"I'm Scared to Come Out of My Shell": Contraceptive Care for Migrants in St. Louis

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Washington University in St. Louis

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“I’M SCARED TO COME OUT OF MY SHELL”: CONTRACEPTIVE CARE FOR MIGRANTS IN ST. LOUIS

By

Julie Deleger

A Thesis
Submitted in Partial Fulfillment
Of the Requirements for Honors in Anthropology
In the College of Arts and Sciences
Washington University in St. Louis

Advisor: Professor Rebecca Lester, LCSW, PhD

March 21, 2023
Abstract

This thesis established that migrants in St. Louis face a unique combination individual, interpersonal, and institutional barriers when accessing contraceptive care. These dynamics were examined using the social ecological model (SEM), which provided a valuable framework for understanding the multi-layer challenges at play. The research methodology involves a combination of ethnographic research, based on in-depth interviews and online surveys, as well as critical literature reviews. The data collected was then analyzed thematically to identify patterns and trends.

Chapter 1 offers insight into the factors influencing decision-making for the St. Louis migrant population. Chapter 2 of the thesis explores individual-level barriers to accessing contraceptive care, such as personal and cultural beliefs and limited knowledge about available resources. Chapter 3 delves into interpersonal-level barriers, highlighting the critical role of social support and examining the impact of the public charge clause and its associated rumors. Chapter 4 focuses on institutional-level barriers, including financial constraints and insurance complexities, language barriers, and medical misinformation. Chapter 5 outlines the expressed needs of migrants and potential measures that could be adopted to improve access to care, including enhanced resource access and information, reduced fear, and minimized financial strain.

The study’s findings contribute to a more comprehensive analysis of the challenges shaped by multiple overlapping factors, as analyzed through the lens of the social ecological model. This insight can work to better inform interventions, such as the potential development of a mentorship program, geared towards improved contraceptive care access for the migrant population of St. Louis.
Acknowledgements

Firstly, I would like to thank Professor Rebecca Lester, my thesis and major advisor, and Professor Bret Gustafson, my thesis seminar coordinator, for their unwavering support and guidance throughout this project. Additionally, thank you to my readers, Professor Geoff Childs and Professor Eliza Williamson, for taking the time to review my thesis and provide me with invaluable advice.

This thesis could not have been completely without the invaluable insights of my study participants. Thank you for trusting me with your stories and letting me share your narratives. I would like to extend gratitude to the passionate workers and volunteers at the International Institute of St. Louis, Casa de Salud, and the Missouri State U.S. Committee for Refugees and Immigrants for their tireless work in supporting migrants in the St. Louis region.

I would also like to thank my family, Papa, Maman, Elliot, and Maddie, for being my constant cheerleaders, inspiring me to put my best foot forward, and keeping the family groupchat alive with dog pictures. Special thanks to my dog Maddie for being the hardest-working, power nap companion I could ask for. Lastly, thank you to my beloved 37 roommates—Caro, Amee, and Bianca—for knowing when to make me UP dumplings with peanut sauce during my writing grinds.

This thesis could not have been completed without all your help, so thank you!
Appendix

Long-Action Reversible Contraception (LARC): refers to a type of birth control that provides long-term protection against pregnancy, typically for 3 to 10 years, depending on the specific method. LARC methods include IUDs, implantable contraceptives, and injectable contraceptives. LARC methods are highly effective at preventing pregnancy and do not require daily, weekly, or monthly attention.¹

Oral Contraceptive Pill: known as “birth control pill” or “the pill”, a type of medication, also that is taken orally to prevent pregnancy. It works by releasing hormones (either estrogen and progestin, or just progestin) that prevent ovulation (the release of an egg from the ovary) and thicken the cervical mucus, making it difficult for sperm to reach the egg. The pill is taken daily, typically at the same time each day. It is a very effective method of birth control when taken correctly, but it is not foolproof and can be less effective if the pill is missed or taken at the wrong time. Some common side effects of the pill may include nausea, breast tenderness, irregular bleeding, and mood changes, but these side effects often go away after a few months of use. The pill is available by prescription from a healthcare provider.²

Intrauterine Device (IUD): a small, T-shaped device that is inserted into the uterus to prevent pregnancy. There are two types of IUDs: hormonal IUDs, which release small amounts of the hormone progestin, and copper IUDs, which do not contain hormones. Hormonal IUDs work by thickening the cervical mucus and thinning the lining of the uterus, which makes it difficult for sperm to reach the egg and for a fertilized egg to implant in the uterus. Copper IUDs work by releasing copper ions that are toxic to sperm, preventing them from reaching the egg. IUDs are a very effective form of birth control, with a failure rate of less than 1%. IUDs. Must be inserted by a trained healthcare provider and can last from 3-10 years.³

Arm Implant (i.e., Nexplanon): small rod or capsule that is inserted under the skin of the upper arm, by a trained healthcare provider, to release hormones (progestin) that prevent pregnancy by thickening the cervical mucus and preventing ovulation. It provides long-term protection against pregnancy (typically up to 5 years) and has been found to be 99% effective.⁴

Birth Control Patch: a type of hormonal contraceptive that is worn on the skin to prevent pregnancy. It works by releasing hormones (estrogen and progestin) into the bloodstream through the skin, which prevent ovulation (the release of an egg from the ovary) and make it

difficult for sperm to reach the egg. The patch is worn on the skin for a week at a time and is then replaced with a new patch. Although considered 93% effective, its success rate drops with improper use (not being changed in time or falling off). This form of contraception is only available by prescription from a healthcare provider, but can be switched out at-home.⁵

**Deferred Action for Childhood Arrivals (DACA):** a U.S. immigration policy that provides temporary protection from deportation and work authorization to certain individuals who were brought to the United States as children and do not have a legal immigration status. It was implemented in 2012 by the Obama Administration through an executive action. According to the U.S. Citizenship and Immigration Services, DACA recipients, also known as "Dreamers," must meet certain criteria to be eligible for the program, including being under the age of 31 as of June 15, 2012, having arrived in the United States before the age of 16, and having lived in the United States continuously since June 15, 2007. They must also have a clean criminal record and be currently in school, have graduated from high school, or have been honorably discharged from the military.⁶

"**Undocumented**": refers to the immigration status of an individual who does not have a valid immigration visa or other legal documentation authorizing them to be in the United States. This can happen for a variety of reasons, such as overstaying a temporary visa, entering the country illegally, or losing or never having obtained proper documentation. The term "undocumented", rather than "illegal" or "unauthorized", is used because it acknowledges that these individuals may have a long history in the United States and may contribute to their communities in many ways, even if they do not have a US-government recognized legal status.⁷

**Legal Permanent Resident (LPR):** a foreign national who has been granted the right to live and work in the United States permanently. LPR status, also known as having a "green card," is granted by the U.S. government through a process called "adjustment of status." To be eligible for a green card, an individual must typically meet certain criteria, such as having a close family member who is a U.S. citizen or LPR, being sponsored by an employer, or being a refugee or asylum seeker. Once an individual has a green card, they can live and work in the United States indefinitely and are eligible to apply for U.S. citizenship after meeting certain requirements, such as living in the United States for at least 5 years as an LPR.⁸

**Student Visa:** A student visa is a type of visa that allows foreign nationals to study in the United States for a specific period of time. There are two main types of student visas: the F-1 visa, which is for academic students, and the M-1 visa, which is for vocational or nonacademic students. To be eligible for a student visa, an individual must be accepted into a school or

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program in the United States that is approved by the Student and Exchange Visitor Program (SEVP), a division of the U.S. Department of Homeland Security (DHS). They must also meet certain financial and academic requirements and be able to demonstrate that they have a residence outside the United States that they intend to return to after completing their studies.\textsuperscript{9}

**Refugee**: legal status granted to individuals who meet the definition of a refugee as defined in the 1951 Refugee Convention. This definition states that a refugee is an individual who has fled their country of origin due to a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group, and is unable to or unwilling to return to that country due to such fear. Refugee status is granted to individuals who are outside of their country of origin and unable to return due to the aforementioned fear of persecution. Refugee status is distinct from other forms of legal protection, such as asylum or humanitarian protection, and confers specific rights and protections to refugees under international law.\textsuperscript{10}

**Asylum-seeker**: An asylum seeker is an individual who has fled their country of origin and is seeking protection from persecution, violence, or other human rights violations in another country. Specifically, asylum-seekers are individuals who have applied for international protection, but whose claim for refugee status has not yet been determined. Asylum seekers are often in need of protection and may have experienced trauma or persecution in their country of origin. They may have fled their home country to escape violence, persecution, or other human rights abuses, and are seeking safety and security in another country. To be recognized as a refugee, an asylum seeker must demonstrate that they meet the definition of a refugee as outlined in the 1951 Refugee Convention and its 1967 Protocol.\textsuperscript{11}

**Public Charge Clause**: refers to a provision in U.S. immigration law that allows the government to deny admission or adjustment of status to individuals who are deemed likely to become a "public charge."\textsuperscript{12} In this context, the term "public charge" essentially refers to individuals who are unable to support themselves and their dependents without relying on government assistance. The clause has been part of the U.S. immigration law since the late 19th century and has undergone several changes, particularly over the past two decades. In August 2019, the Trump Administration expanded the definition of public charge to include a broader range of public benefits, making it more difficult for low-income immigrants to obtain permanent residency or visas. This change faced widespread criticism and legal challenges, with advocates arguing that it would disproportionately impact low-income and blue-collar immigrant

The Biden Administration has since announced plans to reverse the Trump-era rule and restore the previous definition of public charge. The impact of the Public Charge Clause on immigrants and their access to social services continues to be a nuanced and evolving issue in U.S. immigration policy.  

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**Introduction**

I sat on the Zoom call, camera off, apprehensive about my ability to connect with Fatima in this virtual setting. As we began our conversation, I quickly realized that the absence of a face-to-face interaction didn't mean the absence of emotion. She spoke with a voice that was both hesitant and raw, “I guess I’m so scared to come out of my shell to seek for help, so I just do most on my own.”

Her words echoed in the room. As she continued, it became clear this fear was rooted in something deeper than concern with access to birth control. Fatima worried about being unable to care for her daughter, about her own status as a non-citizen, and about the possibility of getting herself into even more trouble. This fear was rooted in survival, vulnerability, and a liminal state of being.

Despite the challenges she faced, her resilience and determination shone through. As we said our goodbyes and the screen went black, I couldn’t help but reflect on the profound impact of her story. Regardless of the research we read or the statistics we review, Fatima’s experience was a reminder that all this data we know to be true comes with a narrative that we have yet to uncover.

**BACKGROUND TO MIGRATION IN ST. LOUIS**

St. Louis is no stranger to international migration. In the early 20th century, St. Louis was a destination for European immigrants, particularly those from Germany and Ireland, who came to the city to work in its growing industrial sector, and the St. Louis immigrant population has continued to increase in recent years.\(^\text{15}\) According to the American Community Survey, St. Louis had a foreign-born population of approximately 5.5% in 2019, which has been steadily grown since 2007, and is primarily home to immigrants from China, India, Mexico, Germany, and Bosnia.\(^\text{16}\)\(^\text{17}\) Per Pew Research Center’s most recent survey, Missouri is also home to approximately 60,000 undocumented migrants. In more recent years, St. Louis has become a

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destination for refugees and immigrants from around the world, welcoming refugees fleeing violence and persecution from their home countries from more than 40 different countries since the 1980s.\textsuperscript{18} \textsuperscript{19} Although St. Louis’s foreign-born population is lower than national trends, the city continues to be home to a diverse and consistently increasing international community.

**BACKGROUND TO CONTRACEPTIVES IN ST. LOUIS**

As reproductive health becomes increasingly politicized, the state of Missouri maintains some of the most restrictive policies on contraceptive care in the United States. As of 2021, Missouri requires parental consent for minors seeking contraceptive care and is one of only two states in the country that prohibits any publicly funded family planning program.\textsuperscript{20} \textsuperscript{21} Insurance coverage for contraceptive care also became increasingly limited during the Trump presidency in 2017, which saw that Missouri health insurances need not require insurance coverage for over-the-counter methods, vasectomies, and tubal ligation, as well as providing with an essentially unlimited scope for refusal provisions.\textsuperscript{22} Furthermore, Missouri is one of the few remaining states with no requirement for sex education in its curriculum, as well as no requirement that any sex education provided be unbiased, culturally appropriate, or promote

\textsuperscript{18} St. Louis Public Radio. (2018, June 20). St. Louis has been a home to refugees for more than a century. https://news.stlpublicradio.org/government-politics-issues/2018-06-20/st-louis-has-been-a-home-to-refugees-for-more-than-a-century
These laws and restricted information flows are particularly difficult for marginalized populations to navigate, a phenomenon in the data. St. Louis region has one of the highest rates of unintended pregnancy in the country, which disproportionately affect black and Hispanic women.

In the face of these challenges, various organizations exist to help mitigate the propagation of gaps in healthcare. The Contraceptive Choice Center, based at Washington University in St. Louis, offers free contraception to women who are at risk of unintended pregnancy, in addition to counseling, education, and follow-up care. However, unlike most metropolitan cities in the US, St. Louis is only home to two Planned Parenthood centers, clinics that provide various women’s health services to individuals with and without insurance, of which only one is located near a Metro stop. The Missouri Family Health Council (MFHC) also provides family planning services to low-income women in Missouri, in addition to operating two clinics in the St. Louis area with a range of services. The MFHC is currently piloting it’s The Right Time Initiative, which seeks to increase contraceptive access and reduced unintended pregnancy, particularly to individuals with no or limited health access, by partnering with local health departments and community organizations. Despite these efforts, the state's

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restrictive policies and lack of publicly funded family planning programs make it difficult for many women to obtain the contraceptive care they need.

The reproductive health climate has only worsened with the recent *Jackson v. Dobbs* decision in 2022, which overturned *Roe v. Wade*'s federal protection of abortion. The Supreme Court decision set forth a chain reaction of state trigger laws, including Missouri’s immediate and near-total ban of abortion. Although abortion is not considered a form of contraceptive care, the encroachment on any reproductive welfare comes with concerns of even more intrusive bans. Various news outlets expressed concerns over the potential criminalization of IUDs and emergency contraception in states with trigger laws, such as Missouri’s. For marginalized populations already living in fear of the law, this decision has drastic repercussions on perceived access to contraceptive care.

**REVIEW OF THE LITERATURE**

This thesis draws on the social ecological model (SEM) to examine the overlapping dynamics impacting the provision and access to contraceptive care for migrants in the St. Louis region. The SEM, which posits that individual health outcomes undergo multiple levels of influence, provides a framework for understanding the various factors that impact individuals' access to contraceptive care.

