

Senior Honors Thesis

**Understanding Participation of Latino Immigrant
Women in a Cervical Cancer Prevention Program in
South Philadelphia: *Thinking Beyond Culture***

Paola Abril Campos Rivera

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Thesis Advisor: Professor Emilio Parrado

eparrado@sas.upenn.edu

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Introduction

Once a predominately male enterprise, today women from developing countries are almost as likely to migrate to developed countries as men. In fact, for several Asian countries such as the Philippines immigrant women in the US outnumber their male counterparts (Tyner 2003). Global economic restructuring; strong service economies in developed countries along with structural adjustments in developing countries, have created the supply of and demand for female workers resulting in the feminization of international migration.

Women started to migrate to the United States in greater numbers after the legislative changes in the second half of the century, such as the US Immigration and Nationality Act of 1965 (Mummert 1999). This wave of migration was further facilitated by the Amnesty “Ley Simpson-Rodino o IRCA” in 1986, allowing the head of the family to bring the other members of the family and acquire legal residency. Almost half of all immigrant workers in the US were women in 1990 (Schoeni 1998) and the number of working-age immigrant women more than doubled between 1970 and 1990 (from 2.7million to 6.4 million) (Schoeni 1998).

Latinos are the largest immigrant group in the US today, and by the year 2050, one in four women in the US will be Latina (Aguirre Molina 2003). Although research on Latina immigrant women has significantly increased in the past two decades, existing research studies about Latinas and their health have many limitations. Only few studies on health (Zambrana; Breen; Fox; Gutierrez-Mohammed 2001) disaggregate

data by Latino subgroups, which is increasingly important since Latinos are not only the fastest growing minority group but are also “becoming the most heterogeneous ethnic/racial group in the country” (Aguirre Molina 2003:3). Secondly, longitudinal studies about Latina health in the US are almost inexistent, obscuring the real generational differences and changes during the lifetime of a migrant woman. Lastly, many studies fail at capturing the variable of immigration status. There are challenges to include this variable in research studies such as its non-static nature; the immigration status of a person might change several times throughout his/her lifetime or the difficulty in asking research participants about their residency status.

This paper will explore women’s participation in a cervical cancer prevention program; a community health worker model intervention targeted at Latino women living in South Philadelphia. The dimensions of analysis in this study are the following: culture, gender and marginalization. Within this theoretical framework the study will compare the different assumptions about women’s participation (or lack of it) by health practitioners and community health workers to the self-reported reasons of the participants. The aim of this paper is to disentangle cultural, migration-related determinants and structural factors of women’s participation in this cervical-cancer prevention intervention¹.

Immigrants and Health Care

¹ “To disentangle cultural and migration-related determinants of gender inequality” (Parrado et al 2005:348)

Immigrants' access to health care has been shaped by changes in immigrant legislation and welfare reforms. Immigrant women entering the US prior to 1982 had access to amnesty and thus, were in a better position than women entering after 1986 who were restricted to any state provision by the Immigration Reform and Control Act. After the Illegal Immigrant Reform and Immigrant Responsibility Act of 1996 immigrant women were denied governmental support programs such as food stamps, and access to health care (Medicare) was restricted except for access to emergency rooms.

New and even old immigrant destinations in the US are not prepared to meet the health needs of a changing population. According to the US Census Bureau, in 2002, thirty two percent of Latinos compared to eleven percent of non-Hispanic whites did not have health insurance and the number is higher for Latino immigrants (DeNavas-Walt et al 2004). Hispanic women remain significantly behind other ethnic and racial groups in the use of cancer screening tests (Navarro et al 1998). The mortality rate of cervical cancer of Latinas is forty percent higher than among white women (National Cancer Institute: 2000).

Acculturation has proved to have a negative impact on the health of immigrants since “less acculturated Latinas experience fewer health problems and risk factors [but] are also less likely to have access to health care services when they need them” (Amaro & de la Torre 2001:26). The healthy migrant theory predicts that immigrants arrive to the US in good health; “studies had shown that Latinos are healthy (physically and mentally) when they arrive in the United States, but their health deteriorates over

time” (Scarinci 2003:119). Lack of health insurance coverage, among other factors, might explain this phenomenon.

To address the challenge of accommodating the needs of a growing immigrant population novel methods have been put into practice such as the Community Health Worker Model (CHWM). Although the model lacks standardization (in training and outcomes), studies have shown that community health workers “are the most effective liaison to preventive health services” (Wasserman et al., 2006:82) and have the potential to increase individual’s screening rates. The community health worker model aims at filling the void of at least preventive health for underserved populations and act as a liaison between immigrants and health services. The training of community members to deliver preventive health information to their community has resulted in an effective way to reach out to immigrant populations.

However, some of these health interventions are either guided by inaccurate cultural assumptions or fail to acknowledge the structural context adequate of particular subgroups. Undocumented immigrant women’s health in the US remains largely understudied which lends itself to misrepresentations. Due to the challenges for data collection, several studies fail to take into account immigration status as a structural constraint that a significant percentage of the Latino immigrant population faces. Structural limitations are reflected in health inequalities between migrants and non-migrant women such as discrepancies in cancer screening rates. Sharp health disparities among minority populations in the US have serious implications for public health, health care and health policy.

