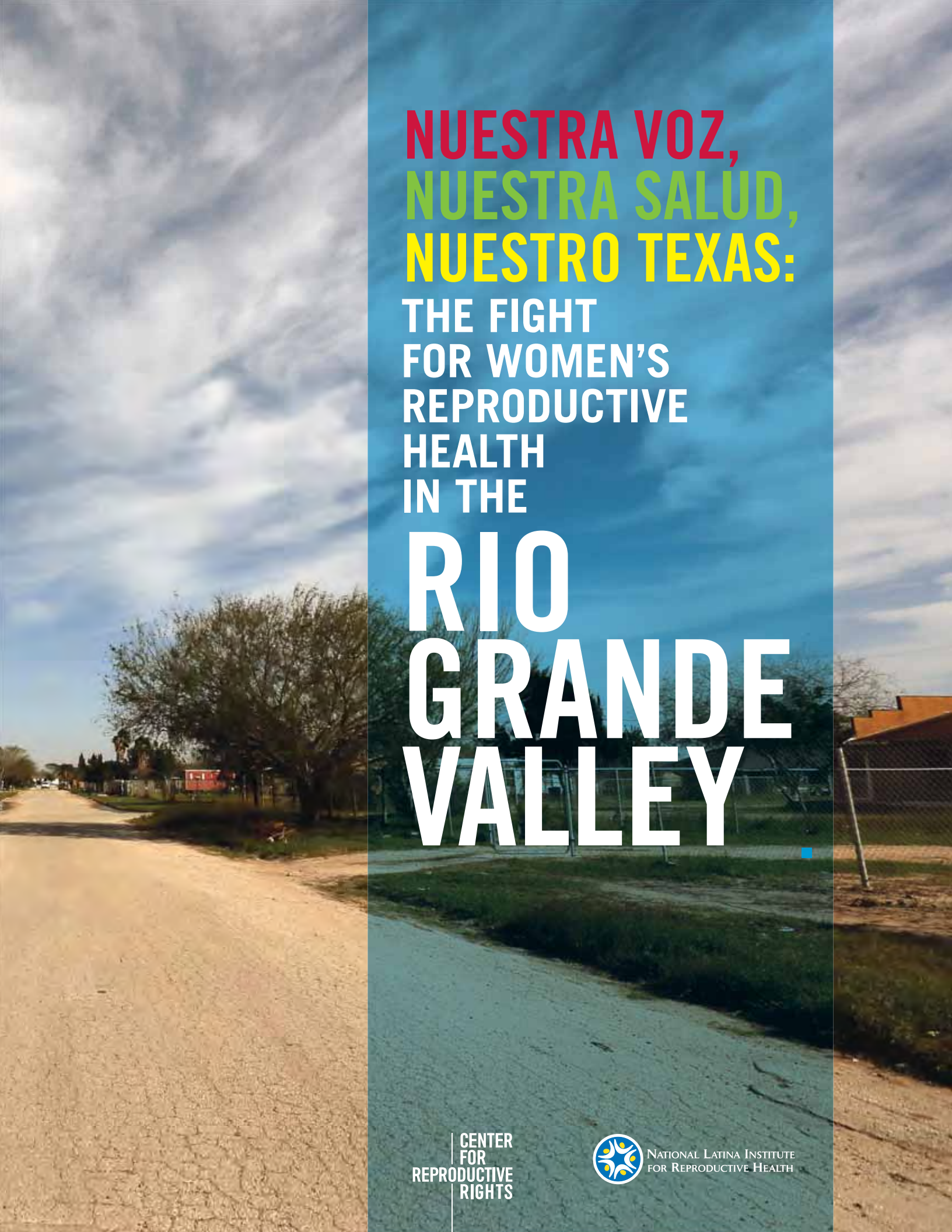

NUESTRA VOZ, NUESTRA SALUD, NUESTRO TEXAS:

THE FIGHT FOR WOMEN'S REPRODUCTIVE HEALTH IN THE RIO GRANDE VALLEY

CENTER FOR REPRODUCTIVE RIGHTS

NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH

NuestroTexas.org

November 2013

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GAP

EXECUTIVE SUMMARY

Access to affordable reproductive health care has never come easily for women living in the Lower Rio Grande Valley (the Valley), one of the poorest regions in the U.S. and home to a large population of immigrants and Latinos.