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29 Guttmacher Institute. (2023, January 20). Six months post-Roe, 24 U.S. states have banned abortion or are likely to do so: Roundup. https://www.guttmacher.org/2023/01/six-months-post-ro-24-us-states-have-banned-abortion-or-are-likely-to-do-so-roundup


health and well-being. This model proves particularly useful in comprehensively understanding the unique challenges faced by migrants in St. Louis as they access contraceptive services, as each of these components is riddled with political controversy, personal barriers, legal constrains and variations in societal perceptions.

At the individual level, migrants are known to face a range of challenges that impact their ability to access healthcare services. Research in Europe building off of these widely accepted barriers to care revealed that cultural beliefs and values may also impact an individual's willingness to use contraceptives. Taken together, current literature confirms the ubiquitous presence of these individual-level challenges to healthcare access, which can be applied to contraceptive care by extension.

Interpersonal factors, such as the existence—or lack thereof—social networks and family support, are key players in an individual's access to both healthcare and contraceptive care, specifically. The attitudes and beliefs of individuals toward contraceptive use are often shaped by the social networks and support systems of migrant communities. In some cases, these networks may stigmatize or discourage contraceptive use, contributing to low uptake among migrants, rather than providing much-needed guidance. Nevertheless, social support and community engagement can be a beacon of hope by providing reliable information

and advocacy for access to contraceptive care. Research shows that social factors at the interpersonal level can both hinder and facilitate migrant access to healthcare, especially when it comes to the more taboo subjects of contraceptive care.

At the institutional level, the availability and physical presence of healthcare services and resources is a crucial factor impacting access to contraceptive care. Numerous studies have all demonstrated the significant effects of language barriers, lack of health insurance, and limited financial on migrant access to healthcare. Language barriers can prevent migrants from effectively communicating their health concerns and understanding their medical treatments, and cause continued nuanced difficulty due to limited health literacy. In addition, many migrants lack health insurance or face financial constraints due to citizenship complications and/or socioeconomic status, making healthcare both unaffordable and inaccessible. Migrants may face significant challenges accessing healthcare services due to limited availability, geographic location, and long wait times. Furthermore, the cultural competency of healthcare providers, a skill taught throughout medical training, which refers their ability to communicate effectively and respect patients’ values and beliefs of different

backgrounds, deeply influences healthcare outcomes for migrants.\textsuperscript{44,45} More concrete societal factors, including policies and regulations, also impact the provision of contraceptive care to migrants in St. Louis.\textsuperscript{46,47,48} As previously noted, these societal disparities are felt more profoundly by predominantly low-income and legally vulnerable populations, such as the St. Louis migrant community.

In the city of St. Louis, the social ecological model provides valuable insights into the intricate web of factors that impact on the provision of and access to contraceptive care for migrants. From the personal to the societal, every level of influence shapes migrants’ ability to access necessary birth control services. This thesis contributes to the existing literature on contraceptive care for migrants in St. Louis by applying the SEM framework to examine the multiple factors that impact access to contraceptive care for this distinct population. This approach provides a comprehensive understanding of the various challenges that migrants face in accessing contraceptive care, including individual, interpersonal, community, and societal factors in the local area. Because of its focus on the St. Louis region, this thesis adds to the existing literature by providing a specific geography and context.

\textsuperscript{45} DeCamp, L. R., Kavalieratos, D., & Zickmund, S. L. (2014). Missed opportunities: limited English proficiency and timely access to interpreter services in the primary care setting. Journal of General Internal Medicine, 29(9), 1284-1289. doi: 10.1007/s11606-014-2895-6
The existing literature on contraceptive care for migrants is primarily focused on institutional-level factors, such as language barriers, financial constraints or the impact of federal policies on access to contraceptive care. This thesis builds on the aforementioned literature by taking a multi-level approach, examining the several layered dynamics at play with contraceptive care for migrants in the region. Furthermore, the focus on the experiences of migrants in St. Louis, specifically, supplements the limited literature on the experiences of migrants in Missouri and the greater Midwest region of the United States. Essentially, this thesis contributes to a more comprehensive understanding of the challenges faced by migrants in St. Louis as they access contraceptive care through various pathways and provides insights that can inform interventions to improve access to care for this population.

ARGUMENT

This thesis presents a multi-faceted, anthropological examination of the social ecological factors that shape migrant access to contraceptive in the St. Louis region. Drawing on ethnographic research and critical literature review, this thesis reveals the complex web of challenges present at the individual, interpersonal, and institutional level. Chapter 1 seeks to comprehend the diverse reasons for seeking contraception, the criteria for selection, and the pathways involved in the decision-making process. Chapter 2 explores individual-level barriers that impede access to contraceptive care such as personal and cultural effects and limited resource knowledge. Chapter 3 delves into interpersonal-level barriers and underlines the critical role of social support, as well as examining the impact of the public charge clause and its associated rumor mill. Chapter 4 focuses barriers present at the institutional level, such as
financial constraints and insurance complexities, language barriers, and medical misinformation. Finally, Chapter 5 outlines the needs expressed by the migrants and the potential measures that could be adopted to improve access to care, which includes enhanced resource access and information, reduced fear, minimized financial strain. This chapter also briefly analyzes how the arrival of Afghan refugees in St. Louis provides a stepping stone for potentially piloting a mentorship program to address gaps in contraceptive care. By investigating these multiple factors, this thesis aims to provide a comprehensive understanding of the challenges faces in accessing contraceptive care using the SEM framework, and, ultimately, offers practical recommendations rooted in personal narratives to reduce these disparities.

This thesis argues that a comprehensive examination of the social ecological factors that shape migrant access to contraception in the St. Louis region—including individual, interpersonal, and institutional-level barriers—can support the development of contextual measures informed by lived experiences to reduce disparities and improve access to reproductive and sexual health care. Applying the social ecological framework allows a more holistic understanding of the unique set of barriers faced by this population. By centering the experiences and perspectives of migrants, I seek to illuminate the hidden complexities shaping access to birth control services for the migrant community in St. Louis, and ultimately encourage stakeholders to enact interventions and policies grounded in a deeper understanding of the contexts in which these experiences are embedded.
Methods

This project obtained approval from the Washington University in St. Louis Institutional Review Board (IRB). This research was conducted in two phases, over the course of six months (from June 2022 to December 2022). The first phase consisted of semi-structured, in-depth participant interviews with migrants who have sought/are seeking contraceptive care in the St. Louis region and healthcare providers/stakeholders to extrapolate initial themes. The second phase involved distributing an online survey to corroborate these themes with a broader Missouri migrant participant base. While the results have been generated from a pool of true experiences of real individuals, no personal information was collected so that the data may be completely anonymized.

The context of the study led to predominantly qualitative data collection and analysis methods. Specifically, the social ecological model (SEM) framework model guided the methodology and results. The SEM framework, pulled from multiple disciplines, introduces ecological perspectives originating from Urie Bronfendbrenner’s theory to more comprehensively understand health disparities.49 This framework considers both individual and contextual implications of health access, which allows us to evaluate these systems with the understanding that individual and social environmental factors are both dynamic and mutually influencing.50 51

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RECRUITMENT

Participants for the in-depth, semi-structured interviews were recruited via various avenues, including recruitment flyers placed in public places and the dissemination of recruitment materials through local networks and community-based organizations serving the St. Louis migrant community. Participants recruitment for the interviews also utilized WashU’s Volunteer For Health (VFH) Participant Registry, which consisted of weekly email blasts to 1000 registry individuals as well as social media postings on Twitter and Facebook. Due to the vulnerable and tight-knit nature of the St. Louis migrant community, snowball sampling was used as an additional recruitment strategy. Recruitment for survey respondents—in the project’s second phase—occurred the same way, with the addition of a follow-up email containing the survey to individuals who had expressed an interest in the study participation but did not wish to be interviewed.

Eligibility for study participation required being over the age of 18, born outside the United States (including Puerto Rico), and having sought/currently seeking contraceptive care in the St. Louis region. The stakeholder interviewees were identified and contacted based on their position with local networks and community-based organizations. The participant populations were composed of 6 in-depth interviewees, 4 of whom were migrants and 2 of whom were community stakeholders, and 9 complete survey respondents. In this research, 11 countries of origin are represented by the migrant pool, including Iran, Nigeria (n = 2), Lebanon, Mexico, Argentina (n = 2), Canada, the United-Kingdom, Spain, Jordan, Jamaica, and China.
DATA COLLECTION

The semi-structured, in-depth interviews were conducted in English over Zoom, with the camera off, or via phone call. After obtaining the participants’ verbal consent, these interviews were audio recorded and stored on a separate and secure device. This study did not provide payment or compensation to participants. The participant question guide was informed by the SEM framework described above, and contained descriptive questions related to contraceptive choices and decision making, barriers experienced in accessing contraception, and suggested methods to increase support for migrants seeking contraception in St. Louis. Due to the open-ended and semi-structure nature of these interviews, follow-up questions were often asked to clarify participant narratives.

The online survey used for data collection in the second phase was created using REDcap, with the consent information sheet included in the survey heading. Survey respondents were screened for eligibility prior to completing the survey. Questions in the online survey were adapted from those in the participant interview guide and were supplemented with frequently asked clarifying questions. The survey was divided into five structured sections:

1. Eligibility and screening questions
2. Background & demographic information
3. Birth control selection & contraceptive decision-making
4. Experienced barriers in accessing contraceptive care
5. Reflections & takeaways from experiences accessing contraceptives in St. Louis

The only required sections were the eligibility screening questions and the reflection questions.

Answers choice format included short answer, long answer, multiple choice, and yes-no.

Additionally, participants were offered the opportunity to leave their email to be considered
and potentially contacted for a follow-up interview. Incomplete survey responses (n = 12), defined as those not answering all the required questions, were dismissed from the study.

TRANSLATION & ANALYSIS

Interviews were transcribed verbatim from the audio recordings. These in-depth interviews were subsequently open-coded by hand, line-by-line. As study themes began to emerge, they were recorded in an additional document for tracking purposes.

For data extrapolated from the online survey, the multiple-choice and yes-no questions were analyzed statistically using Excel. Conversely, the text-heavy questions (both short and long answers) were open-coded by hand and tracked similarly to the interviews.

Throughout this participant data was entirely anonymized. The names used throughout the thesis are for the readers ease and have been obtained via a random name generator online. These names have no ties to, nor do they represent, the names of the actual participants in this study.
Results

PARTICIPANT DEMOGRAPHICS

Study participation totaled to be 6 semi-structured, in-depth interviews (4 with migrants and 2 with community stakeholders). The number of online survey responses was capped at 21. Countries of origins for the interviews included Iran, Nigeria, Lebanon, and Mexico. Countries of origins represented in the online survey included Nigeria, Argentina (n = 2), Canada, the United-Kingdom, Spain, Jordan, Jamaica, and China. Participant ages in the study ranged from 20 to 59 years old, with the mean age being 34 years old, and the median age being 30 years old.

Study participants (for both phases) also varied in their citizenship status, the time they had spent leaving in St. Louis, their employment status, and their use of birth control methods. These participants demographics have been outlined in the tables below.

Figure 1. Participant US citizenship status

<table>
<thead>
<tr>
<th>Citizenship status</th>
<th>Participant count (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen</td>
<td>3</td>
</tr>
<tr>
<td>Non-citizen</td>
<td>3</td>
</tr>
<tr>
<td>Legal permanent resident (i.e., “green card holders”)</td>
<td>2</td>
</tr>
<tr>
<td>Student visa</td>
<td>2</td>
</tr>
<tr>
<td>H1-A/B visa (i.e., “work visa”)</td>
<td>0</td>
</tr>
<tr>
<td>Asylum-seeking or asylee</td>
<td>0</td>
</tr>
<tr>
<td>Refugee</td>
<td>0</td>
</tr>
<tr>
<td>Humanitarian temporary parolee (Afghanistan &amp; Ukraine)</td>
<td>0</td>
</tr>
<tr>
<td>DACA recipient</td>
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</tr>
<tr>
<td>Undisclosed</td>
<td>2</td>
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Figure 2. Participant time spent living in St. Louis, MO

<table>
<thead>
<tr>
<th>Time spent in St. Louis, MO</th>
<th>Participant count (#)</th>
</tr>
</thead>
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<td>1 – 2 years</td>
<td>3</td>
</tr>
<tr>
<td>3 – 5 years</td>
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</tbody>
</table>
Figure 3. Participant employment status

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Participant count (#)</th>
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</thead>
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<tr>
<td>Employed</td>
<td>8</td>
</tr>
<tr>
<td>Unemployed</td>
<td>5</td>
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</table>

Figure 4. Participant contraceptive choice and usage

<table>
<thead>
<tr>
<th>Contraceptive use</th>
<th>Participant count (#)</th>
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<td>Yes</td>
<td>10</td>
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<tr>
<td>Oral birth control pill</td>
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<tr>
<td>IUD (hormonal &amp; non-hormonal)</td>
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<tr>
<td>Arm implant (Nexplanon)</td>
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</tr>
<tr>
<td>Birth control shot (Depo-Provera)</td>
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<tr>
<td>Ring</td>
<td>0</td>
</tr>
<tr>
<td>Patch</td>
<td>1</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>0</td>
</tr>
<tr>
<td>Cervical cap</td>
<td>0</td>
</tr>
<tr>
<td>Male birth control (DMAU)</td>
<td>1</td>
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<tr>
<td>Sterilization (tubal ligation or vasectomy)</td>
<td>0</td>
</tr>
<tr>
<td>Emergency contraception (i.e., Plan B)</td>
<td>0</td>
</tr>
<tr>
<td>Internal/External Condoms ONLY</td>
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</tr>
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<td>No</td>
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EMERGING THEMES

Throughout the interview coding process, themes surrounding migrant perceptions of birth control and barriers to contraceptive access began to emerge. Firstly, reported the same criteria considered for their contraceptive choices and participants noted clear limitations in their birth control options. Many recurring themes in participant narratives are expected from previous research, such as language barriers, financial/insurance difficulties, medical
misinformation, and lack of resource knowledge (i.e., existence of community-based health centers, or different services provided by Planned Parenthood). Additionally, themes determined by the qualitative nature of this research were extrapolated from participant interviews, notably the influence of the community rumor mill in relation to the public charge clause and the presence—or absence—of social support. Many participants indicated a similar desire for increased support in accessing contraceptive care by improving accessibility physically, psychologically, and financially.
Chapter 1: Understanding Contraceptive Choices

Contraceptive decision-making in the United States is a complex process shaped by a variety of social, cultural, and economic factors. According to data from the Centers for Disease Control and Prevention (CDC), oral contraceptives and female sterilization are the most commonly used contraceptive methods among women in the United States. These methods are closely followed by external condoms, intrauterine devices, and male sterilization.

Factors influencing contraceptive choice among women in the US range from effectiveness to side effects and personal preference. In addition to these individual factors, there are also societal and cultural factors that can impact contraceptive decision-making. Some women may face barriers to accessing contraceptives due to cost or lack of access to healthcare. These barriers prove to be particularly influencing when it comes to contraceptive decision-making for migrant women, who face citizenship complications, insurance ambiguities, and navigating a foreign medical landscape. Understanding these complex spheres of influence behind contraceptive decision-making can reveal the root causes of barriers to birth control for migrant women, as well as the ways in which they can be contextually remediated.