Latinos in Philadelphia

Since the mid 1990's Latino migration to Philadelphia has increased, reflecting larger national trends such as dispersal of immigrants away from traditional immigrant gateways (Singer et al 2008). In 2006, the city of "Philadelphia ranked sixteenth in the number of foreign-born residents among all metropolitan areas" (Singer et al 2008:5). Among the foreign-born population in Metropolitan Philadelphia in 2006, twenty eight percent were from Latin America, Mexico alone accounting for eight point four percent (Singer et al 2008:9).

South Philadelphia has been a quintessential international immigrant gateway for different waves of migration starting with the European migration at the beginning of the twentieth century. By mid-century the area became the portal neighborhood for Italian immigrants, and today, its immigrant population comprises South Asian, Chinese and a growing Latin American population (mainly Mexican) (Singer et al 2008).

The characteristics of particular immigrant groups further reveal specific challenges to ensure their access to health services and other social services. Nearly two thirds of Mexican immigrants in Metropolitan Philadelphia, both male and female, reported that they either did not speak English well or not at all. In the case of the Mexican population in South Philadelphia approximately eighty percent of them are undocumented. In 2006, Mexican immigrants in Metropolitan Philadelphia had the lowest naturalization rates among fourteen other origin migrant groups, only twenty

two of Mexicans have been naturalized (Singer et al 2008). Mexican women in the US are also the immigrant group with the least years of education (5 years less than U.S.-born women) and they are also the least likely to participate in the labor force among other Hispanic women (Schoeni 1998). There is a stark difference in levels of human capital between women from Asia, Europe and women from Mexico and Central America; Mexican and Central American women (except Cuba) having the poorest human capital endowments.

Community Health Worker Model (CHWM)

The model consists in training community members to be community health workers called *consejeras*, *promotoras* or *lay health advisors*. Selected community members receive training in health promotion and preventive health. Literature on this intervention has demonstrated that lay health advisors' effectiveness relies on their "intimate understanding of community social networks, strengths, and health needs" (Rhodes et al. 2007:418). They are part of the community in which they intervene and thus, can deliver appropriate messages to their community. In their study, Rhodes et al. found that "all studies (37) indicated that the LHAs [lay health advisors] matched the target population in their communities in terms of countries of origin and current geographic location" (Rhodes et al. 2007: 419). The increasing cost of health care and the changes in US demographic trends has made this model, which is labor intensive but relatively low cost, attractive to reach out to vulnerable communities such as those that face cultural and linguistic barriers (O'Brien et al.).

The community health worker model is based on the assumption that cultural differences among other factors prevent these minority groups from reaching out to social services and health care resources. *Promotoras* are used to meet these believed needs since they have the “ability to reach others with culturally sensitive approaches, tailoring their methods and messages to meet the special needs of their network of friends and neighbors” (Larkey 2008:49). Their function is to act as a point of contact to access social services by “brokering of interactions between immigrants and the culture and institutions of their host society” (Wasserman et al.2006:69).

The next part of this paper will look at the theoretical background of the study based on culture, marginalization and gender; the three dimensions of analysis. Then the background of the intervention will be provided followed by a section on methods and results. Then a discussion will follow which will include the study’s limitations.

Theoretical Background

Culture and Ethnic Identity

Race and ethnicity are socially constructed concepts as evidenced by the changes overtime of ethno-racial categories in the United States (Loue 2006). Categories are often arbitrarily imposed on specific groups and are based on reductionist ideas about the group’s culture and identity. To talk about a Latino culture in the US is to negate the dynamic nature of culture and the diversity of national-origin subgroups.

Hondagneu Sotelo (1994) argues that traditional social relations and cultural resources neither disintegrate nor continue intact, but are shaped through processes of migrations and settlement taking into consideration the new social context. Latino

immigrants in the US are a self-selected group that faces different structural constraints according to citizenship status and national-origin. Their interaction with the host society and their new status within it affects their behavior and practices; as Nagel states, “culture is constructed [...] by the actions of individuals and groups and their interactions with the larger society” (Nagel 1994:162). Therefore, the concept of a static Latino culture can only represent a broad generalization of the myriad of cultures of Spanish-speaking countries and their various experiences of migration.

The cultural competence² concept is based on this monolithic understanding of culture and it implies that institutions need to acquire the specific cultural knowledge about the target population in order to appropriately deliver social services. One example of applied cultural competence is the Community Health Worker Model (CHWM). The conceptualization of Latino culture in the CHWM is a very particular “conceptualization of culture within the socio-political context of program delivery” (McQuiston & Flaskerund 2003:93). Thus, a reductionist idea about Latino culture seems to be the rationale for this type of interventions obscuring other factors that might lie at the heart of health inequalities such as structural exclusion.