But in 2011, what had been a fraying, yet still largely intact, reproductive health safety net began to unravel entirely. This was the year the Texas legislature cut state family planning funding by two-thirds and authorized a regulation known as the "affiliate rule" that barred all Planned Parenthood health centers—the largest source of preventive reproductive health care services in the state—from receiving state family planning funds because of their brand affiliation with facilities that provide abortion. For decades, women could turn to family planning clinics located in or near their communities as a trusted source for affordable contraception, annual exams, and other forms of preventive care. But since the recent policies went into effect, 28 percent of state-funded family planning clinics in the Valley have closed entirely, and many more have reduced services while raising fees.

This is a human rights report that documents the consequences of Texas's recent policy decisions on Latinas, their families, and entire communities. In interviews and focus groups conducted in the four counties of the Valley, 188 women shared information about the key barriers they face in finding timely and affordable reproductive health care, and the myriad ways this struggle impacts their lives.

BARRIERS TO REPRODUCTIVE HEALTH CARE

Lack of Accessible Clinics: The closure of nine out of 32 family planning clinics in the Valley funded by the Texas Department of State Health Services (DSHS) has had a disproportionate impact on rural communities who depended on these facilities. Women now no longer know where to go to get contraceptive supplies or obtain a

range of services—from annual Pap tests to mammograms. Moreover, they have lost care from providers they had long trusted to serve the needs of a largely immigrant, Spanish-speaking community. The demand for services is now concentrated on fewer clinics, leading to delays of many months for an appointment at one of the few clinics that continue to offer reduced-rate services.

Cost: Regardless of their immigration, employment, or health insurance status, women identified cost as a primary barrier to reproductive health care. Nearly all women consulted for this report live on incomes below the federal poverty level—in many cases, far below—and any extra health care expense requires compromising on other necessities such as food or clothing. The cost of one month's supply of contraception, as well as the fee for an annual exam, has increased by three to four times since 2010. Specialty tests such as ultrasounds and mammograms that women used to be able to receive at local clinics at subsidized rates are now no longer available from many clinics. Clinics now refer women to private doctors who charge rates far beyond what women can afford, and the referrals expire long before women can save enough to use them. Some women who received abnormal results years ago from Pap tests or breast exams have yet to be able to afford necessary follow-up tests to obtain more information about the status of their health.

Transportation: Limited availability of public transportation and the high cost and difficult logistics of private transportation are key barriers to women's ability to obtain affordable reproductive health care in the Valley. As local family planning clinics have closed, transportation barriers have increased, forcing women to travel to clinics further away from their homes. This burden falls particularly hard on women living in *colonias*, as these communities are generally not accessible by public transportation. Getting to and from a doctor's appointment for women without private transportation may require weeks of preparation to request time off from work, arrange for child care, save money for gas, and wait until friends and neighbors are available to drive them to appointments. Services that helped alleviate the travel burden, such as mobile reproductive health clinics and *promotora* programs, have been scaled back or eliminated since the budget cuts.

Immigration Status: Those without authorized immigration status in the U.S. experience difficulties in accessing reproductive health care for many reasons, often aggravated by cost and transportation. Undocumented women fear traveling outside their communities due to the ubiquitous presence of border patrol agents. Others are deterred from going to clinics because they guard their immigration status carefully, even with health care providers, and they are unable to produce the required documentation to qualify for reduced-rate services. Although health care is more affordable in Mexico, undocumented women avoid crossing the border to seek care for fear of not being able to return to the U.S.