VARYING REASONS FOR SEEKING CONTRACEPTION

There exists a variety of reasons why individuals seek out contraceptive services, including menstrual control, hormonal therapy, and preventing potential pregnancies. This

study determine the primary reason participants—migrant women on birth control in St. Louis—sought birth control was for family planning efforts, expressing no desire to be currently pregnant.

Family planning, or the ability to make informed decisions about the timing and spacing of pregnancies, is an important aspect of reproductive health and one of the primary reasons people seek out contraceptives in the first place. Per the Guttmacher Institute, approximately 45% of pregnancies in the United States are unintended, with the majority of these occurring among women who did not use contraceptives or used them incorrectly or inconsistently.\(^5\)\(^4\) As such, contraception can help individuals to plan and space their pregnancies in a way that aligns with their personal goals, values, and circumstances. For some people, this may mean using contraceptives to avoid pregnancy until they are ready to start a family. For others, this may mean using contraceptives to space their pregnancies to allow for sufficient time to recover from childbirth, care for existing children, or achieve other personal and professional goals.

Fatima was 19 when she had her first daughter. Since then, for the past 2 years, she has been on oral contraceptive pills,

“It has to do with me not wanting to get pregnant for now. I had a child. I had a daughter, so I just want to give a reasonable break before having another, and I need birth control for that. So those are my reasons. Not wanting to get pregnant.”

Omar, who has a 6-year-old at home, expresses similar sentiments regarding the prioritization of outside elements when asked his reasons for seeking birth control:

“Yes, just to be safe and in the area of helping my spouse to also be that we can cut our births, not have kids we don’t want, the major reason was actually to have a focus on the decision when it comes to the number of children we decided upon.”

Distaste for condoms was also noted in expressed reasons for contraceptive services. Omar explains:

“[I] Would have made use of condoms. I don’t like them. I don’t want to keep using it.”

Although condoms offer a fairly available, effective, and affordable method of contraception, personal preference may inhibit their use. Like Omar, some individuals may dislike using condoms for a variety of reasons, such as finding them uncomfortable or inconvenient, or having allergies or sensitivities to certain materials used in condoms, while others may be concerned about the potential for condom failure.

**CRITERA FOR CONSIDERATION**

When selecting a type of birth control, many individuals consider the potential side effects of different methods. Different types of birth control can have different side effects, and what is tolerable or unacceptable can vary from person to person. Some common side effects of birth control include changes in menstrual bleeding patterns, nausea, weight gain, mood changes, and skin irritation.⁵⁵

It is important for individuals to be aware of the potential side effects of different birth control methods and to discuss any concerns with a healthcare provider. Some methods may

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have fewer side effects compared to others, and a healthcare provider can help an individual weigh the potential benefits and risks of different methods. Some individuals may prefer a method with fewer or milder side effects, whereas others may be willing to tolerate more side effects in exchange for a higher level of effectiveness.

Fatima, who uses condoms and oral contraceptive pills, voiced her concern regarding the side effects while getting on birth control:

“I think this is my preferred method because I don’t think there could be more side effects.”

Omar settled on male birth controlled, called dimethandrolone undecanoate (DMAU), rather than having his spouse use the oral contraceptive pill:

“I thought of it. We both agreed, and it was our collective idea that I go for it because of what we heard was safer for the male than the female, so we decided that I go for it.”

When selecting a type of birth control, many individuals consider the ease and accessibility, defined as recurrence and depth of visit to medical offices, of different methods. Some methods, such as the pill or the patch, require ongoing action or preparation to be effective, while others, such as the contraceptive implant or the copper intrauterine device (IUD), are long-acting and require less ongoing effort. Ease and accessibility proves particularly important for those who have difficulty remembering to take a daily medication or are unable to acquire a barrier method before every sexual encounter. Long-acting reversible contraceptives (LARCs), such as the implant or IUD, can be an attractive option for individuals who want a highly effective method that does not require this ongoing action or preparation. Conversely, LARCs may be less convenient for some individuals as they require a visit to a
healthcare provider for insertion and may require follow-up visits for removal or replacement. This aspect of LARC can be particularly off-putting for migrants wishing to minimize their presence in clinical spaces due to financial and legal concerns.

Condoms and the pill are methods that can be used as needed and do not require ongoing maintenance or visits to a healthcare provider. Condoms are a one-time use method that can be easily carried and used as needed. The pill, meanwhile, requires daily ingestion but does not require any ongoing visits to a healthcare provider. This aspect can be particularly appealing for individuals who lead busy lives or who prefer a more flexible or convenient method. This factor is particularly attractive for migrant individuals who may wish to minimize medical visits due to fear of legal repercussions or due to being under/uninsured.

Ease and accessibility emerged as recurrent themes when discussing the criteria considered for participant’s choice of birth control:

“I know, like, they mentioned that I could try something else, but I guess I was just dealing with a lot of personal things that I just never got time to make that appointment and to get on something else. So that’s where I am right now.”

- Maria

“[On her decision to obtain the Nexplanon arm implant] So that I can remove it anytime I want to remove”

- Emily

“[On her decision to pursue oral contraception] Because it for a particular period of time”

- Maria


57 Planned Parenthood, Birth control methods. (2021)

58 Planned Parenthood, Birth control methods. (2021)
“Cause it was easily accessible,” was expressed by both Simi and Lucia as their reason for choosing the oral contraceptive pill over other forms of available contraception.

Fatima prioritizes minimal interactions with healthcare personnel, stemming from a fear of visiting a doctor’s office in-person. Although she is open to other methods, her concerns have limited her to using oral contraceptive pills, where she can access contraception without stepping foot in a clinic:

“I would be open to trying other methods of birth control. But the ones I know of, I guess you have to meet the doctor in person. It doesn’t have to be pills. So that is why I think pills is the best option for me.”

Fatima goes on to explain that she had not been adequately informed about the presence of side effects—in her case, debilitating migraines—with the oral contraceptive pills. However, regardless of this experience, she expresses that she would still have pursued this method even if she had been informed of the painful side effects due to its easier accessibility.

“Yeah, I still would have [gotten the pills if I had known about the side effects]. So, I will pursue it with the mindset that there is a side effects. Instead of going through it blindly. But anyways, I would still go for it.”

Negative health experiences, both personal and rumored, can significantly impact a person’s criteria for selecting birth control. If someone has had a negative experience with a particular type of birth control in the past, such as side effects or complications, they may be more selective in their choice of contraception in the future. Similarly, if someone has underlying health conditions, such as certain types of cancer or diabetes, they may need to be more cautious in their selection of birth control to avoid potential risks or interactions with their existing medical treatment. Individuals hearing of negative health experiences, such as
painful IUD insertions, through various sources inevitably influence criteria considered when selecting birth control. Participant testimonies support this belief:

“[I was] most comfortable with [the pill]”

Sofia explains her decision not to pursue any LARCs, even after observing her inability to remember taking an oral contraceptive pill every day:

“I was scared to use an IUD insertion because I heard from other family members, like my cousins, that they would gain weight. And I know a specific cousin said that the IUD I don't know, I got stuck and she had some difficulty, so I was pretty scared to do that myself”

Ultimately, negative health experiences—whether personal or not—can shape a person’s priorities and preferences when it comes to selecting birth control as they may be more inclined to prioritize safety, effectiveness, and convenience in their decision-making process.

PROCESS & PATHWAYS FOR SELECTION

Examining the process for contraception selection and pathways for accessing care is crucial for understanding and addressing the barriers faced by migrant women accessing birth control in St. Louis. There exist a variety of ways through which individuals can seek and acquire birth control, however, these channels are much more restricted for migrant women.

Many countries offer free or low-cost contraception at public health clinics, which can be an important resource for migrant women who may not have private insurance or the
financial resources to pay for contraception out of pocket. However, access to these clinics may be limited in certain areas or for certain groups of women, such as those who are undocumented or who face specific language barriers. Migrant women may also access contraception through private healthcare providers, such as family planning clinics or private doctors. These providers may offer a wider range of contraceptive options than what is available at public clinics, but they may also be more expensive and/or require out-of-pocket payment at the time of service. In some cases, migrant women may be able to access contraception through online or mail-order pharmacies, which can be a convenient option for those who live in areas with limited access to in-person healthcare providers. However, there exist clear risks, such as receiving counterfeit drugs, associated with buying any online medication online.

There are several options for women to obtain birth control in St. Louis, including visiting a reproductive healthcare provider, such as a gynecologist or a family planning clinic, to obtain a prescription for birth control pills or other methods. These providers may be located at hospitals, clinics, or private practices. Visiting a pharmacy to purchase over-the-counter birth control methods, such as condoms, and sometimes prescription birth control offers an alternative point of access that does not require physician and/or hospital visits. Beyond this,

61 Jones, et al., Barriers to contraceptive access among migrant women: A systematic review. (2018)
63 Jones, et al., Barriers to contraceptive access among migrant women: A systematic review. (2018)
64 Smith, et al., Contraceptive access among migrant women in the United States: A qualitative study. (2020)
there exist several organizations in St. Louis that provide low-cost or free reproductive healthcare services, including contraceptive services and counseling, to individuals who may not have access to these services otherwise, including Planned Parenthood, community health centers (i.e., Betty Jean Kerr People’s Health Center and Casa de Salud), and non-profit organizations that specialize in reproductive healthcare (i.e., Contraceptive Choice Center).\textsuperscript{65}

The participants in this study described various points of access to birth control in St. Louis. Almost half of the participants (43%) expressed accessing contraceptive services via birth control. Some participants also described accessing their contraception through “friends of friends”. For example, Fatima, explains that she has a friend who is friends with a doctor. Although Fatima has never spoken to this physician—all communication is limited to the intermediary friend on an irregular basis—he handles her birth control prescriptions.

“I had a connection to a doctor, through a friend, and he seems to be he handled my contraceptive pills personally, and if I need condoms, I go to chemist. Because he doesn’t necessarily discuss that. He just handles the pills.”

Although this informal underground network enables the Fatima to access the contraceptive healthcare she requires, it puts her at risk for lower-quality healthcare, as she is unable to interact directly with the physician. Additionally, the physician becomes inherently unable to provide comprehensive or contextual contraceptive advice, nor can they monitor the health effects of this birth control.

The participants in the study discussed their experiences accessing contraceptive services and elaborated on their decision-making process for choosing a method. Yasmin

describes the process as being provided with a chart of the pros and cons of different methods and asked questions about her health concerns, which ultimately led to her decision of using the pill:

“Basically [they used a] chart, and it's like pros and cons for every different type of control. Okay. If you get on a pill, this is like, what the side effect? I don't know if you an IUD this is what could happen and so we talked about every single category, and then they asked some questions about if I'm getting migraines or any health concerns that would exclude any of those categories. And then I didn't want to get an IUD at the time, so we settled on pills. When I came out from Planned Parenthood, they gave me prescription for three months, and then they're like, okay, so whenever you are ready and just call the pharmacy, we can send you a prescription after that. Or if you want to go start with the primary care doctor again, we can talk to them about having the pills refilled.”

Yasmin also described a painful experience attempting to obtain an IUD at a university health center, but, was ultimately unable because her cervix was too narrow and the health center—which lacked an ultrasound machine to guide the process—could not complete the procedure.

“Not at a time, but last year here I was about to get an IUD at WashU, actually. They go through everything, and it was explained, but I ended up that couldn't get an IUD because my cervix was so tight that it wouldn't let the rod just actually go up. And that was like, one of the most painful things I went through. And then they didn't have an ultrasound machine that would guide them, so it would've been nice if I was told that this might happen. Or like if they're going to be turning people away from getting an IUD but it was like 30 minutes of poking.”

In her experience, Fatima recalls being told by a healthcare provider that the pills she was considering had the least side effects and were manageable, noting that the information was expressed verbally without any physical written information provided:
“I asked questions, and I was told this is the least side effects, that others have more complicated side effects. So, I guess I will just stick to this one. It’s more like I can manage it. I didn’t get any proper information. It was just spoken to me.”

This interaction suggests that Fatima had concerns about the potential side effects of different contraceptive methods, and that the provider’s response addressed the primary question without providing any further information or clarification. As a result, Fatima—an uninsured, undocumented migrant woman—may have felt uncertain or insecure in her birth control choice (oral contraceptive pill), her desire to acquire birth control altogether, and could discourage her from seeking medical advice in the future. Ultimately, the provider does not appear to have fully addressed her concerns or provided her with adequate information to make an informed decision, leaving Fatima with certain side effects that may have been avoided or lessened with the use of a different contraceptive method. This account demonstrates the need for healthcare providers to take their time to fully address patients’ questions and concerns and provide them with the necessary information to make informed decisions about their healthcare, especially when their patient’s demographic is historically marginalized, predisposing them to negative health outcomes within the US health system.

A third participant, Omar, mentioned doing his own research about different methods and their side effects on the Internet, but ultimately relied on the recommendation of their physician:

“Well, actually I read about few articles because the side effects I also saw some websites. I make it on the Internet most of the time, so I got lots of information from there, but none of which I really took into consideration. As long as the physician said that the drugs are safe, I take them.”
Although Omar was able to conduct some personal research online prior to his visit, this interaction reveals the immense trust placed in physicians’ hands when it comes to health advice. As a result, physicians must proceed with extreme care, caution, and understanding when offering contraceptive counseling services to migrant individuals; physicians take on the role of trusted navigators amidst this complex and foreign healthcare system. Migrants must continue to be both informed and involved in their own healthcare, which includes personal research and the support of their healthcare provider.

Although contraceptive care is considered a medical pursuit, migrant women may also seek social pathways. These pathways can include accessing contraception through community organizations or advocacy groups that provide reproductive health services or support.66 These organizations may be able to connect women with resources and information about how to access contraception, as well as provide support and guidance throughout the process.67 Migrant women may also access contraception through their social networks, such as friends, family members, or other trusted individuals who can provide information and assistance in navigating the healthcare system.68

One participant, Sofia, also noted the lack of insurance and the need to find an affordable option as a factor in their decision to choose the pill.

“It was because I felt like that would be the first one to try growing up and not really speaking about contraception methods and not really knowing where to start. And also, I had to do my own research because I don’t have health insurance, so figuring out what I could get that was affordable. So that all kind of let me start on the appeal and see how that works.”