A widespread argument for the lack of participation and under screening is that particular Latino cultural attitudes towards prevention and disease in general result in under screening and underutilization of health services. These explanatory models oftentimes overestimate the relevance of culture and ethnicity in understanding

² Term coined by MacKenzie (1995) defined as “the demonstrated integration of population-specific related cultural values, disease incidence, prevalence, or mortality rates, and population-specific treatment outcomes”.

health-seeking behavior among ethnic groups. The result is an emphasis on the importance of delivering culturally sensitive messages and materials instead of contesting the larger structural context. These assumptions on the influence of cultural attitudes also guide research agendas. Some studies (Austin et al. 2002), for instance, use the theoretical framework of Health Belief Model to identify culturally specific factors influencing cancer screening practices among Hispanic women.

In several studies about CHWM with Latino populations, the following Latino cultural traits were recurrent: *machismo*, fatalism, family-oriented and traditional gender roles. In Puschel et al. (2001) study, “health care providers and representatives of community agencies[cited] cultural values of machismo and a passive attitude toward preventive care as barriers to screening” (2001: 585). Traditional gender roles based on patriarchal authority within the household are seen as cultural barriers to women’s screening practices by healthcare providers. Furthermore, the researchers also found that “the attitude called ‘fatalismo’ in the literature was mentioned in about half of the interviews conducted with health care providers and representatives of community organizations” (Puschel et al 2001: 585). However, the authors also mentioned that fear of deportation appeared as a perceived reason by health practitioners for cancer screening.

These assumptions on the cultural determinants of women’s participation are one of the subjects of inquiry in this study.

Marginalization

The experience of migration to the United States is one of marginalization. The borderless organization of labor and the expansion of low-wage jobs are a result of structural violence (Segura & Zavella 2007) which confines immigrants to the least protected and lowest paid jobs. Low income status, lack of access to health care and institutional barriers to integrate into mainstream society further marginalize immigrants who have come to the US in search for a better life.

Lack of social support is a factor that greatly shapes the migration experience; migration is a highly disruptive event that often weakens or strains social bonds” (Parrado et al 2005:351), especially for women. Disruption in social networks, in particular, separation of the family is probably the most evident factor of marginalization that permeates immigrants’ lives. Their social capital is significantly reduced after migrating and they face obstacles to reap the fruits of their human capital in the new society. The importance of social networks is widely acknowledged in international immigration scholarship (Pessar and Mahler 2001; Mackenzie and Rapoport 2006). Social networks not only are an enabling condition for migration but also represent one of the most valuable assets (as social capital) of immigrants once they settle in the US.

Furthermore, when settling in their new host societies, immigrants face “oppression that is based on racial/ethnic, class, gender, and legal status” (Hancock 2007:178). This oppression “blocks avenues to more gainful employment and opportunities for advancement, especially in the formal sector” (Hancock 2007:178). Changes in federal public charges for immigrants, especially during the 1990s anti-immigration movements, increased penalties to undocumented immigrants worsening their

marginalization. In their study on non-citizen immigrants, Carrasquillo et al. (2000) mentioned that, “because of their legal status, these immigrants are easily exploited and often work “off the books” in [...] low-paying jobs that do not provide benefits” (Carrasquillo 200:921). Lack of legal residency can therefore be a strong influence on the cultural formation of Latino immigrant identity in the US.

In the context of access to health services, residency status, income and time in the US seem to be the most important determinants of access to health care (Carrasquillo 2000). Immigrants face many structural limitations that prevent them from accessing health care. Some of these limitations were mentioned in a study on Latina Recruitment for Cancer Prevention Education by Larkey et al.; “lack of transportation, need for childcare, lack of sick leave from work, scarcity of evening health care services, and competing family responsibilities” (Larkey 2008:48). Furthermore, linguistic, geographical and political isolation (Malkin 2007:420) of immigrants also result in their underutilization of health services.

A widespread assumption among health practitioners and community leaders is that lack of women’s participation in both preventive practices and community health interventions is due to lack of knowledge and low levels of acculturation. In Austin et al. study, “low socioeconomic status, poverty, low levels of education, lack of knowledge, and acculturation have been established as reasons for the low screening rates in Hispanic women” (Austin et al. 2002:123).

Gender

Migration is an ongoing process not an event, and more specifically a “gendered process” (Pessar & Mahler 2001:3). The study of gender in migration literature has evolved from being one more variable to being viewed as “one of the fundamental social relations anchoring and shaping immigration patterns” (Hondagneu-Sotelo 2003:3). The “explanatory power of gender” (Mahler & Pessar 2006:16) is evident in the growing migration research which has used gender to understand the various stages in the transnational process of migration: from decisions about who migrates and who stays behind to patterns in political participation of immigrants to the US, both in American and in home-oriented organizations (Goldring 2001). Current research agendas are centered on determining those gendered domains in which the greatest and least gains for immigrant females have been made and how the women make sense of them (Pessar 2003).

