondents as an important gap in achieving RH care where "most of the time they are not aware of the services available for them." Many respondents report that their clients who do not access RH care are unaware of the no-cost RH care program at MCHD. One respondent suggests this may be due to the marginalized status of Latinx clients that disconnects them from the community resulting in "lack of supports to learn about available RH services." Improvements in community outreach programs will increase knowledge about RH services and eligibility.

Respondents suggest using community partners such as WIC coordinators, CHWs, and perhaps a patient liaison to help educate patients and improve advertising within the clinic. Clinics can forge community alliances and bring RH services to CBOs that have already

developed a close relationship with the Latinx community: “bring your service to those places. Work on a cultural responsive campaign to inform the community and do not be afraid to go where the need is.” However, not all respondents agreed with referral to all CBOs because some do not offer abortion care. Access to abortion care is important for this community “even if the community says they do not feel the service important and that it should not be legal.” Additionally, suggestions for advertising RH care services in Spanish language on radio and TV stations, YouTube, and Facebook may reach a larger audience. Such advertising can address the more pressing needs of the community that include addressing birth control options, cervical cytology testing, and STI care according to community partners. Additional focus groups in the future will be necessary to compare evidence and determine how best to pass on information about Oregon RH Program.

Bilingual and bicultural services

Bilingual/bicultural services show respect for the patient and a desire of clinic staff to build a lasting relationship. One respondent writes, “it is very challenging to reach these women and build trust with them.” Services offered in not only the Spanish language but also that are culturally sensitive will improve access to RH care and fortify the relationship between clinic and patient. Some women may avoid clinic services for fear of cost. Respondents suggest hiring bilingual/bicultural employees to improve the experience of RH care by enhancing access to eligible services and explaining cost and the process of screening and testing in the native language of the patient.

Respondents report concern regarding inadequate health literacy, which may or may not be due to a language barrier. One respondent recommends teaching clients “that early detection reduces mortality” in order to dispel fear of possible positive test results and encourage

participation in recommended screening programs. Another respondents writes, “it may sound ? [sic] in 2020 but we are still far from seeing reproductive and sexual health as something normal to talk about, we need to put more effort in normalizing this starting at schools when kids are experiencing those first normal changes in their bodies.” The provider and staff should be aware of the level of health literacy among Latinx female patients to promote patient education that is culturally sensitive and empowers patients to make informed decisions.

Structural barriers

Within the free text responses, immigration concerns were frequently cited as barriers to care. Respondents cite, “fear due to [immigration] status,” “now the public charge” status, inability to access health insurance (due to immigration), being asked to disclose personal information such as social security numbers (which they may or may not have) and proof of income when they are often paid in cash. Further discussion with the Latinx community regarding what clinics can do to encourage safe and accessible access to RH care regardless of immigration status is suggested.

Clinic hours during working hours present a challenge for working families to schedule appointments. Evening appointments, walk- in access and same-day appointments are suggested to improve access. However, even with a diversity of appointment times, one respondent reports that “many of the times women seek outside services as health systems are overwhelmed and have limited time to see and listen to patients.” This suggests the need for large scale problem solving to improve access by adding more appointment slots to reduce long wait times.

Childcare and transportation are additional barriers to care cited within free text of the survey. One respondent writes, “mom does not want to take her kids to her doctor’s appointment but does not have anyone she can leave them with.” Creative childcare options at a clinic may

help ease this burden. As for transportation, a respondent states, "… a lot of times families have one car that they share, or depend on rides [from others]." Diverse clinic hours may help overcome some of the transportation barriers as clients may be able to schedule appointments when their partner and family vehicle are home. Clinics may consider conducting future listening sessions or focus groups to explore ways to ease these burdens and improve access to care.

Limitations

This survey was a response to a project change resulting from the COVID-19 pandemic and the following limitations are evident. Responses constitute second-hand information and are limited in the degree to which they represent the actual women of the Latinx community, not to mention that a convenience sample was used, which is an inadequate representation of the population of community partners as a whole. The majority of respondents worked in an outreach capacity, which may influence the degree to which poor outreach was cited as a barrier to RH care. Although the survey was tested prior to official submission to participants, the testers were NPs. Testing of the questions may have been better performed by testers who identify more with the cross-section of community partners.