This quote suggests that the Sofia had limited knowledge about contraceptive methods and did not have opportunities to discuss them growing up. Her personal circumstances led her to do her own research to inform herself on available options, a search that was complicated by their lack of health insurance. As a result, her decision to try a particular method may have been influenced by a lack of knowledge about other options and limited access to information and resources. This situation highlights the importance of providing individuals with access to accurate and comprehensive information about their reproductive healthcare options and ensuring that they have the resources and support they need to make informed decisions about their health. Sofia’s experience also suggests the need for more inclusive and comprehensive sex education that addresses the needs and concerns of individuals from diverse backgrounds and experiences. Empowering migrant women to access better-suited contraceptive methods is a process that takes place both within and beyond the clinic.
Chapter 2: Individual Barriers

PERSONAL & CULTURAL EFFECTS

Personal beliefs and values can impact access to birth control for migrant women in several ways. Some women may have personal or religious beliefs that prohibit the use of certain forms of birth control, such as the birth control pill or certain types of condoms. This can limit their access to these methods and make it difficult for them to effectively plan and manage their reproductive health.

Cultural norms and stigma can also play a role in access to birth control for migrant women. In some cultures, there may be a stigma attached to using birth control or discussing reproductive health, which can make it difficult for women to access these services or even discuss their options with a healthcare provider. This can be particularly true for migrant women who may be unfamiliar with the cultural norms and practices of the country in which they now live. One study found that Latin American immigrant women living in the United States were less likely to use hormonal contraceptives due to cultural beliefs and values.69

Cultural beliefs and norms can significantly impact access to birth control for migrant women in the St. Louis region. In particular, the prevalence of religious beliefs among the Hispanic population in the area may shape attitudes towards reproductive health services, including birth control. Specifically, some individuals may hold pro-life beliefs and view abortion care services as a sensitive or controversial topic. Additionally, discussing reproductive health may be considered taboo or controversial within some cultural groups, which can create

barriers for migrant women seeking out information about birth control options or accessing these services. These barriers can be reproduced generationally, as well. Sofia recalls the lack of conversation surrounding contraception because of the complexity of these religious, social, and familial dynamics.

“Most of the Hispanic people I know that are in Missouri or the St. Louis region are very religious. So, when we talk about abortion care services, that can be very sensitive to people, and there’s a lot of people that are pro-life. Personally, I know that I had to kind of advocate and basically face my own family because I believe that woman should have the right to abortion care services. So, I can tell you from my own personal experience, like you said, very taboo, or people don’t want to talk about it, just kind of shut it down.”

Sofia’s story underscores the role those religious beliefs can play in shaping attitudes towards reproductive health services, including birth control, among migrant women in the St. Louis region. She notes that many Hispanic people in the area are "very religious," and that abortion care services can be a sensitive topic for those who hold pro-life beliefs. Overall, suggests that religious beliefs may influence whether migrant women feel comfortable seeking out or using certain forms of birth control or reproductive health services.

Furthermore, the quote suggests that discussing reproductive health, including birth control, may be considered taboo or controversial within certain cultural or religious groups. This may create additional barriers for migrant women seeking out information about birth control options or accessing these services. The speaker notes that they personally had to "advocate" and "face [their] own family" to support a woman's right to abortion care services, indicating that there may be resistance or reluctance within some cultural groups to engaging with these issues.
Overall, this quote highlights the importance of considering the role of religious beliefs and cultural norms in shaping access to birth control for migrant women in the St. Louis region. It is important for healthcare providers and other organizations to be sensitive to these cultural dynamics and to work to ensure that migrant women have access to the reproductive health services they need, regardless of their personal beliefs or cultural backgrounds.

According to data from the Pew Research Center, approximately 66% of Hispanic adults in the United States say that religion is "very important" in their lives, and 44% report attending religious services at least once a week. Additionally, a survey conducted by the National Opinion Research Center found that 59% of Hispanic adults in the United States identified as Catholic, while 22% identified as Protestant. The Catholic Church officially opposes the use of most forms of birth control, including the use of artificial contraceptives such as the birth control pill. The church teaches that every sexual act should be open to the possibility of procreation, and that using artificial means to prevent pregnancy is morally wrong. The church does permit the use of natural family planning methods, which involve monitoring the menstrual cycle and avoiding sexual intercourse during periods of fertility. This religious perspective limits the range of birth control options available to practicing Catholic migrant women, particularly if they are not aware of natural family planning methods or do not have access to them. The official teachings of the Catholic Church on birth control, which oppose the

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use of most forms of artificial contraception and promote natural family planning methods, can inevitably create significant barriers for migrant women seeking access to these services due to their personal beliefs and cultural norms.

Cultural differences in sexual health education can have a tremendous impact on access to contraception and reproductive health services. In some cultures, there may be a lack of comprehensive sexual education, resulting in individuals having limited knowledge about birth control options and how to effectively plan and manage their reproductive health. This lack of information can create barriers for individuals seeking out information about birth control options or accessing these services. Additionally, cultural and social norms may discourage open discussion of reproductive health topics, which can make it difficult for individuals to seek out information or resources related to contraception. These cultural differences can be particularly pronounced for migrant women, who are subjected to myriad other barriers to care. Sofia describes this phenomenon:

“Right, there wasn’t much at all, to be honest. My mother grew up without any, like, sexual health education, so I actually had to educate her on the different contraception. As far as my knowledge of it, there was barely any besides, like, use condoms.”

This retrospective emphasizes how cultural differences in sexual health education can affect access to birth control. Sofia states that she did not receive much sexual education, and that her mother also did not receive any sexual health education. This lack of comprehensive sexual education can create barriers for individuals seeking out information about birth control options or accessing these services. Without sufficient knowledge about the range of birth
control options available and how to effectively use them, individuals may be more likely to rely on methods that are less effective or have higher risks, such as condoms.

Additionally, she also implies that cultural and social norms may discourage open discussion of reproductive health topics, which can make it difficult for individuals to seek out information or resources related to contraception. Sofia explains that she had to educate her mother on the different types of contraception, indicating that there may be a taboo around discussing these topics within their family or cultural group. This reluctance to discuss reproductive health can create barriers for individuals seeking out information or resources related to contraception, as she may be hesitant to ask questions or seek out information due to fear of judgement or backlash.

Overall, the quote highlights the importance of addressing cultural differences in sexual health education to ensure that individuals have access to accurate and comprehensive information about birth control options. This is especially important for migrant women, who may face additional barriers to accessing reproductive health services and knowledge due to limited social networks.

When discussing cultural differences’ impact on access to contraception for migrant women with the Missouri Refugee Health Coordinator (MRHC), she revealed several key factors at play. Evidently, one barrier mentioned was the influence of cultural beliefs and practices on decision-making around healthcare, specifically the role of the “male head of household” in some cultures. This dynamic may make it difficult for women to access certain types of care, including contraceptive options, as decisions about healthcare may be made by others rather
than by the individual seeking care. She explains that this dynamic has most recently been observed with the Afghan refugee arrival in Missouri.

Another element noted in the conversation is that of health literacy, which refers to a person's understanding of how to navigate the healthcare system and make informed decisions about their own health. Migrant women who are new to the United States may have limited health literacy, particularly if they are unfamiliar with the healthcare system or medical terminology in their new country. This can make it challenging for them to access the care they need, including contraceptive options.

The MRHC also emphasized the importance of cultural awareness and sensitivity among healthcare providers. This means that healthcare providers should be knowledgeable about the cultural beliefs and practices of their patients and should strive to provide care in a way that is respectful and sensitive to these beliefs. This can be especially important when it comes to issues related to reproductive health, as cultural beliefs and practices can vary significantly from one culture to another.

Lastly, she also emphasized that accessing care may be more challenging for people who are new to the United States, particularly in the current national climate, in the post-Trump administration and current Dobbs v. Jackson era. This may be due to changes in healthcare access or ease of access depending on location. A person seeking contraceptive options may find that the options available to her vary depending on their location. Cultural differences have the potential to be an influential barrier to healthcare access for migrant women, especially if

healthcare professionals are unable to approach the situation with cultural sensitivity, understanding, and respect.

Cultural affects can significantly influence migrant women's access to contraceptive care. These differences may affect an individual’s understanding of their reproductive health and their ability to make informed decisions about contraception. Some cultural beliefs may discourage the use of certain forms of contraception or may stigmatize those who seek out such care. Beyond this, a lack of understanding of the healthcare system in a new country paired with existing health barriers can also make it difficult for migrant women to access contraceptive care. St. Louis boasts a rich cultural history and is home to a multitude of migrant communities from around the world, therefore, it is imperative that this diversity is reflected in the context through which contraceptive healthcare is provided.

**LACK OF RESOURCE KNOWLEDGE**

The lack of knowledge regarding available resources continues to impede migrant women's access to contraceptive care in St. Louis. Several study participants noted that had never heard of Planned Parenthood and/or Casa de Salud, two of St. Louis’s most prominent clinics offering affordable reproductive health and migrant health services, respectively. Contraceptive resources for migrants in St. Louis are limited to begin with, thus this lack of knowledge of existing resources exponentially ostracizing migrants from contraceptive care.

During the interview with Yasmin, she draws on her personal experience to reveal the intricate interplay between migrations status and resource knowledge. Yasmin reflects on her on initial lack of knowledge and how it shaped her contraceptive journey.
"Another one is I didn't even know about Planned Parenthood, so that was like another one. But I feel like sometimes it's because I wasn't a refugee and I think maybe when refugees come here, they are informed about this kind of stuff. I was an immigrant. I came here with a green card. A lot of times I wasn't American enough, but I wasn't a refugee so I can't take advantage of some of those programs they have for refugees. I don't know if [my difficulty accessing birth control] was because of my situation [i.e., citizenship status].”

Yasmin’s use of the phrase "weren't American enough" evokes a sense of exclusion from programs and resources that are available only to US citizens, adding another layer to the already complex issue of reproductive health access in the United States. This sense of alienation points to a possible source for lack of knowledge about resources, such as Planned Parenthood. However, Yasmin implies that her status as a green card holder place her in a liminal space, as she also does not have access to resources reserved for those with refugee status.

When asked about the biggest challenge she faced in accessing contraceptive care, Iman, a student from Jordan who has been living in St. Louis for one year, simply points to her knowledge in accessing existing facilities. She expands on her perspective by explaining that because she has no primary care physician, she is stripped of the first place most people turn to when navigating the healthcare landscape, which results in being unaware of where to go to access birth control. This trend proves to be consistent across national migrant demographics, as well. A 2022 study by the Pew Research Center found that less than half of recent Hispanic immigrants to the US have a primary care provider, which is significantly lower than their
domestic-born counterparts, of whom 77% report have a PCP.\textsuperscript{74} \textsuperscript{75} Without access to a primary care physician—typically the first point of access for healthcare—resource knowledge becomes increasingly limited and complex.

This lack of resource awareness for migrants in St. Louis extends beyond contraceptive support in reproductive healthcare. Sofia notes experiencing similar barriers to care due to a lack of knowledge of existing resources when it came to pre- and post-natal care during her miscarriage.

“To be honest, I don't think that most people know how to access healthcare or mental healthcare access. There’s a lot of health disparities. As a person that recently had a miscarriage, I didn't know how I was going to get that care for prenatal care due to not having insurance because for undocumented woman they only cover like, labor delivery, no prenatal, postnatal, postpartum care.”

Throughout these interviews, it became increasingly apparent that when individuals are aware of existing resources, they are often hearing of these through word-of-mouth. Sofia explains that she was made aware of the presence of such resource because of her student status, and claims that, without it, she would have had difficulty knowing where to begin.

“Yeah, I actually heard of [contraceptive care resources] through word of mouth because I've been in school for a while, so that's how I heard of them. And also, I think this was 2018, I knew somebody that was working for Planned Parenthood and actually invited me to attend one of their conferences. So that’s how I got to know about Planned Parenthood. But I know as far as I feel like if I wasn't a student, I wouldn’t know my options if I didn't have health insurance. And also, in regards to my immigration status, it's difficult reaching out. Like, I know of Casa de Salud and JFK Clinic,

which works with the immigrant and undocumented population that a lot of people don’t know. So, I am one of the few lucky people that do know how to reach out to find resources.”

Importantly, she highlights the specific challenges at play for migrants with reaching out and seeking healthcare assistance as a result of their citizenship status. Although she acknowledges that JFK Clinic and Casa de Salud are important organizations providing much-needed care to migrant communities in St. Louis, she draws attention to the face that oftentimes, the populations they cater to are unaware of their existence. This observation highlights the lack of resource knowledge, despite the existence of clinics in metropolitan region, and the impacts this has on contraceptive care access for migrants in St. Louis.

This lack of resource awareness creates challenges that are unique for migrants in the United States, Missouri, and St. Louis (a town sitting at the border of two states) due to the face that resources for contraceptive care are not federally regulated. Beyond this, the Missouri Refugee Health Coordinator, comments on the increasing complexities as laws on reproductive health continue to change from state to state in a post-Dobbs v. Jackson world.

“I think we’re moving into an era where the broader national climate around this conversation particularly is maybe going to make accessing care more challenging for people who are new to the United States and the healthcare system. And what you could anticipate being more commonly accessible or available, no matter where you were, is now going to be like, okay, you live in Illinois, here’s what you have access to. But you move 200 miles away to a different state and your environment is going to change or your access is going to change or the ease at which you’re able to have these conversations might change depending on where you seek care.”

She articulates how the ease of obtaining healthcare services and engaging in healthcare conversations may vary widely based on geographic region—services which were
once universally accessible may now be limited depending on the state or location of healthcare provision. These circumstances underscore the importance of compiling and disseminating comprehensive information on healthcare infrastructure and resources available based on state, region, and city location, especially for newly-arrive populations.

The widespread lack of resource awareness for migrants in St. Louis emphasizes the importance of recognizing the potential difficulties associated with accessing healthcare in different locales. Once these challenges are more thoroughly understood, stakeholders can proceed in addressing the urgent targeted and contextually informed healthcare outreach strategies that account for the specific needs of a foreign-born population in St. Louis as elucidated throughout these participant interviews.
Chapter 3: Interpersonal Barriers

THE PIVOTAL ROLE OF SOCIAL SUPPORT

Social support from family, friends, and community members can play a pivotal role in helping migrants overcome these obstacles and access the care they need. Prior research has highlighted the pivotal role of social support in promoting contraceptive use among migrants and other underserved populations.\textsuperscript{76, 77} By offering various types of support, the presence of a trusted individual in a person’s birth control journey of social support offers a promising strategy to improve access to contraceptive care for migrants in St. Louis.

By providing practical, emotional, and physical assistance, social support helps to mitigate some of the aforementioned barriers to care for migrants. Specifically, social support from family members or friends could offer transportation to appointments, help with childcare, or the provision of translation services, all of which are known to help overcome more logistical difficulties in accessing care.\textsuperscript{78} Additionally, by reducing isolation and stigma experienced when navigating such a taboo type of healthcare, social support allows migrants to feel both at ease and empowered when making decisions regarding their contraceptive choices.\textsuperscript{79} Notably, increased social support—either from partners, family members, or community organizations—has been shown to be positively correlated with contraceptive use.\textsuperscript{80}

can be especially vital in promoting contraceptive use among migrant population. Social support plays a crucial role in enhancing access to contraceptive care for migrants, either by offering practical assistance, an emotional sounding board, and/or promoting birth control utilization. Ultimately, the presence of this support empowers migrants to overcome the multiple barriers and navigate overlapping social dynamics when seeking birth control.