Academic research on gender and migration has also focused on changes in gender relations due to migration and, in “how migration reconfigures new systems of gender inequality for men and women” (Hondagneu-Sotelo 2003:7). Extensive gender studies research has suggested that “differences in local contexts of employment and neighborhood are crucial to understanding the ways that gender identities; performances and relations are negotiated and reshaped in the domestic sphere” (Bondi & Rose 2003:232). Mahler and Pessar (2006) urge us to ask how “international migration and other cross-border activities that bring people into new gendered contexts change gender relations, and, if so, in what direction(s)? (Mahler & Pessar 2006:42).

Malkin (1999) emphasizes the importance of family networks for women to attain a broad spectrum of goals from challenging certain gender patterns to finding employment. For women it is almost impossible to find a job without social networks (Malkin 1999). Furthermore, immigrant women who live in complex households with greater access to social networks can more easily obtain information on how to navigate through a host of social institutions such as churches, clinics and schools (Jaqueline & Hagan 1997). Immigrant women struggle more to build a new social network from which they can learn how to navigate the new system than men. In a study, Parrado et al. (2005), found that “perceived lack of social support, constructed as the number of times that women report that they do not have anyone to listen to them, to make them feel secure, to inform them about the local environment, to turn to for help, or to give them a ride, if needed, is higher among migrant than nonimmigrant women” (Parrado et al. 2005:356). The isolation that migrant women experience due to lack of social interaction with their kinship and other women is a major obstacle for them to overcome challenges in adjusting to their new social reality and increasing their social capital. Furthermore, immigrant women experience the combined effect of different types of oppression based on legal status, gender, class and ethnicity that confine them to low-wage, low-skill jobs.

Program Background

In the summer of 2008, a research team led by Matthew O'Brien, MD Robert Wood Johnson Clinical Scholar from the University of Pennsylvania started the implementation and evaluation of a *promotora*-led cervical cancer prevention

program³ in the South Philadelphia Latino community. For this Community-based Participatory Research six *promotoras* were recruited from the Latino community in South Philadelphia. Advertisements were posted in the local Hispanic newspaper and other places. However, most of the *promotoras* were recruited through personal contacts of the program coordinators with a community-based organization that helps Latino immigrants. Two of the *promotoras* were already very involved with this local community organization called Casa de los Soles. Consistent with the literature review on community health workers the *promotoras* were women identified as “natural helpers”. They all underwent a simple recruitment process; they were interviewed and then invited to participate. A Nurse Coordinator, Rebecca Bixby, BA, BSN, trained the *promotoras* on delivering talks about cervical cancer prevention and women’s health.

The *promotoras* had to first recruit participants to fill out a survey to determine eligibility and then contact the eligible participants to attend two, three-hour workshops on cervical cancer prevention. Upon completion of the workshops they had a free Pap smear at a women’s clinic. The *promotoras* recruited 120 participants; since it was a randomized trial half of the women formed the intervention group and the other half a control group. From the intervention group (N=60) 46 women participated in the classes resulting in a participation rate of approximately 75%.

Methods

³ The American Cancer Society recommend for all women who have been sexually active or are eighteen years old or older, to have an annual Pap test and pelvic examination.

Since the aim of this study was to understand women's participation in this community health worker intervention, a qualitative study was conducted to preserve the diversity of participants' experiences and motives for participating. During the months of March and April 2008, 12 taped in-depth interviews were conducted in Spanish to participants and community health workers. The interviews were transcribed in Spanish and later translated into English.

Four women were recruited from the last group to participate in the program. All four participants in this last group declined the invitation to participate in the workshops several times before accepting; they received visits by the *promotoras* in their homes. This was the last strategy the *promotoras* used to increase participation as one of the *promotoras* mentioned in an interview "our last resource was to go look for them in their homes". This group of women was therefore the hardest to recruit, which became the extreme group sample. Two other participants were recruited from two different workshops given at the beginning of the study; the base comparison group. The other six interviews were conducted to the *promotoras*⁴. In addition, I performed participant observation at eight three-hour classes led by the *promotoras*, including the two classes taken by the last group of the intervention.

The participants were women between the ages of 24 and 30; all of them were born in Mexico and they preferred to give the interview in Spanish. They had migrated relatively recent (between 5 and 10 years ago) and are currently living in South

⁴ For these six interviews to the *promotoras* data was collected by Allison Squires PhD, RNRResearch Fellow, Center for Health Outcomes & Policy Research, University of Pennsylvania School of Nursing

Philadelphia. Table 1 in the Appendix shows the responses of women to various standardized questions.

All of the women are likely to be undocumented residents, although, they were not asked directly due to the sensitivity of the topic, the majority of the Mexican immigrant population in Philadelphia is undocumented. Furthermore, none of them except one had gone back to Mexico after their first arrival to the US.

Results

Recruitment Challenge

One of the main challenges of the intervention, as mentioned before, was women's participation. The *promotoras* struggled to recruit women especially towards the end of the intervention. One *promotora* expressed her experience:

At the beginning we thought that we were going to have all of them in the classes, but not, only few of them came, so we realized that was a problem, so we had to call them again. Some of them were working, some of them did not pick up the phone, and some said no, that they were not there.