The questions were specific about "Latinx women" to reflect wording in RHEA and Oregon RH Program, however this may have affected responses regarding transgender patients within the Latinx community. In future studies, questions regarding gender should include transgender instead of only male or female. Using terminology such as "Latinx patients with a uterus" would likely be more appropriate.

The survey was entirely in English, which may have been a barrier for some community partners for whom English is a second language. It is possible that results would have been richer if the survey were offered also in Spanish. The survey was limited in determining whether clients

lived in rural or urban areas. Results, therefore, cannot be generalized to exclusive rural or urban centers. Although we did ask what clinics could do in the future to facilitate access, it would have been helpful to ask what are the current facilitators to access RH care that are observed at various clinics now, including what MCHD should keep doing to encourage access.

Conclusion

This project collected data regarding barriers to access RH care among Latinx women in the greater Portland area via a survey submitted to community partners. Several findings were in alignment with the literature and include implications regarding immigration status (e.g., public charge rule and fear of deportation) and whether bilingual/bicultural care is offered. Additional findings highlight barriers that were not found in the literature, such as inadequate outreach, inadequate childcare/transportation options, and limited clinic hours. Future research that gathers data directly from Latinx women will fortify these results and ensure efforts are appropriately guided to increase access to the Oregon RH Program among the Latinx community in the greater Portland area.

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Figure 1.

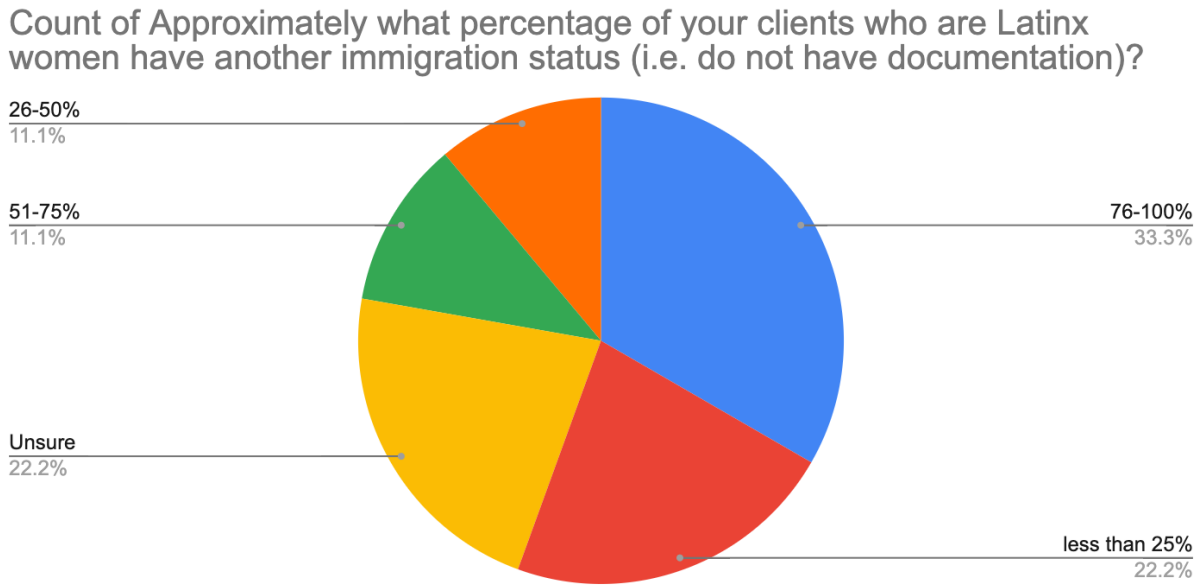
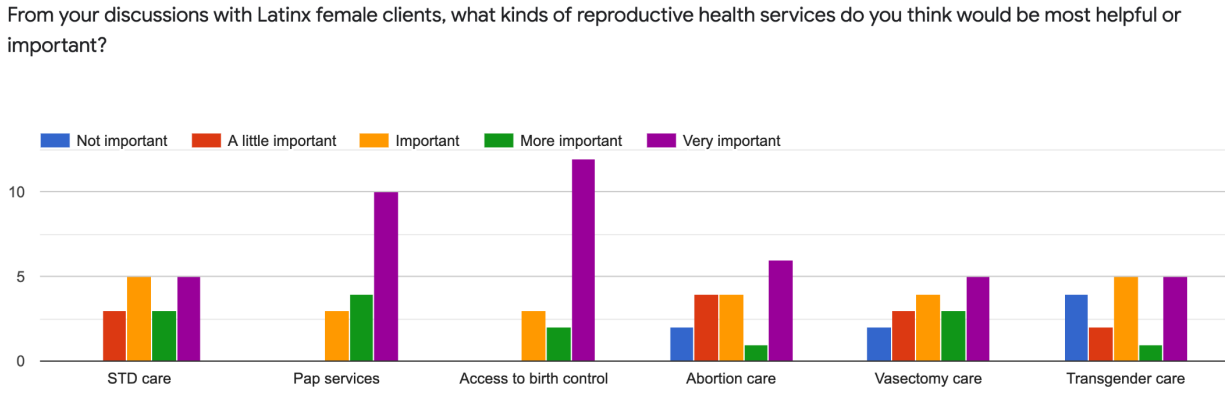