Yasmin’s experience after facing a defect in her birth control provides insight into the multiple ways in which the presence of social support can improve an individual’s health outcome. Initially, she describes feeling both apprehensive and uncertain regarding seeking out help. However, Yasmin’s roommate at the time happened to volunteer at Planned Parenthood, which proved instrumental in assuring she obtained the necessary care.

“I was working, and I had a birth control defect. I was like scared of being pregnant and I was basically didn't know where to turn. My family are not particularly ___ with this, but I didn't know if I'd come to my dad or I'm pregnant without being married, what the reaction is going to be, so I was kind of scared and then I had a roommate that was volunteering at Planned Parenthood, so she took me there the first time.”

Yasmin’s experience underscores the importance of social support as a crucial factor in facilitating access to reproductive healthcare, especially for migrants who face cultural stigma and other obstacles. Despite initially turning to online resources for information on contraceptive care, she eventually sought in-person support from Planned Parenthood, where they encountered a welcoming and non-judgmental environment.

“I didn't reach to any online group. I got all of my information online. The only other people that knew about the situation was my boyfriend at the time. And I don't know, it was kind of easier for me to not talk to family members or even close friends about it. [...] [I’m grateful that Planned Parenthood staff] were there when they basically I needed them the most. And it was completely like,
whatever they say about Planned Parenthood, they don't judge, they're not doing anything. So, I was really appreciative of that because as somebody that was living here alone and all the cultural stigma behind being in a relationship or getting pregnant and stuff, I thought, if something happens, I still have some people in my corner.”

Her remarks shed light on the multifaceted nature of seeking social support for sensitive healthcare concerns, particularly regarding contraception and unintended pregnancies. Despite relying on online resources for information, Yasmin chose not to seek assistance from online groups, which suggests that—while the internet is a valuable source of knowledge—it may not always provide the necessary emotional support for individuals dealing with more nuanced healthcare decisions. Moreover, Yasmin’s hesitation to discuss sensitive healthcare topics with family or close friends highlights the impact of cultural stigma and shame on access to social support. As a migrant facing cultural prejudice, she may have felt that confiding in loved ones would lead to disapproval and judgment, further emphasizing the necessity for culturally responsive healthcare services and non-judgmental support systems capable of guiding individuals without the fear of stigma or shame.

Yasmin reports that her experience which such stigma and shame in the setting of reproductive healthcare goes beyond birth control access. As xenophobia and hate crimes continue to rise in the U.S., Yasmin reflects on presence of predominantly white, elderly protesters who regularly stand outside of the St. Louis Planned Parenthood location. She clarifies that her sense of stigma as a migrant is only further intensified by their presence, as she feels as though she is reinforcing harmful stereotypes by seeking any kind of healthcare. Ultimately, Yasmin explains that, without the physical presence and social support of her
friends, she would be reluctant to seek treatment at this Planned Parenthood “even if [her] life depended on it.”

Similar to Yasmin, Sofia also felt as though she could not turn to her family—albeit for very different reasons. Sofia recalls turning to her peers at school rather than her family for information on contraceptives and reproductive health resources, as she perceived her family to be wholly unprepared to offer this type of assistance.

> “I turned to friends or people at school because pretty much my family didn’t know much about that, so I couldn’t really rely on them to talk to me about what resources or what services were available.”

In this situation, Sofia’s social network played an instrumental role in providing vital information and support, which enable her to more effectively navigate birth control access in an unfamiliar environment. Here, the importance that relevant and accurate information be provided by a trusted source is underscored. Without these resources in place, individuals, especially those already marginalized by the healthcare system, may become isolated and unable to obtain the necessary contraceptive care.

Omar’s experience highlights the significance of social support networks in facilitating access to contraceptive for migrants residing in St. Louis. He emphasizes the role of his friends, who had been living in the U.S. for longer, in providing essential information about contraception and reproductive health, in general. He recalls speaking to one friend, specifically, throughout his process of seeking birth control as Omar believed him to be more knowledgeable than he was regarding the subject.

> “Yeah, I spoke with a friend I know from Detroit. I told him I was going to opt for that, and he advised me to. He’s a health worker, so he has better understanding of the whole thing. Yeah.”
This interaction demonstrates how social networks can offer vital information and support while allowing individuals to acquire information from a reliable source. Although Omar clarifies he received emotional support from this individual, he also expresses his gratitude for his spouse and her family who—unlike earlier participants—offered unrelenting support as he sought contraceptive care.

Simi provides similar insight to the undeniable power of social support seeking contraceptive care as a migrant in St. Louis. She explicitly states relying on her citizen friends, who have been in the U.S. for longer, to acquire birth control, especially condoms. Conversely, Fatima notes an immense amount of difficulty accessing birth control as she only has one friend whom she sees infrequently. For both Simi and Fatima, the existence of a social network and the presence of social support decides the difference between whether she does or does not have access to contraception. By leveraging these interpersonal connections, it becomes apparent the instrumental role social support places in migrant access to contraceptive care.

Overall, these experiences underscore the importance of building and fostering robust social support systems to ensure that migrants have access to the information and guidance required throughout their contraceptive journey. By recognizing the pivotal role of social support in accessing contraceptive care for migrants in St. Louis, healthcare providers and policymakers can work to address the distinctive needs and challenges faced by this population, enhancing accessing to critical health needs. The inclusion of this understanding when discussing methods to improve contraceptive access will be further outlined in Chapter 5: Next Steps.
THE PUBLIC CHARGE CLAUSE AND ITS RUMOR MILL

The public charge clause and its associated rumors have proven to be a clear obstacle in migrants’ access to healthcare of any kind, including contraceptive care. In recent year, the public charge clause, defined more thoroughly in the Appendix, has wreaked havoc on immigrant health in the United States by causing substantial fear and confusion around which factors are and are not considered.\(^8^1\) At its core, the public charge clause is a longstanding immigration law which bars individuals from adjusting their immigration status, including obtaining citizenship, if they are or have been demonstrated to be reliant on government assistance.\(^8^2\) In 2019, The Trump Administration's proposed changes to the public charge rule sparked widespread rumors and misconceptions, which only amplified led migrants’ avoidance of all healthcare interactions.\(^8^3\)

Although the public charge clause considers a variety of factors, such as age, health, and income, it does not consider the use of non-cash benefits, including Medicaid and other health services, when establishing public charge determination. The U.S. Citizenship and Immigration services specifies that it does not consider the following health program when determining public charge status: Children’s Health Insurance Program (CHIP), Medicaid (other than support for long-term institutional care), including public assistance for immunizations and for testing and treatment of symptoms of communicable diseases, health clinics, short-term rehabilitation


services, and emergency medical services, Health Insurance through the Affordable Care Act, any benefits related to immunizations or testing for communicable diseases, treatments or preventative services related to COVID-19, including vaccinations, and home and community-based services (HCBS). As a result of these provisions, contraceptive care, whether through Medicaid or another federal funding, is not considered for public charge determination.

Despite this provision, rumors and misunderstandings about the public charge rule have led many migrants to avoid seeking out necessary healthcare services, including contraceptive care. Thus, while the public charge clause does not technically prevent migrants from accessing reproductive healthcare services, the rumors and confusion surrounding the rule have contributed to significant barriers for this population. By centering participant narratives rather than analyzing existing policy, these challenges in accessing care can be more thoroughly understood and addressed.

When asked whether he felt his citizenship status interfered with his ability to seek out birth control services, Omar responded unequivocally.

“Initially, yes, I thought of it. I had to speak with a friend about it in the advance. It was a problem.”

Even from the very beginning of his cycle, the repercussions of seeking contraceptive care never left Omar’s mind. Only once he was able to confirm there would be no impact was, he able to navigate his acquisition of birth control more confidently.

Yasmin firmly believes that the “rumors” surrounding citizenship impacts remain the biggest barrier to accessing birth control. She even goes as to state that, where her situation

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not requiring of immediate attention, she likely wouldn’t have pursued contraceptive care in the U.S. altogether.

“I did not know, and I was actually kind of scared to use Obamacare [Affordable Care Act] because I was a green card at the time, and I was told that if I use any sort of any program, that is like federal funded, that would interfere with me getting my citizenship later. And I didn’t even want to try it. I didn’t know. And then when they brought it up, I didn’t want to try it. But then the lady that was helping me set it up, she went and did some research, like background research, and she said, well, based on what I read, it’s not going to interfere. So, I was really happy that she took that extra step to figure out if this is okay with me doing it.”

Yasmin’s experience illuminates the pervasive fear and uncertainty among migrants regarding government-funded healthcare programs. Despite eligibility under the Affordable Care Act (ACA), she describes wariness of using it due to concerns over the public charge clause and its potential impact on her citizenship status down the line. This anxiety stemmed from unsubstantiated rumors circulating within and outside of her community, resulting in Yasmin’s discomfort with seeking any sort of reproductive healthcare. However, through the assistance of an informed and dedicated healthcare provider, Yasmin was able to receive accurate information regarding the true impacts of enrolling in ACA as a green card.

When asked about where this understanding comes from, and whether she was informed of this upon receiving her green card, Yasmin expands:

“*I think this was one of those information that just kind of floats around in immigrant communities or like, people have the fear without actually anybody knowing. So, I heard of it, but it was not like when I got my citizenship, somebody would have come and say, hey, by the way, we can’t use it, or I heard it from a lawyer. It was like something that I heard from my friends and family, but I was never in a position to actually want to use any government funded health insurance or anything. So, I actually never got into it until research it or contacting the lawyer to ask. So, it was just something*
I heard. [...] So, it’s just kind of floating around immigrant communities is something to look out for, something to be aware of.”

Her explanation sheds light on the prevalence of these rumors and misinformation surrounding the public charge clause within immigrant communities. Yasmin acknowledges that, although they had heard about the potential impact of using government-funded healthcare programs on their immigration status from friends and family, they had not received clear guidance from a legal expert or government source. Notably, she did not encounter any warnings about the rule during the citizenship process nor did they hear about it from a legal professional. Rather, the participant only sought out information on the public charge rule when considering using government-funded healthcare programs, indicating the widespread nature of these rumors within their community and the potentially harrowing effects they can have on preventative and emergency medicine. Yasmin underscores the importance of healthcare providers being aware of and addressing these rumors, as they can significantly impact migrants’ ability to access essential healthcare services, in addition to contraceptive care. As a result of this understanding, it becomes essential for legal stakeholders, policymakers, healthcare professionals, and community workers to taking active steps in dispelling misinformation surrounding the implications of the public charge clause for citizenship and birth control access.

Yasmin emphasizes the fact that, in her opinion, this misunderstanding of public charge determination and the effects of the “public charge rumor mill” have become so entrenched and pervasive across migrant communities because the stakes are so high. When existing in this
in-between of citizen and not, migrants repeatedly sacrifice basic human needs, such as healthcare, to achieve “legal” government recognition.

“Getting that citizenship is an ultimate goal. You don’t want to do anything that jeopardizes that ultimate goal.”

Fatima states that she hasn’t even attempted to access any public welfare or social services due to concerns over citizenship and employment status. Even though she denies knowing about any “public charge” her convictions on the possible impacts of seeking health assistance remain steadfast, which only proves how far-reaching the dissemination of misinformation can be in the United States’ most vulnerable and marginalized populations.

“I have not ever tried any of [public welfare and/or social services. I just have doubts. I just feel I might not be eligible. [...] I just feel like I go out there and I get myself into some kind of trouble and that I won’t be able to get myself out anytime soon. I just feel like I don't really know much. Yeah. I feel it's more like when they say it to you, it sounds too good to be true. When you get and you see actually more you have more to offer than what they have to offer to you.”

Here, we see the pervasiveness of fear and uncertainty that many migrants face when considering accessing government-funded social services. Despite potentially being eligible for such programs, Fatima expresses doubts and hesitations about their eligibility and the possible negative consequences of utilizing such services—that she might get in some kind of “trouble”. She feels but uninformed and increasingly skeptical about the programs and her ability to navigate them, which are only compound by the fact that at the time of this interview, she did not have the appropriate documentation. Furthermore, Fatima notes that, when presented with these programs, they sound too good to be true, and they believe that they have more to offer than what these programs may provide. These concerns illustrate the impact of rumors
and misinformation about the public charge rule within migrant communities, resulting in hesitancy to access aid, while also shedding light on broader skepticism about the government’s ability to provide meaningful support.

Fatima’s lack of legal documentation adds a layer of complexity to her concerns, and ultimately dictates the contraceptive choices she makes. Her preference for birth control pills underscores the importance of birth control options that are convenient and easy to use, particularly for individuals who face logistical barriers tied to seeking in-person care tied to their citizenship status.

“But the [other birth control options] I know of, I guess you have to meet the doctor in person. It doesn’t have to be pills. So that is why I think pills is the best option for me. It’s not just going to see the doctor in person. I’m just worried about going out, leaving my daughter alone, and I wouldn’t want to carry her about knowing this. I’m scared of me not being a citizen yet and taking her along. I just feel it’s best to just remain in with her for safety."

Fatima’s hesitation to attend a medical appointment in person highlights the additional challenges faced by undocumented migrants, who may fear the potential repercussions of interacting with the healthcare system. This fear is only exacerbated by the widespread rumors and misinformation surrounding the public charge clause and downstream potential of jeopardizing citizenship attempts. Additionally, Fatima’s concern for her daughter’s safety is particularly striking, as it reveals the difficult choices that many migrants must make when seeking care. She points out that her concerns regarding immigration status and fear of potential harm intertwine with her desire to prioritize the safety of her daughter, making it difficult for her to leave home to access contraceptive services.
Using further reasoning, increased legal status protection inherently ties to increased comfort when seeking healthcare. Sofia corroborates this logic with her story: as a recipient of DACA, she felt as though she was more capable of seeking out health-related resources and advocating for herself. She observed feeling more comfortable taking advantage of existing opportunities as a result of her status, which highlights the importance of policies that provide a pathway to citizenship or other forms of legal status for migrants in addressed improved reproductive health outcomes.

“It was very hard for me to get any type of healthcare, whether that was reproductive healthcare, just because you’re, like, sharing your information and you don’t know what’s going to happen, like, there’s always that fear, especially, like, I think it helps that I have DACA, which kind of gave me, like, more of a like, okay, I’m safe from deportation. So, I think it would be harder for me if I was like my mom, if I didn’t have DACA, I would probably not go to any healthcare provider at all. I would probably wait until, like, it was really bad pain, and then I had to go to the ER because that’s what my parents did. So DACA kind of helped me put myself out there as far as, like, getting my healthcare needs.”