The first group of women to participate in the workshops led by two *promotoras* was comprised of women who were related to them; sisters, mothers or friends. As they started to call participants who were recruited by other *promotoras* participation in the workshops became a problem. None of the participants of the last group who were interviewed were related to the *promotoras*, they were all recruited in public events

(i.e. Mexican Independence Day), by other *promotoras* or through a door-to-door strategy. One participant comments,

I got to hear about the program because of Rosa⁵, she sells pans, those Royal Prestige pans, and she offered them to me. I told her I already had them and then she invited me to the program. She was the one who gave us the papers, and we filled the survey.

The recruitment strategies for the base group and the extreme group were different. The two women of the base group were recruited by a *promotora* whom they reported to know very well and for a long time. Only one of the participants of the extreme group mentioned that she was recruited by “a friend who is a *promotora*”. The other women were recruited when the *promotoras* started to go look for them in their homes. One *promotora* said, “Right there we convinced them, we told them, what it was for, why it was so necessary for them to go to the classes”. The role of the *promotora* as a community member who knows how to reach out to their peer immigrant women became more evident. A *promotora* reflected, “When they saw how much we insisted, I think they said, yes it is important, and we’ll go”.

The participants also noticed the effectiveness of this last strategy as one participant said, “It was not until they decided to come to our house to ask us that we decided to go there”. Another participant mentioned, “She (*promotora*) told me that is was very important that I participated”. One participant of the last group even said, “What I

⁵ The names of all the informants were changed to maintain their privacy and confidentiality

liked very much was that they insisted us a lot to participate”. She also mentioned, “They motivate you when they insist you so much”.

The *promotoras* took the time to explain them what the program was for,

 Maria and Luisa came and they told me look do you know that this is something good for you, you will learn and they started telling me exactly what I was going to do.

Assumptions on women’s participation

One of the *promotoras* mentioned that lack of knowledge prevented women from participating,

 People do not know, they do not know what they do not want. Many [women] do not want to accept, and this frustrates me, they do not know what they are rejecting, they are rejecting prevention mechanisms for their health, their quality of life

She then went on to say,

 we called them, we speak the same language, we try to reach them at their homes, but people do not know, do not know and this frustrates me, because we are not telling them lies, we are telling them we want to protect their health

This assumption is common among health care providers and community leaders as well. They believe that women who do not participate are women who are less knowledgeable about cervical cancer or women’s health issues. Another participant

said, “there is a lot of people who do not know, who dedicate themselves to their work, to their homes”.

The belief that women who are less knowledgeable about health also come from the rural parts of Mexico was also mentioned. One of the *promotoras*, when asked what a major obstacle was, replied, “it is the culture because many of us we come from villages, and when we arrive here it is a whole different world”. This assumption about cultural barriers to regular screening is also widespread in the Community Health Worker literature. The same *promotora* also mentioned, “We have the culture that only when we feel strong pain, or we feel something really weird is when we go to the doctor”.

However, all the women from the extreme group sample reported to have a Pap smear every year. One participant said, “Because I do, every year, I get tested, every year, every year...” Two of them reported having a regular cervical cancer screening even before migrating; the other two after giving birth in the US. Only one out of the two women of the base group reported regular cervical cancer screening. In fact, one of the informants of the base group mentioned only having had a Pap smear once and that during pregnancy here in the US. She said in the interview, “I did not know anything” and when asked about whether she had had a cervical cancer screening she responded, “Yes, but I did not know that with that (Pap test) they detect (cancer) and I had only done it once”. The other participant of the base group mentioned, “I learned a little bit more why it is necessary (Pap smear) I used to do it because the doctor used to tell me, but not because I really thought it was necessary”. In contrast, a woman from the extreme sample group mentioned that her mother had informed her

since she was young that she had to get screened for HPV, she said “well because of my mom, she does it every year and she had told me what it was for and what are the risks if one does not take care of oneself”. She also said, “I knew everything (laughs) I mean everything about cancer, why it happens, and that we should take care of ourselves every year”. Three participants had their first Pap smear during their first pregnancy, one participant mentioned, “During pregnancy you learn a lot”.

Revising the Machismo argument

Regarding *macho* cultural attitudes, the most common example being their male partners preventing women from participating, none of the women mentioned facing such an obstacle. Although the stories of women who did not participate are missing, women who for various reasons were reluctant to participate did not mention any *macho* attitude from their husbands. When asked, what did your husband or other family members tell you about you participating? One participant said,

My husband tells me, yes you should go ‘mija’ because that is good for you, it is good if you are getting checkups every year, he tells me it is fine and he lets me go.