Figure 2.



Appendix A

Survey: Latinx Women and Reproductive Health Care

This is a survey to evaluate ways to improve access to reproductive health care for Latinx women with another documentation status (i.e. who are undocumented). Thank you for taking the time to fill this out.

1. What county do you work in? Select all that apply.
   Check all that apply.

   - Clackamas
   - Clark
   - Multnomah
   - Washington
   - Other

2. What is your professionalrole?

3. Do you work directly with Latinx women? Mark only one oval.

   - Yes
   - No

Latinx women

4. How long have you been working with Latinx women? Mark only one oval.

   - 0-1 years
   - 1-5 years
   - 5-10 years
   - 10+ years n/a
   - Other: _____

5. What kind of services do you provide to your Latinx female clients?

6. Approximately what percentage of your clients who are Latinx women have another immigration status (i.e. do not have documentation)?

   Mark only one oval.

   - less than 25%
   - 26-50%
   - 51-75%
   - 76-100%
   - 0%

- Unsure
- Other: _____

7. Do your Latinx female clients access reproductive health services? Mark only one oval.

- Yes
- No
- I am not sure
- Other: _____

Clients who DO access reproductive health services

8. How do your Latinx female clients find out about reproductive health services? Select all that apply.

Check all that apply.

- Me, I supply my clients with community resources, including health care resources Flyers or advertisements at church
- Flyers or advertisements at community center Friends
- Community health fair
- Clinic
- Other

9. For your Latinx female clients who have another immigration status and who DO access reproductive health services, what challenges or barriers to care do they face?

10. For your Latinx female clients who DO access reproductive health services, where do they go for reproductive health services? Select all that apply for the majority of your clients.

Check all that apply.

- Clackamas County Clinic
- Washington County Clinic
- Multnomah County Clinic
- Clark County Clinic
- Private Clinic
- Nurse Practitioner
- Medical Doctor P
- hysician Assistant
- Naturopathic Doctor
- Free Clinic

- Other:

Clients who DO NOT access reproductive health services

11. For your Latinx female clients who have another immigration status and DO NOT access reproductive health services, what challenges or barriers do they face?

Reproductive health information

12. From your discussions with Latinx female clients, what kinds of reproductive health services do you think would be most helpful or important? Mark only one oval per row.

	Not Important	A little important	Important	More important	Very important
STD Care					
Pap services					
Access to birth control					
Abortion care					
Vasectomy care					
Transgender care					

13. Please list any other reproductive health services that you feel are important that were not listed above.

Multnomah County Health Department (MCHD)

14. What can health centers do to improve access to reproductive health services?

15. Did you know that Multnomah County Health Department (MCHD) offers reproductive health services free of charge to most women, including those with another immigration status? Mark only one oval.

- Yes
- No

16. What can MCHD do to better inform or advertise about reproductive health services? Select all that apply. Check all that apply.

- During primary care appointments
- While scheduling appointments
- Through community partners

- Other:

Reproductive health care after childbirth

17. If your Latinx female clients accessed women's services during pregnancy, how did their access to services change after they delivered their baby? Check all that apply.

    - They continued to access care at the same level as before pregnancy
    - Their access to care was reduced after baby was born
    - Their access to care was improved after baby was born N/A
    - Other

18. Please discuss any additional information about reproductive services and pregnancy here.

Additional thoughts regarding access to reproductive health care

19. Please discuss any additional questions, comments or concerns regarding your Latinx female patients who access reproductive health services.