Sofia’s account emphasizes the significant role that fear and uncertainty surrounding immigration status can play in limiting healthcare access for individuals who lack legal status. Specifically, concerns around disclosing personal information and potential consequences of doing so proved to be a considerable barrier in accessing the contraceptive care she required. Despite this apprehension, Sofia also highlights the somewhat protective effects DACA status has granted, by providing a degree of safety and comfort when accessing the appropriate healthcare resources. Her testimony underscores the potential benefits of policies that protect and support the health needs of migrants, including those lacking documentation, in a more legally binding way.
Sofia expands on the repercussions of the fear from the public charge clause, casting a net that extends beyond the realm of contraceptive care.

“Yeah, I think there's always that fear of taking out any type of funding from the state or federal government if you think maybe a pathway to citizenship would come and that's going to arrange your chances of attaining that. A lot of people don't want to get any type of funding because of that fear.”

Sofia’s insight further acknowledges the interplay between immigration status and healthcare access, as defined by the public charge clause. She notes the widespread concern among migrants regarding accepting any form of funding from the state or federal government typically stems from fears of jeopardizing their future citizenship prospects. This apprehension is especially acute for individuals who already face barriers to healthcare access based on their immigration status, such as language barriers or financial constraints, as they may hesitate to seek resources that could potentially compromise their standing. As demonstrated in the stories above, many migrants may consequently forgo seeking contraceptive care altogether, thus reducing access to birth control.

These findings underscore the importance of culturally sensitive and tailored approaches to contraceptive care that consider the unique challenges faced by migrant populations as a result of citizenship status. As demonstrated by these participant narratives, the impact of the public charge clause and associated rumor mill on contraceptive access has proven to be beyond detrimental. Despite the clause not considering the use of non-cash benefits for public charge determination and accepting Medicaid and CHIP, rumors and misconceptions surrounding it have led many migrants to avoid seeking any healthcare services, including those related to birth control.
Chapter 4: Institutional Barriers

FINANCIAL CONSTRAINTS & INSURANCE COMPLEXITIES

In a country without universal health coverage and a business model of health, individual’s abilities to acquire medication, such as birth control, boils down to a price tag. The consequences of these systems are far-reaching and—in the context of reproductive healthcare—life-changing. A study from the Guttmacher Institute found that uninsured individuals were less likely to use contraceptive methods and more likely to suffer from unintended pregnancies.\(^85\)

In Missouri, of foreign-born individuals (including foreign-born citizens and legal permanent residents), 20% report no health insurance coverage, compared to 9% of U.S. Missourians.\(^86\) These rates soar when looking specifically at non-citizens, where 32% decline receiving any kind of healthcare coverage, either public or private.\(^87\) Non-citizens continue to experience disproportionate financial challenges when looking outside of health coverage status: 42% of non-citizens are at or below the state poverty line, compared to the 29% of their U.S. born counterparts.\(^88\) The profit-driven model of healthcare in the U.S. has left many to grapple with the weight of financial burden, often deciding between their health and their livelihood. As a result, contraceptive decision-making continues to be shaped by citizenship status and its effect on financial capabilities and insurance coverage.

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\(^87\) Migration Policy Institute. (n.d.). Missouri: Profile of the foreign-born population.

\(^88\) Migration Policy Institute. (n.d.). Missouri: Profile of the foreign-born population.
The disproportionate lack of insurance for migrants in St. Louis poses significant roadblocks to the process of seeking contraceptive care. Yasmin, explained that she was forced to stop taking her birth control after losing her job, and was only able to continue after clinic staff took the time to set her up with public health insurance:

“And then after that, it was actually because I lost my job at that point. I didn’t even have access to get more birth control, so they actually set me up with the Obamacare, and I could get birth control.”

As noted, losing in the U.S. healthcare system often means losing access to essential healthcare services, such as birth control. The repercussions prove to be even more dire for migrants, as they required to jump through various rings to receive any sort of government-issued health subsidy. Yasmin, now a PhD student at Washington University in St. Louis, reports an enormous ease in access to birth control services since her transition to the student health insurance plan. Even with more comprehensive health coverage, Yasmin still notes difficulty in seeking her preferred method of birth control. She drew on her experience being told she needed to receive an ultrasound-guided IUD insertion—not offered at the on-campus health clinic—to illustrate the complexities of trying to navigate the health insurance landscape as a foreign-born student.

Sofia, a DACA recipient, echoes this testimony that individuals’ access to healthcare falls on their ability to acquire health insurance. She reminds us that being excluded from federal aid or Medicare further exacerbates the challenges of obtaining insurance coverage.

“So, we’re not eligible for Medicare or any federal aid. The only possible way that you could get health insurance would be from your employment, and that also depends on how long you’re employed with that employer and all of that. So as far as I have a partner, so I could get health insurance through him now, which I
have done, but he just got a new job, so I have to wait until he reaches the amount, he has to stay there for me to be under him.”

Migrants, disproportionately unable to obtain this coverage, are ultimately required to pay for typically covered health expenses out-of-pocket. Fatima discloses these effects of being uninsured on process acquiring birth control,

“Yeah, there was no insurance for me. I've never had any insurance on anything I can remember. It all has to be for my pocket. I’m paying out of my pocket. There's no insurance covering that. I guess I'm so scared to come out of my shell to seek for help, so I just do most on my own.”

These firsthand accounts expose the deep-seated structural barriers to receiving healthcare services without insurance coverage. Without this adequate coverage, migrants are backed into a corner, forced to choose between paying out-of-pocket or foregoing contraceptive care altogether.

When paying out-of-pocket for these birth control expenses, Fatima highlights that these costs are not negligible. She states that, although she has a friend helping her make ends meet for her contraceptive care, the price tag of accessing this remains at the forefront of her psyche day in and day out.

“I have someone that actually assists. A friend of mine, I just give her what I have, and she completely get it for me. So sometimes I give her $30. I give her any amount I have. I don't really have a particular price for this contraceptive, she is the one who gets it directly. So, I just give her what I have.”

Facing inquiry about the qualitative nature of these costs—whether or not she has to account for it every time she spends her money, she chuckled and replied,

“Yeah. Yeah, it's definitely something I have to save up for.”
Fatima describes the ensuing consequences of navigating financial limitations. She states that, given a situation where she is forced to shoulder an unexpected cost or give up birth control, she would do everything in her power to maintain some kind of access to contraceptives:

“I don't think I'm ready to give up that because it's very important to me right now. It's, like, my top priority, so I wouldn't want to give up. […] It's stressful. It is stressful trying to make an extra cost just for the contraceptive.”

Omar and Sofia, respectively, similarly echo this sentiment. Their consumption of birth control and the amount she can access depend almost entirely on her ability to pay.

“It ranges between, it's usually between 30 days I have—usually from 22 dollars to let's say 79, I think. In between those amount it varies depending on the number of days you buy. […] Usually, one month. Yeah, sometimes I get as much as for three months, six months, depending on my financial capability.”

- Omar

“[What are the biggest challenges with contraceptive costs?] I think not knowing where to go get contraceptive and how you're going to be able to pay for that because that's like something you have to pay every time you run out.”

- Sofia

This understanding and interaction with birth control costs expose the harsh realities for migrant access to contraceptive care in St. Louis. Fatima emphasizes that her current financial capability dictates of often she can visit a healthcare provider and acquire birth control. This illustrates the pervasive predicament faced by migrants—who are disproportionately impacted by limited resources—as they decide the frequency with which they can access this critical component of healthcare.
When discussing the role of limited financial capacities on contraceptive care for migrants in St. Louis, the Missouri Refugee Health Coordinator, expands on how an avalanche of fast-paced decisions cause an enormous amount of pressure. This stress inevitable translates to migrants struggling to receive the healthcare they need.

“They're like there's a lot of things they have to remember and do. They're getting enrolled in the benefits, getting their kids in school, getting jobs, learning how to pay their bills. A whole lot, in the very beginning, it's like front loaded. I think maybe that's a barrier within the overall system is that a lot is so front loaded you have people that are just trying to get adjusted and they're needing to absorb a lot of information in a short amount of time.”

When migrants first arrive in St. Louis, they must cope with a wide range of challenges and decisions, including enrolling in benefits, finding work, learning how to pay their bills, and enrolling their children in school, and so on. The sheer volume of these responsibilities become undoubtedly overwhelming, especially seeing as they must be completed in such a short amount of time.

Additionally, she explains that this initial transitory period is the time when most agencies can provide far-reaching support for these individuals. While there exist programs that serve people for a longer period of time, they are inherently more limited and may only be available for individuals who are struggling and need extra assistance. This phenomenon suggests that migrants who appear as being able to “manage on their own”, but in reality face financial constraints, may not have access to these programs required to receive discounted or sliding-scale birth control.

Sofia experienced this lack of sufficient financial resources and the mismatch between what agencies currently provided and is required firsthand:
“During [the time I was first seeking contraceptive care], I was working full time and only going to school part time, so [I had no difficulties affording birth control]. But now it kind of it's different because I'm going to school full time and I'm not unemployed, so that's very difficult because then I'm not insured so I am trying to apply to the JFK Clinic. And that's another barrier because now I'm married, so they're looking at my husband's income. And so there tends to be, like, a cap of, like, how many people live in your household and you know, the proper relief level. And even though, like, we're barely making it to qualify for certain programs, you might be out of that income that they're looking for. So that's something I'm looking at now because that's where I am. I'm like, okay, well, we're making enough to make a living, so it's kind of, like, really hard right now.”

This narrative highlights how existing resources do not adequately account for the lived experiences of migrants struggling to afford reproductive healthcare in St. Louis. Although Sofia has no current income and her husband is in-between jobs—leaving them without health insurance—they are still barely making enough to qualify certain financial support programs, including the ones for contraceptive care, due to their joint-income status.

Ultimately, the Missouri Refugee Health Coordinator underscores the importance of recognizing the complex and mutually influencing factors, included financial constraints, that can limit migrants' access to contraceptive care in St. Louis. She describes more specifically the undeniable value of increased funding for expanded education provided by resettlement agencies such as her own.

“I think that's kind of an area that could be seen as a barrier or an area where if we had a little bit more funding for that expanded education, I think is, potentially, something our health promotion money could be used for. And our programs, there's some guidelines that are provided federally and the funding that we're providing to resettlement agencies, they're going to identify populations that are most in need and come up with programming. But access to contraception and or conversations around reproductive health can be had it might be challenging to get it
pulled together in a time and place that people really seeking information can access it.”

This powerful testimony serves as a call to action for policymakers and healthcare practitioners to address the systemic barriers that hinder the access of migrants to vital healthcare services. Importantly, her reflection addresses a more nuanced understanding of financial constraints for St. Louis migrant population—one that may not be intrinsically reflective in existing quantitative census data.

The problems with these “hidden costs” go beyond insufficient federal funding. When asked about the cost of birth control, Omar, described difficulty not with the cost of the medication itself but rather with the transportation costs incurred as he traveled to the clinic.

“Initially it was difficult for me when I came in as a new resident and some different time, one of the major challenges I faced was the distance to the clinic and the cost of transporting myself to clinic. I think it was just that too. And then go to the local provider, the cost is always on high side. [...] Those were major problems I had here.”

He specifies, that because most busses leave so early, he would have to take significant time off work, thus foregoing an importance source of income and highlighting yet another “hidden cost”. Considering the limited reach of St. Louis’s public transit system, this issue is only compounded for migrant residents living further away from central St. Louis, where living costs are lower.89

The absence of widespread healthcare coverage in the United States, intertwined with a healthcare system driven by profits, has far-reaching implications for an individual's ability to obtain contraceptive care. The ramifications are particularly harsh for migrants, who face

unequal financial obstacles and are more susceptible to being uninsured. Consequently, their access to contraceptives is often molded by their citizenship status and the impact it has on their financial means and insurance coverage. The narratives shared by participants illuminate the deeply entrenched structural barriers to receiving healthcare services in the absence of insurance coverage, forcing migrants to make a difficult choice between paying out-of-pocket or relinquishing contraceptive care altogether. The exorbitant cost of contraceptives further compounds the financial burdens endured by migrants, who must often save up to afford them and are confronted with challenging choices when unforeseen expenses arise. Overall, the existing healthcare system sustains disparities in the access to reproductive healthcare, leaving countless individuals without the care they require to make informed decisions about their reproductive wellbeing.

**LANGUAGE BARRIERS**

Language barriers can have significant effects on migrant women's ability to access contraceptives and make informed decisions about their reproductive health. Migrant women who do not speak the dominant language fluently may face linguistic and cultural barriers when seeking reproductive healthcare services, including contraception, in a country where they are not proficient in the language. These barriers can prevent migrant women from obtaining necessary information about contraception, making informed decisions about their reproductive health, and accessing the services they need.

One study conducted in the United States found that language barriers are a significant obstacle for Latinx immigrant women seeking reproductive healthcare services, including
The study found that Latinx immigrant women who did not speak English fluently were less likely to receive contraception counseling and less likely to use effective contraception methods. They were also more likely to experience unintended pregnancies and abortions compared to Latinx immigrant women who spoke English fluently. The study suggests that language barriers may prevent Latinx immigrant women from fully understanding their reproductive health options and making informed decisions about their reproductive health. Furthermore, another study conducted in the United States found that language barriers were associated with lower rates of contraceptive use among Hispanic immigrant women. These women were less likely to use contraceptives if they had limited English proficiency or if they encountered language barriers in healthcare settings.

A similar study conducted in Canada found that language barriers were a significant barrier for immigrant women seeking reproductive healthcare services, including contraception. The study found that immigrant women who did not speak English or French fluently were less likely to receive information about contraception, less likely to use effective contraception methods, and more likely to experience unintended pregnancies compared to immigrant women who spoke English or French fluently. These findings highlight the importance of language access in enabling immigrant women to make informed decisions about their reproductive health and access necessary healthcare services.

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There are several factors that contribute to the impact of language barriers on migrant women seeking contraception. One factor is the lack of language services and interpretation services at healthcare facilities. Migrant women may be hesitant to seek healthcare services if they are not confident in their ability to communicate with healthcare providers or if they fear being misunderstood. This can prevent them from receiving necessary information and services, including contraception.

Overall, language barriers can have significant impacts on migrant women's ability to access contraception and make informed decisions about their reproductive health. Additionally, some migrant women may be hesitant to seek out such services due to cultural beliefs or social stigma surrounding reproductive healthcare. This can be exacerbated by language barriers, as migrant women may have difficulty accessing information and support from healthcare providers or community resources that could help them navigate cultural and social norms. By addressing language barriers and providing culturally sensitive care, healthcare providers can help ensure that migrant women have the information and support they need to make informed decisions about their reproductive health and access necessary healthcare services.

Yasmin summarizes these challenges when describing her experience navigating the reproductive health scene as a native Persian speaker:

“And I don’t recall now, but because I speak Persian, and this is not one of those languages that interpreters are readily available. If it's Mandarin Spanish, it's like more available. And especially with being in Montana, I was living here for like couple years, but I didn’t

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have any knowledge of medical vocabulary, so I was really scared of going to the doctor and what's going to happen. But when I went there, the first question, my roommate was with me and they basically walked through everything explained, which was good because it gave me an overview.”