Another woman from the extreme sample group mentioned, “He never opposed to it, he said, yes it is important, go”. In fact, two participants mentioned that it would be a good idea to have the same workshops but targeted to men. One participant said, “There are many men who are very careless, I can tell you, my husband has been here for ten or eleven years and since he arrived he hasn’t been to the doctor”. One of the informants mentioned that at least “the health problems of women can be revealed

because they get pregnant, and they have to go to a clinic” but men are never forced to attend a health clinic. One woman said,

Since that talk that I went to I told him, because you know how that lady (*promotora*) was telling us about how men can also get it (HPV), and he has some little bumps, and I asked to Dona Clara, and what she told me then I came and told him, ‘Where? And I told him where, he then told me ok, but will you come with me? I told him yes, I’ll go with you.

And then she said, “not only him but there must be many (men) that are the same, I do not get sick, nothing will happen to me or whatever”

Self-reported reasons

The self-reported reasons of the extreme group for declining to participate before attending the workshop ranged from having a cold to change of jobs and lack of time. One participant mentioned laziness as her reason, she said, “Laziness I think, and it happened to me, I am telling you, because I said to myself what am I going to do there, I have nothing to learn”. Another mentioned her constant changing of jobs as the reason why she could not attend the previous times. She also said that there is no time to participate, “one becomes slave to the home”. One participant mentioned that she was told that no one could take care of her children at the workshop and that is why she could not attend.

Why other women did not participate?

When asked to tell us their opinion on why other women did not participate, women mentioned that some women are close-minded, or might feel fear and embarrassment.

Both *promotoras* and participants mentioned that women in the US are centered only on their jobs and on their families. One participant said, “They lock themselves up in their houses with their children and there is nothing else beyond their husband, their children and nothing else”. Another participant commented on the same topic,

There are many women who close themselves up and they only dedicate themselves to their work or to their children and their husbands and they forget they have to take care of themselves.

One *promotora* mentioned, “We arrive with the idea that we came to work and nothing else, so we do not worry about other things”.

It is interesting to note that participants from the extreme sample group had similar assumptions about women who do not participate than the assumptions that health care practitioners and *promotoras* had of the participants themselves. The stereotype of the woman with little knowledge and subordinated to her male partner oftentimes appears in the narratives of the participants themselves. One participant mentioned the problem of high fertility among Latino women as the result of ignorance, she said,

One problem is ignorance, they do not take care of themselves (practicing safe sex) and then the husbands are so *machos*, like “I command, I say and you do’ so women are like...I do not know if they come from places where there is no...where they do not teach them anything...so they have many children.

The same participant also mentioned the combination of religion and *machismo* as a barrier to participation, she said,

For a lot of them is ignorance, and for others the problem is their husband, it might be fear, because as I was telling you macho men are like, 'let's leave it to God', 'as many children as God wants to send us'

Another participant said regarding *macho* attitudes,

And as I was telling you, there are men who are so *machista*, and 'you do not go out because I say so' so there are women who would like to go out, they would like to do things but if their husband does not allow them, and they are slaves to their husbands, they cannot do it.

Most of them also agreed that those were only excuses, one participant said, "If it is for our health there is no obstacle that can prevent us from not participating". They mentioned that not having someone to look after their children or not having the permission of their husbands were only excuses. One woman said,

If we want we can make some free time and organize ourselves, with a friend, we can tell her look I can leave my kids with you today and I go and then tomorrow you go.

Most of them they expressed their belief that women were responsible for caring for themselves as one participant said, "Well, I understand them but at the same time they are women and they need to understand that it is our body". One *promotora* mentioned, "they unable themselves to go out and open their eyes".

The most common solution that they proposed to the problem of low participation was talking to friends. One participant proposed to advertise it in the radio and one *promotora* mentioned the lack of publicity in TV, on radio and newspapers of preventive medicine.

Interests in participating

Interests in participating of the extreme group and of the base group showed no stark differences. Most of them mentioned their interest in learning more about cancer and about their health, “one has to look after oneself”, one participant said. They also mentioned personal reasons such as their mother having cancer or because they wanted to have a free Pap smear. One participant said, “Yes I pay for the Pap smear and the mammogram and it is expensive”. However, most of them emphasized their desired to learn more and to know more about how to take care of themselves, for instance, one participant said,

Because I am a woman and we have to take care of ourselves because if we do not look after ourselves who will look after us, that is why it interested me

Two participants also mentioned their interest in prevention, “in case we have something to know how to treat it or control it”, and another woman said, “it is surprising, prevention is very important for health”.

Perceived gains/Outcomes

Increase information was a common perceived gain, “There were many things that I learnt that I did not know” or “I did not know that men were the carriers or HPV”.

Another participant said,

I learnt a lot more, because I knew some things and about the Pap test I knew, what causes cancer I also knew, but for instance what they say that having sexual relations causes cancer because they are with other partners I knew it caused HIV , I knew that but I did not know it caused cancer.

All of the women have had a Pap test before and had some idea about Cervical Cancer however the workshops seemed to have improved their knowledge about the purpose of a Pap smear and the mechanisms of HPV transmission. One participant told her experience about her first Pap test,

I did not know, I went to the doctor to make an appointment because I was not feeling well, I have gastritis so they gave me an appointment and they also gave me another appointment but I did not know what was it for, I arrived, they told me to lie down, open my legs, undress this and that and I said what are they doing to me.