Her story highlights the challenges faced by individuals who speak languages that are not commonly available as interpretation services, such as Persian. Yasmin notes that it can be difficult to access interpretation services in these languages, which can make it difficult to communicate with healthcare providers and understand information about reproductive health. Additionally, she mentions that she did not have knowledge of medical vocabulary, which can further hinder their ability to communicate about their healthcare needs and understand information provided by healthcare providers. However, Yasmin notes that she received some support from their roommate, which helped them to understand information about their healthcare and gave her an overview of the process. Overall, this quote illustrates the challenges faced by individuals with limited language proficiency and lack of familiarity with medical vocabulary when seeking reproductive healthcare services, and the importance of access to interpretation services and support from others in overcoming these challenges.

Omar expressed a similar difficulty attempting to obtain a medical translator for a language other than Spanish when seeking healthcare advice:

“Yeah, it's usually complicated, but most times I ask questions and I get Spanish translator. It is always when the physician gets to explain better that I get to know.”

This quote suggests that the individual has experienced difficulties accessing translation services when seeking birth control. The individual mentions that it is "usually complicated" to obtain translation services, and that they are often only able to access Spanish translators.
Regardless of the limited range of translator options, Omar explains there is "always" a better understanding when the physician can explain things. This observation suggests that the individual may struggle to fully understand information about reproductive health and contraceptive options without the support of translation services. However, the individual's ability to ask questions and the effectiveness of the physician's explanations suggest that they are actively seeking information and trying to overcome language barriers to make informed decisions about their reproductive health. Overall, this quote illustrates the challenges faced by individuals with limited language proficiency when seeking reproductive healthcare services and the importance of access to translation services in helping them to make informed decisions about their health.

When asked if they would have had an easier time navigating the healthcare in their country of origin, Lebanon, due to these languages, Omar expressed,

“Yes, I would have. Definitely. I would have easier time. Yeah. I would've had easier access to most of those resources because of my ability to, you know, lobby. That's where I come from. So, it's going to be much easier for me. Yeah.”

This response suggests that Omar believes that he would have had an easier time navigating the healthcare system in their country of origin, Lebanon, due to his ability to "lobby" and his familiarity with the cultural and social norms of the country. Omar notes that he would have had "easier access to most of those resources" and that it would have been "much easier" for him overall. This observation suggests that language barriers and lack of familiarity with the healthcare system and cultural norms may have presented challenges for Omar as he sought reproductive healthcare services in a country where he feels less proficient in the
dominant language. Overall, this quote illustrates the importance of language proficiency and cultural familiarity in enabling individuals to access and navigate healthcare systems and obtain necessary healthcare services, including contraceptives.

Yasmin notes that she experienced difficulties understanding information provided in Persian, even when it is written, and that she sometimes feels that interpretation services will only serve to further confuse her.

“And this is not only like with a medical system, but I have seen this when you go, I don't know, to the Social Security office, whatever they are providing as a person speaking or it's not right. So, it's more confusing at a time when you read the sentence that it's supposed to be in Persian and you're like, okay, I sometimes get the feeling of, okay, whoever they're going to bring is just going to make me more confused. But it's just easier to start from basic terminology like a nurse practitioner. I build up on that.”

This quote highlights the challenges faced by individuals when accessing services, such as reproductive healthcare, in a language that they are not proficient in. Yasmin suggests that it is easier to start with basic terminology, such as that used by a nurse practitioner, and build upon this knowledge. Although language barriers undoubtedly hinder individuals' ability to fully understand and make informed decisions about their healthcare, starting with basic terminology can help to overcome these barriers. This situation illustrates the challenges faced by individuals with limited language proficiency when seeking reproductive healthcare services and the importance of access to interpretation services and clear, simple communication in helping them to make informed decisions about their health.
Beyond mere language barriers, participants also described experiences of discrimination rooted in a belief that they do not speak English proficiently. Sofia describes one such instance:

“There's a lot of systemic racism in the healthcare. I'm trying to think about a time where I personally faced. I think there's this stigma of me showing up at a doctor's appointment and just because I look Latina, a lot of people think that I don't know English, so they would automatically ask me if I needed a translator or try to talk to me in Spanish, and it was just like, I know English.”

This experience highlights the impact of systemic racism on individuals' experiences accessing healthcare services, including reproductive healthcare and contraceptives. Sofia notes that she had experienced a stigma and assumptions about their language proficiency based on their appearance as a Latina person. Sofia explains that healthcare personnel often automatically assume she needs a translator or to speak Spanish, even though she is fluent in English. This interaction suggests that language barriers can be exacerbated by biases and assumptions about individuals' language proficiency based on their appearance or ethnicity.

Sofia’s experience highlights how language barriers and system racism intersect within the healthcare system, ultimately impacting an individuals' ability to access and understand birth control information and make informed decisions about their contraceptive choices.

Sofia further notes that there may be language barriers and that some resources may require information about immigration status, which can be difficult for undocumented individuals to share (the participant herself had DACA status while her parents were considered legally undocumented). She describes her own experience as a translator for her parents to paint the picture, reflecting on the fact that she does not share their same difficulty navigating
the medical landscape as she was able to learn English, the language of her host country, growing up.

“[As for as contraceptive health goes] I think that's also another one because there's not much education on it, and there's also that language barrier to it. And, when you do qualify to certain resources, they might need to ask you for immigration status, which if you're undocumented, that's going to be hard for you to share. Okay. So, when I grew up as the translator for my parents, that's how I know about it. As far as for myself, thankfully, I didn't have to go through that because I was raised here. Even though I wasn't born here, I was able to learn English.”

This story illustrates several challenges faced by individuals when accessing reproductive healthcare services and contraceptive care due to language barriers. Sofia notes that there is a lack of education on reproductive health, which can make it difficult for individuals to understand their options and make informed decisions. She also notes that language barriers can be an additional challenge when seeking reproductive healthcare services, and that the requirement to provide immigration status when accessing certain resources can be a barrier for undocumented individuals, specifically. Sofia notes that she has personal experience serving as a translator for her parents, who are undocumented, which suggests that she is familiar with the challenges faced by individuals with limited language proficiency in accessing healthcare services. Importantly, Sofia notes that she herself not personally faced these specific language barriers due to being raised in the country and learning English.

These narratives highlight several challenges faced by individuals accessing contraceptive care due to language barriers. One challenge presented is the lack of access to interpretation services in languages other than Spanish, which can make it difficult for
individuals who speak languages such as Persian to communicate with healthcare providers and understand information about reproductive health. Another challenge is the lack of familiarity with medical vocabulary, which can make it difficult for individuals to understand and communicate about their healthcare needs. Additionally, these narratives highlight the impact of systemic racism in the healthcare system, including the assumption that individuals who are Latina do not speak English and the need to provide immigration status when accessing certain resources, which can be a barrier for undocumented individuals. These accounts demonstrate how language barriers can hinder individuals' ability to access and understand information about reproductive health, leading to challenges in obtaining necessary information and treatment pertaining to birth control.

MEDICAL MISINFORMATION

For individuals to make informed decisions regarding their reproductive health, it is crucial that they receive consistent access to accurate, comprehensive, and reliable medical information. The presence of medical “misinformation”, such as limited knowledge of birth control options available or lack of side effect awareness, permeated throughout my interviews. The survey found that 25% of participants did not feel well-informed regarding their contraceptive decision, which can be compared to a national survey that reported 30% of females felt they received all the information they needed before choosing their birth control method.94 This low level of information satisfaction across the board, compounded with the

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even lower rate for migrants, highlights the urgency of addressing this gap in contraceptive education.

Similar to national levels, where 33% and 32% of reproductive-aged women use oral contraceptives and male condoms, respectively, the majority of participants in this study disclosed relying on condoms and/or the pill as their primary method of birth control. Further analysis reveals that this choice is consistently made without thorough information on the full range of contraception options available. Fatima reported not receiving any printed material that detailed the benefits or drawbacks of various forms of birth control, explaining that,

“I asked questions, and I was told this is the least side effects, that others have more complicated side effects [...] I didn't get any proper information. It was just spoken to me.”

Ultimately, this lack of information has caused Fatima to stick with her current birth control method which is less suited to her lifestyle than other alternatives, as she does not have the coverage/ability to seek medication changes and contraceptive counseling in the near future. Another participant, Simi expressed frustrated over medical professionals’ failure to convey sufficient information on longer-acting, lower-maintenance, and more efficient contraceptive methods. Universally, participants recount having to do their own extensive research to identify potential side effects and success rates.

These cycles of limited reproductive health information knowledge are often generational, which exacerbates this existing gap. Sofia states that,

“[in terms of sexual health education] Right, there wasn't much at all, to be honest. My mother grew up without any, like, sexual health education, so I actually had to educate her on the different contraception. As far as my knowledge of it, there was barely any besides, like, use condoms.”
Her personal account of educating her own mother on the subject of sexual health, illustrates the significant information void within the migrant population of St. Louis.

Ultimately, this narrative exposes the widespread insufficiency in reproductive health knowledge and pressing need for comprehensive sexual health education to reduce medical misconceptions and promote informed decision-making among Missouri’s migrant community.

Instances of medical misinformation in the realm of reproductive health extend beyond simply being unaware of the totality of options—they can have direct and debilitating consequences on individual health. Fatima’s account illustrates these impacts:

“I wouldn’t say I was well informed of all the side effects, because after ingesting this, I found out about side effects that I had no idea about. It’s a headache. I have this headache. It comes and goes for, like, three to four months. I literally had no idea [about the possibility of getting headaches]. I went for these contraceptive use, thinking there would be no side effects, so I had no idea about that. [These headaches] do get in the way [of day-to-day activities] because it’s so frustrating, and when it comes like that, I just need to lie down for hours before I get myself for that day, and then it comes off again, so it really gets in the way activities. Yeah, it does interfere with daily activities and take care of my daughter. But when it comes to taking care of my daughter, I just have to ignore and do. what I can do what I have to do for her.”

Fatima’s story emphasizes the pervasive issue of medical misinformation and misconception surrounding contraceptive side effects within the migrant population. Not only was she poorly made-aware of her contraceptive options, but this misinformation also resulted in frequent and incapacitating symptoms. Fatima’s experience is further complicated by her fear of taking any medication, such as ibuprofen or acetaminophen, to alleviate her headaches. This fear stems from concerns over drug interactions, and how taking over-the-counter pain management could worsen her health or reduce the effectiveness of her birth control.
Unfortunately, because she receives her oral contraceptive pills through a friend who knows a doctor—whom she has never met or interacted with directly—she has no recourse to address these concerns. Being a migrant exacerbates your risk of medical misinformation for a variety of reasons, but also reduces the number of resources to which you can turn to help target specific health issues caused by ill-suited contraceptive care. The lack of knowledge and misconceptions surrounding birth control options and their side effects among this migrant population in St. Louis demonstrates a critical need for enhanced contraceptive programming that is both readily accessible and culturally contextual, in addition to improved lines of communication between educational entities, healthcare providers, and patients.

Oftentimes, the burden of explaining medical information or presenting various options falls on the shoulder of clinical personnel, who already face increasing pressure to provide thorough healthcare in shorter appointment timeframes.95 For migrants, this expectation holds particularly true, as the patient-physician relationships may be one of the few interactions with the health sphere they have due to health literacy barriers. Omar explained that although he is technological adept enough to extrapolate birth control drug information from the Internet, he does not take any of it into consideration—side effects or safety—unless it has explicitly received his physician’s seal of approval.

Ignoring this growing gap will only deteriorate reproductive health outcomes. Thus, when identify points of weakness for contraceptive care in St. Louis, particularly as it pertains to migrants, clear, accurate, and comprehensive information communication lines must be

established. Importantly, these educational initiatives could offer a way to alleviate healthcare worker’s load, while ensuring migrants in the area feel well-informed with their contraceptive and medical decision-making.
Chapter 5: Requested Needs & Next Steps

“To the lawmakers, I would say they should probably put themselves in our shoes and try to make things easier for us. Like me meeting a doctor through a friend: she’s a friend, but she is human—I can’t really trust her. Whatever she gives to me, I have no option than to take it, and someday it could be dangerous or poisonous to my health. So, it’s not really safe. We hide in our shells because of the lawmakers out there is indirectly putting our lives at risk. So, they [the lawmakers] should try making the law equitable as a favor to us which would be really appreciated. [...] I would have asked first information, and stop being scared, and just move out and try those centers that would have been of help to me, the insurance, the community centers, instead of hiding in my shell and getting medication from someone I hardly see. So, I’ll advise them to just step out, get information, and see what comes out of it.”

- Fatima

This research underscores the complex and multifaceted nature of contraceptive care and access for migrants in St. Louis. As we move forward in addressing the glaring disparities on healthcare, it is crucial to illuminate stakeholder voices in reproductive health inequity. Ultimately, this chapter serves as a call to action for policymakers, healthcare systems, and individuals alike to work towards a more just and inclusive healthcare system.

This chapter seeks to shed light on the specific needs and desires expressed by migrants regarding contraceptive care and access in St. Louis. Throughout these conversations, several key changes were expressed. Firstly, increasing access to contraceptive care from an informational standpoint, reducing the fear associated with seeking help, offering birth control options beyond oral contraceptives, and minimizing the financial strain on individuals. By centering the migrant narrative in the discourse of “next steps”, the conception, provision, and distribution of contraceptive services can be more demographically contextual.

REQUEST I – IMPROVED RESOURCE ACCESS & INFORMATION
Although there exist various resources and low-cost clinics throughout the St. Louis region, such as Casa de Salud, Planned Parenthood of St. Louis, Affinia, and the Contraceptive Counseling Center, very few participants expressed knowledge of these resource. Moreover, when asked about their requested needs, increasing information available on points and pathways to access care were repeatedly mentioned.

Despite the local presence of services, as stated above, participants emphasized the need for information on accessing them to be widely publicized throughout the community. As Yasmin noted,

“It's just like if I knew better that there is something like Planned Parenthood to begin with.”

Beyond this, participants, voiced concerns regarding limited resource on how to begin the journey towards contraceptive care in the first place:

“I think there was not enough explanation in my personal experience on accessibility and how it goes back to me knowing who to talk to and how I could get contraception, because otherwise I would have no idea where to go.”