One participant did not perceive any gains in terms of personal knowledge, she said,

No, no changes because I knew everything (laughs) I mean everything about cancer, why it happens, and that we should take care of ourselves every year

All of the participants from the extreme sample mentioned the company of other women as a perceived gain. When asked one participant what she liked the most about the workshop, she replied, “Socializing with each other is what I liked the most”. Another participant mentioned, “I liked everything, the conversation with the other women; they were all very nice, very friendly”. One participant mentioned how being in a group helps to be less embarrassed,

I say yes because how they do it in groups one gets motivated, it is not only one person so there is more conversation so one gets ride of embarrassment and we ask questions.

These feelings of enhanced trust among the participants were mirrored by the *promotoras*' responses. One of them said, “I tell them to have trust, that if they have any problem they can call me [...] we become friends”. Another *promotora* mentioned the socializing extra element of the workshops,

All of a sudden we take a short break from the HPV, we leave it on the side and we start to talk about other things, to talk about everything else, like how do you get along with your daughter, and like that. We start to get more involved with them

One informant mentioned the ability of this kind of programs to “open up” people, since she said, “It is hard to talk about these issues, about personal issues with people in the community”.

Some participants expressed perceived changes in themselves due to the interaction with other women, one participant said,

Yes, I think it did change us because well all of a sudden you are locked in your own world, only dedicating yourself to your home, and I think that when you listen to conversations like those well you say it is good that there are people who get concerned about us

Another participant also mentioned,

You become more self-aware, I smoke for instance, I know that smoking has many consequences, cancer and other diseases so one becomes more conscious about it

One participant mentioned the value of the diploma that every participant obtained after attending the two workshops, she said “that can motivate more women since I understand that any paper we take from here to Mexico is useful in Mexico to find employment”.

Women’s Social Support and Spatial Mobility

A recurrent theme that appeared in the interviews was women’s lack of social support here in the US. Many women referred to their lack of knowledge in regard to navigating US society. One participant from the extreme group said, “I do not go out, I do not talk, I do not know very well”, and another say, “I only stay at home, take care of my children only that, I do not know about other things”. When putting these thoughts into context, we can see that they reflect an adaptive strategy to a new social context, another woman said, “yes, in Mexico, there is more freedom, you can let the kids go out without any problem, and then us with the family we go here and there, here is very different”. In the context of their lives in the US, their lack of spatial

mobility was also expressed. One participant mentioned, “Here, we are only locked in, or we go from our homes to our jobs and with the kids, it is very different from Mexico”.

Another participant compared her life in the US, to her life back in Mexico and she said,

In Mexico you have your family; you go out to the street, and wow!
And you go here and there, it is another kind of life and here no, to
begin with the weather, the people...

Lack of spatial mobility and loneliness came up in various interviews, one participant mentioned, “most of us we are alone here, we are alone, family is over there”.

Some pointed out to language barriers as a further restriction to freedom as one woman said, “Well, everyone here speaks English and if we do not know how to speak English we cannot communicate with anyone, even less in a hospital if there is no one who can translate for us”.

However, they all mentioned that they have gotten used to it, “Even though is hard, I have gotten used to it”.

One woman expressed her feeling of lack of social support, she said,

We are many mothers here who are alone and we do not have where to
go and sometimes our family is far away and sometimes we tell
ourselves ‘I do not know what to do.

Discussion

Some of the results of this study challenge the assumptions by some of the *promotoras* about the profile of women who did not show interest in participating in this intervention or who showed apathy towards it. The women who were the hardest to recruit reported regular cancer screening tests and reported to know a fair amount about cervical cancer instead contrary to what was expected of them. Furthermore, the diversity of experience among the four informants of the extreme group sample debunks the monolithic picture of Latino immigrant women “who do not know” and therefore, do not participate. One participant is a volunteer at an organization called WAR, Women against Rape, and had previously received training in sexual health. Another one is the daughter of a doctor (mother) and reported knowing everything about cancer.

However, the stereotype of Latino women is so widespread that even the participants evoked the same stereotypical women’s profile when asked about their opinion about other women’s lack of participation. Participants’ answers were similar to the assumptions that the *promotoras* had of them. Furthermore, references to *macho* male partners were also common when imagining other women’s situations. This leaves us thinking about whether the intervention is not reaching to the most underserved and subjugated women or Latino women have in some way internalized the dominant discourse on Latino culture in order to explain Latino immigrants’ behavior.

Women’s reasons for not previously participating had more to do with pragmatic barriers such as changing jobs or lack of daycare than particular attitudes towards prevention. Some women mentioned that at first they did not see what they would gain from participating thus; giving more detailed information about the program at

the time of recruiting might increase participation. Furthermore, none of the studies in the literature review hinted at the fact that lack of participation might also reflect knowledge possession instead of lack of it as some of the results in this study showed.

In terms of the outcomes of the program, all the women as mentioned before have had a Pap smear before participating; participants of the extreme group sample in fact have a Pap smear every year. Thus, increasing rates of screening was not a significant outcome. Nevertheless, women did mention learning more about the specific purpose of the screening and about how HPV is transmitted. Some participants mentioned increased awareness about sexual health.

Another recurrent outcome that participants reported was gained social support and the opportunity to meet and talk with other women. Almost all the participants mentioned this as their perceived gain from the workshop. Enhancing women's social support system is a successful outcome of this intervention. This is an important result given that migration is an experience of marginalization due in part to the disruption of social networks as expressed by the narratives of the women. Feeling lonely and lacking social support were recurrent themes in their stories. Their experiences of marginalization come to light in their responses to how they have adjusted to a new life in the US. Their lives away from their families are defined by a lack of social support and lack of spatial mobility. References to being "locked in" and not free were quite common. Although not directly, the constraint of lack of legal residency appear to be a determining factor of women's access to public resources. This factor was only mentioned by the *promotoras*.

Lastly, participants mentioned their interest in expanding these workshops to target men as well. They agreed that women have greater access to health care services than men which might be an important finding for health care practitioners who tend to focus more on women and their reproductive health.

Limitations of the study

The major limitation of this study is that only women, who did participate, even after many phone calls and visits, were interviewed. The stories of the women who did not participate are missing. Another limitation might be the fact that women in the extreme sample group were interviewed after they had attended the workshop and that might have had an influence on their answers when interviewed, they might have appeared more aware of health concerns and the importance of prevention. However; women in the base group were also interviewed after their participation.

Conclusion

The community health worker model emerged as an intervention to reach out to underserved populations and thus, eradicate health disparities. However, this model is often based on misconceptions about certain populations such as immigrant women's beliefs and practices. Two widespread assumptions about women's under screening and lack of participation are lack of information and cultural barriers. The study found evidence that challenged stereotypical characterizations of Mexican immigrant women who are not readily willing to participate in a cervical cancer prevention workshop.

The discourse on cultural specificity has allowed these programs to emerge, which has both positive and negative aspects. The positive aspect is that at least thanks to this discourse on Latino culture, measures have been taken to help this immigrant population and deliver health services. However, the negative side is that because these interventions often overestimate the relevance of culture, they might fail to recognize a key element that might be at the heart of Latina immigrants' lack of access to health care services; their lack of legal residency and consequent lack of health care insurance.

Given that the community health worker model is a very labor-intensive intervention and that it has limited ability to reach out to a large population emphasis on the responsibility of health care providers to give complete information about the tests and screening the patients undergo or are referred to might in fact result in better outcomes. All of the women, except one had given birth in the US therefore better delivery of information during pregnancy could be a cost effective and more successful way to deliver information to women.

The aim of these community-based interventions could be shifted to increase women's social support and *promotoras* could take more active roles in advocating and effecting structural changes. The role of the *promotoras* in community-advocacy can have "the potential to address structural issues such as poverty, employment, housing, and discrimination" (Ingram et al 2008:422). The emphasis on addressing the socioeconomic determinants of health can have a larger impact on the target population.

Appendix 1 Table 1

	<i>Participant 1</i>	<i>Participant 2</i>	<i>Participant 3</i>	<i>Participant 4</i>	<i>Participant 5</i> <i>(base group)</i>	<i>Participant 6</i> <i>(base group)</i>
Recruitment by a person whom they knew	No, a <i>promotora</i>	Yes, a friend who is a <i>promotora</i>	No, a <i>promotora</i> who also sells pans door to door	Yes, through her sister in law who was recruited by a <i>promotora</i>	Yes, a friend who is a <i>promotora</i>	Yes, a friend who is a <i>promotora</i>
Screening pre-class	Yes, every year after pregnancy in the US	Yes, every year after coming to the US	Yes, before coming to the US	Yes, before coming to the US	Yes, after pregnancy	Yes, only once during pregnancy
Source of knowledge about Pap smears	First pregnancy in the US	Doctor referral	Mother who is also a doctor	Mother	_____	First pregnancy in the US
Speak Spanish at local clinic	Yes, nurses but not doctor (translator)	Yes, translator	Yes, but not in hospitals	Yes	Yes	Yes, translator
Reason for not participating previously	Feeling lazy: “What am I going to learn?”	Time conflict due to changing jobs	Sickness	Had to take care of her kids	Participated the first time	Participated the first time
Work	Yes, par time	Yes	Yes, par time	No, but before she did	No, but before she did	Yes, par time
Children	Yes, 1	No	Yes, 3	Yes,5	Yes, 1	Yes,1
Married or Living with a partner	Yes	Yes	Yes	Yes	Yes	Yes
Speak English	No	No, a little bit	No, she understands	No	Yes, a little bit	No
Years in U.S.	10 years	5 years	6 years	6 years	6 years	5 years

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