This lack of awareness underscores the need for given the significant need for expanded access to contraceptive, beyond merely a physical presence. Migrants face a particularly pressing need for enhanced guidance navigating the healthcare system and accessing birth control, as studies have shown migrants are significantly less likely to have a primary care physician (PCP) compared other demographics. Although exact data remains limited, one study conducted by the Migration Policy Institute found that immigrants, both documented and undocumented individuals, are less likely to have a usual source of healthcare, including a PCP,
compared to native-born individuals, which inherently impact reproductive health access. This experiences was corroborated by Iman, who, when asked about items requiring most urgent changes to support migrants and their reproductive choices, points to "the knowledge and the access to facilities. Like I don't know exactly where to go since I don't have a PCP." Without a PCP, migrants may not know where to turn for contraceptive care in the first place, exacerbating existing health barriers. As a result, improving information on accessing birth control proves to be crucial to begin addressing these gaps in reproductive health equity.

The need for improved resource access for migrants seeking contraceptive care in St. Louis extends beyond physician contracts; expanding written materials and publicizing clinical sites are fundamental. When asked how she wishes she had navigated her journey with contraceptive care, Fatima explained,

"I would have asked for information and stopped being scared and just moved out and tried those centers that would have been of help to me, instead of hiding in my shell and getting medication from someone I hardly see."

Her reflection highlights the perceived lack of safety that ensues unfamiliarity in accessing contraceptive care facing migrants throughout the St. Louis region. Furthermore, it also sheds light on practices of resorting to unsafe potentially dangerous methods of obtaining medication. Her use of the phrase "hiding in my shell" alludes to the sense of isolation many migrants feel as they experience minimal support in their efforts accessing contraception and underscores the need for increased outreach and education pertinent to resource availability.

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Overall, Fatima’s perspective reveals that expanded contraceptive access goes beyond simply having low-cost clinics and programs available: it means ensuring those in need of this care are provided with widely available, accurate, and clear information on its existence in the first place.

This articulated need for enhanced outreach was echoed by several other participants throughout this study. More specifically, Simi, who emphasized the importance of education and awareness in accessing contraceptive care, noted that,

“If folks are given proper education and information about this, the chances of being misinformed will be reduced, they will be a helpline to assist you in getting better contraceptive.”

She continues by suggesting educational seminars among other forms of outreach campaign to begin addressing this widespread lack of resource awareness as well as sexual education.

REQUEST II – REDUCED FEAR

When asked about the most pressing changes that need to occur when it comes to reproductive health, Participants consistently expressed a need for increased comfort and reduced fear when accessing these services. Yasmin spoke of the need to not be afraid of losing citizenship status when seeking help, stating that, "going through and not being afraid of losing citizenship because I'm seeking help now that would actually help a lot." As noted in Chapter 3, much of this discourse ties back to the public charge clause and its associated rumors. Participants point to concerns for self-reliance and citizenship effects as needing to be addressed prior to promoting the use of public welfare to seek birth control. Simi revealed that
she was afraid of being withdrawn from school if her sexual activity was discovered, while another participant emphasized the importance of creating safe spaces for migrant individuals to discuss their bodies in relation to reproductive health:

"We need to talk about how immigrant people can get contraceptives and be comfortable in sharing what their body is going through, because if there’s not, like, that safe space, then yeah."

This shared unease when seeking contraceptive care is intrinsically tied to the migrant identity and unique to their experience in the United States. Regardless of the misinformation behind these concerns—as discussed in Chapter 4— they all indicate an urgent need to address fear of potential citizenship impacts of seeking birth control, especially via low-cost or public clinics.

REQUEST III – MINIMIZED FINANCIAL STRAIN

Migrant participants in St. Louis articulated a clear need for reducing financial burdens when it comes to acquiring birth control. As discussed in previous chapters, many participants noted that cost was a significant barrier to accessing birth control, with some citing it as their biggest obstacle for contraceptive care. Iman expressed specific concern about the cost of appointments, explaining that,

"[her biggest obstacle to care] is cost. I think to myself, well now if I need to get an appointment somewhere I have to pay for that."

In her situation, even after having jumped through hoops to secure an appointment, she is still thwarted by her ability to pay. The overarching concern of financial strain highlights the
need for greater accessibility to and awareness of affordable contraceptive care options for migrants.

Omar goes on to suggest the possibility of government intervention when it comes to these economic constraints:

“What would have been the best option would have been for the government to do more in the aspect of having this pills for immigrant at discounted rate.”

Programs such as this have already been widely implemented across the world. In Italy, undocumented migrants can receive free or low-cost contraceptives from family planning centers run by the national health service.97 Similarly, Thailand’s Ministry of Public Health provides free contraceptive services to all women, regardless of their nationality or immigration status, through a network of public health clinics and hospitals.98 These programs demonstrate how governments in various countries have already begun implementing programming focused on relieving financial hardships in reproductive care by providing affordable and/or free birth control services, regardless of immigration status.

AFGHAN ARRIVALS: A STEPING STONE

During my conversation with a member of the U.S. Committee for Immigrants and Refugees in Missouri, they highlighted the opportunities for change and innovation in the realm of migrant healthcare that have emerged with the arrival of Afghan refugees in St. Louis.

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In August 2021, following the Taliban takeover and US withdrawal of troops in Afghanistan, the US government launched Operation Allies Welcome, which aimed to evacuate and resettle Afghan allies, including interpreters, drivers, and others who had worked with the US military and government over the past two decades.\footnote{U.S. Department of State. (2021, August 17). U.S. Launches Operation Allies Welcome. [Press release]. https://www.state.gov/u-s-launches-operation-allies-welcome/} St. Louis has been one of the major cities for this broad resettlement effort, with Missouri state welcoming over 1,200 Afghan refugees.\footnote{KSDK News. (2021, September 2). Afghan refugees resettling in Missouri with assistance from community organizations. https://www.ksdk.com/article/news/local/missouri-community-organizations-helping-afghan-refugees-resettle/63-828d0016-7d6f-42e5-93de-69a9cb870f12}

The emergency response to the Afghan crisis required the quick implementation of ideas that had only been theoretical before, resulting in new programs and initiatives that can inform resettlement efforts in the future. This includes increased collaboration between federal and state partners, as well as potential private sponsorship programs that could sustain welcoming communities for migrants. They described observing a distinct reprioritization program and policy development,

“...what we saw happen this last year is this operationalized welcome with the evacuation of the Afghans really was an emergency response that required domestic partners to do things that maybe had only been ideas before. They had to be implemented even maybe before they had been piloted, but just existed somewhere on paper, and we just need to get people into communities. And so, there was a lot of new things that were piloted or done that now I think have informed resettlement. There’s kind of different efforts at the federal level with the different federal partners that are communicating maybe in a more strategic way than they have together.”
With this mindset shift comes an opportunity to advocate for immediate and sweeping policy changes that prioritize the healthcare needs of new arrivals. They explain that although there exist limitations in what individual offices can accomplish, continued collaboration and research can effectively inform federal programs on their next steps. As a whole, the unprecedented and sudden arrival of Afghan refugees grants individuals, governments, and organization, a momentum to capitalize on when discussing and enacting changes to providing care—including birth control services—for migrants in St. Louis.

**PILOTING A MENTORSHIP PROGRAM**

“I wish that there is more talk about in those communities, such as if we know that people go to Casa de Salud or they go to JFK or they go to Affinia, like having a person talk to people about contraceptives and sexual reproductive rights. They need to have a specific person that somebody can go to. And I feel like, I think it’s called ISPN, which is like a network of organizations that work with the immigrant and refugee population maybe like, I don’t know. I feel like there’s nobody that really talks about that. There’s no direct person that you can go to and kind of get resources to people.”

- Sofia

Applying the SEM framework present throughout this thesis, the creation of a mentorship program for migrants to access contraceptive care in St. Louis could effectively address the dynamic interplay of individual, interpersonal, community, and societal factors that influence sexual health behavior and outcomes. In this framework, individual behavior is shaped by broader social, cultural, economic, and political forces that operate at different levels of influence. A mentorship program could begin addressing the broader social, cultural, economic, and political forces operating to influence migrant reproductive decision by providing individual-level guidance. Beyond offering one-on-one support, a mentorship
program could also foster a sense of community throughout the isolating experience of seeking contraceptive care.

Such a program would work by pairing both new arrivals and established migrants with local mentors who have experience navigating the US healthcare system and sexual health services as a foreign-born individual. Mentors would help refugees schedule appointments, understand their contraceptive choices, connect them to accessible resources, and provide additional guidance on required paperwork, insurance policies, and pharmacy options in St. Louis. The mentorship program could be integrated and administered through the health & wellness branches existing resettlement agencies, such as the International Institute of St. Louis.

Previous research has demonstrated the efficacy of similar health mentorship programs within marginalized populations. One study of a mentorship program implemented via an integrated care model for youth living with HIV found that the program led to increased adherence to medication, improved mental health, and reduced risky behaviors.101 Another mentorship program review, this time for immigrant and refugee women, asserted the program led to improved knowledge and attitudes about breast and cervical cancer screening, in addition to increased uptake of screening services.102 These examples demonstrate the potential of mentorship programs to promote health and well-being among migrants, and support the integration of newcomers into their communities.

At the individual level, mentorship programs provide education and support to migrants on navigating the ever-change reproductive health landscape of Missouri, understanding their various birth control, and addressing any concerns or questions unique the migrant identity. At the interpersonal level, mentors can help foster positive relationships between migrants and healthcare providers, which could instill improved communication, trust, and satisfaction with care. Furthermore, at the community level, mentorship programs can help build social networks and connections among migrants, providing social support and promote collective action to address broader community health needs beyond those of sexual health—an often-taboo subject. Finally, at the societal level, mentorship programs can help shed light on systemic barriers to care and health-seeking behaviors so that policy changes may be more culturally contextual. The SEM framework underscores the need for a multilateral approach to the aforementioned contraceptive care challenges. By providing guidance and support, such a mentorship program could help migrants in St. Louis overcome the various barriers to accessing contraceptive healthcare, navigate the overlapping influences at play, and empower them to make informed decisions about their reproductive choices.
**Conclusion**

**SUMMARY**

This thesis shed light on the complex array of social ecological factors and their associated dynamics that shape access to contraceptive care for migrants in the St. Louis region. Through ethnographic research, survey data, and literature reviews, this study has illuminated the multiple levels—individual, interpersonal, and societal—at which challenges to access operate for this population. This project applied the social ecological model to analyze anticipated barriers to care, such as language, financial, cultural, medical, and resource-related constraints, as well as more novel challenges, including the effects of the public charge clause and the radical power of social support.

At the individual level, this study has demonstrated the effect of social and cultural factors on migrant contraceptive decision-making. Significantly, migrants' beliefs, values, and practices around sexuality, reproduction, and family planning continue to be influenced by a range of cultural, religious, and community-specific norms and expectations. These personal backgrounds inevitably impact contraceptive priorities and degree of comfort experience by migrants as they seek birth control.

At the interpersonal level, this study has highlighted the consequential barriers to care faced by migrants, including cultural stigmatization and the associated radical power of social support. Social support networks, both formal and informal, can have a profound impact on migrants' access to care. Social support can help to mitigate some of the anticipated and socially determined barriers to care, but it can also reinforce certain cultural norms and expectations around contraception and family planning. As shown by the rumor mill
surrounding the public charge clause, addressing these obstacles goes beyond merely changing policy. The impact of the public charge, which allows the government to deny visas or green cards to immigrants who are deemed likely to become dependent on public assistance, has created a climate of fear and uncertainty for many migrants in St. Louis that cannot be remedied by only expanding health coverage.

At the institutional level, this study has delved into the system-level barriers to care that migrants face, such as language challenges, financial/insurance constraints, and the dissemination of medical information. These issues plague the larger U.S. healthcare network and disproportionally affect the migrant demographic as a result of systemic health inequities.

Moving forward, this thesis proposed potential next steps, grounded in migrant experiences, for improving access to contraceptive care. By enacting interventions and policies that address the hidden barriers to care and are contextually grounded, stakeholders can work towards reducing reproductive health inequities in St. Louis. Ultimately, this thesis advocates for a more comprehensive and culturally informed approach to addressing contraceptive health inequities faced by migrants across Missouri.

LIMITATIONS

This study acknowledges the limitations of its design, which may affect the generalizability of its findings. While every effort was made to conduct a thorough and comprehensive examination of the social ecological factors that shape access to contraceptive care for migrants in the St. Louis region, there are several limitations that must be considered and acknowledged when reading this thesis.
Firstly, the sample size of this study is limited to migrants residing in the St. Louis region. Therefore, the findings of this study may not be generalizable to other regions, or even other cities within the same region. Furthermore, while efforts were made to include a diverse range of participants, it is possible that the experiences and perspectives of those who did not participate in this study may differ from those who did. Although the survey phase of the approach expands the participant pool, these limitations are exacerbated by a small participant group.

Secondly, this study was conducted primarily from June to December 2022, while the US healthcare systems continued to suffer ramifications of the COVID-19 pandemic. The impact of the pandemic on healthcare delivery and supply chains cannot be understated, as a result, there may have been decreased availability and accessibility of reproductive healthcare services. Moreover, the pandemic has had a disproportionate impact on marginalized communities, including migrants, who may have experienced additional barriers to care. Therefore, the findings of this study may not be fully representative of pre- or post-pandemic conditions.

Finally, it is important to acknowledge that this study is not immune to the subjective nature of qualitative research. While every effort was made to reduce the potential influence of the researcher's own biases and assumptions, the interpretation of the data may have been influenced by my own perspectives, experiences, and university coursework.

Despite these limitations, this study provides a critical contribution to the literature on access to contraceptive care for migrants in the St. Louis region. The findings of this study
provide a basis for further research and policy interventions that aim to reduce reproductive health disparities and promote equitable access to contraceptive care across Missouri.

FUTURE RESEARCH

This study has begun exposing the complex web of social ecological factors that shape migrant access to contraceptive care in the St. Louis region. While the findings of this study provide a foundation for understanding the challenges that migrants face in accessing reproductive healthcare, there is still much that remains to be explored.

Future research in this area should aim to expand the scope of inquiry beyond contraceptive care and examine the broader landscape of reproductive healthcare for migrants. This could include an examination of the experiences of migrants seeking prenatal and post-natal care, cervical cancer screenings, and mammogram access. Continue research could also examine the recent Dobbs v. Jackson Supreme Court decision, reversion federal protection of abortion services, and its impact on migrant populations at a local and national level.

Furthermore, future research should aim to explore the potential impact of policy interventions on improving access to reproductive healthcare for migrants. Such research could examine the effectiveness of policies such as the Affordable Care Act, which provides insurance coverage for many reproductive health services, on improving access to care for migrants. A comparison of migrant contraceptive care between the US and foreign countries could also offer valuable insight in effective system-level solutions.

Finally, future research should continue to prioritize the perspectives and experiences of migrants themselves. By centering the voices and experiences of migrants, future research can
ensure that interventions and policies are grounded in a deep understanding of the contexts in which these experiences are embedded. Ultimately, this study has provided an in-depth exploration of the social ecological factors that shape access to contraceptive care for migrants in the St. Louis region. While the findings of this study have shed light on the multiple challenges migrants face, future research should aim to delve deeper into the complexities of access to birth control services for this population in St. Louis.