IMPACTS ON WOMEN

Delays and Denial of Reproductive Health Care: The high demand and short supply of low-cost reproductive health care has led to severe delays in scheduling appointments, with typical wait times exceeding several months. Problems that could have been diagnosed and treated early become much more serious, as in the case of women with chronic reproductive conditions or early signs of cancer. Later detection often results in more expensive care or the denial of treatment

altogether for women unable to afford specialist fees. In some cases, the long delays are tantamount to a denial of reproductive health care because the window of opportunity to treat a serious condition such as breast, cervical, or uterine cancer may close by the time a woman finally sees a doctor. In other cases, the reason for the visit may be irrelevant by the time the long-awaited appointment arrives, as in the case of women who become pregnant before they are able to access family planning services. Some women consulted for this report who received abnormal diagnoses from routine exams but could not afford specialty care were told by their health care providers to "wait to see if it goes away on its own." Others simply give up on finding timely and affordable reproductive care, opting instead for home remedies or to endure the pain and discomfort of untreated conditions rather than continue a futile search for medical treatment. The risk of being turned away from emergency facilities on the basis of immigration status or inability to pay also deters women from seeking care at health facilities.

Women interviewed for this report told of members of their families being turned away from urgent care, as well as their own experiences being denied treatment for chronic reproductive health conditions. They described an interminable wait to be able to afford tests to diagnose breast, uterine or cervical cancer even after obvious symptoms had manifested. Some were forced to forgo medication to treat sexually transmitted infections. Many women were unable to receive the form of contraception that worked best for them, especially more effective methods that tend to cost more, such as a tubal ligation. Others who had been sterilized discovered unintended consequences after the procedure: as women who no longer have reproductive capacity, they do not qualify for reduced rate cancer screenings.

Health Risks: The inability to obtain affordable reproductive health services and supplies from trusted providers forces women to rely on other sources of care that may jeopardize their health and safety. Many reported purchasing medication and contraception on the black market or relying on friends and relatives to bring low-cost supplies across the border from Mexico. While the informal market is an important source of low-cost reproductive health medicines and contraception, these goods can be ineffective, inappropriate to women's individual health care needs, more likely to be used incorrectly because women do not receive proper instructions, and, in some cases, dangerous to women's health.

Stress, Anxiety, and Insecurity: The vast majority of women interviewed understood the importance of preventive reproductive and sexual health care but had no ability to access it due to cost and other factors. The stress caused by the inability to obtain contraception creates worry about an unintended pregnancy for those already struggling to provide for their existing children. Having to forgo annual Pap tests causes particular anxiety among Latinas due to a high prevalence of cervical cancer in that population. Those who are the principal caretakers of children experience heightened stress about how an illness could affect their families. Further, the decision to travel to Mexico to seek affordable reproductive health care can be a painful, difficult one for women who face tremendous barriers to obtaining that care in the U.S. but fear the violence across the border or know they may not be able to return because of their undocumented status.

RIGHTS VIOLATIONS

The findings in this report do more than demonstrate failures of reproductive health policy—they establish violations of women's fundamental reproductive rights, including the rights to life and health, non-discrimination and equality, and freedom from ill treatment. The federal government and the state of Texas share an obligation to respect, protect, and fulfill the reproductive rights of women in the Valley and to ensure they can exercise those rights on an equal basis with others. Because these women experience multiple and intersecting forms of discrimination on the basis of their race, ethnicity, class, gender, and immigration status, government has a heightened duty towards this population. Yet, rather than allocating a greater share of reproductive health resources to underserved areas like *colonias*, or addressing the structural barriers such as poverty and transportation that prevent women from accessing timely and appropriate care, Texas has implemented reproductive health policies that will further undermine access to care and exacerbate health disparities.

The women of the Valley interviewed for this report have courageously shared their stories in order to show the consequences of government acting in direct conflict with its human rights obligations to ensure women's reproductive health. Given this reality, the women are mobilizing to demand that Texas legislators implement a rights-based reproductive health policy. As Liria from Brownsville said, "We want to grow, give back to this country. As we receive, we also give back to them, to the country in which we live. But for that to happen, we need to be in good health.... I hope that we can count on [elected officials]. We don't need any more talk or promises, we just need them to keep their promises."

A view of a street in a *colonia* near Edinburg.

RECOMMENDATIONS

RIGHTS VIOLATIONS

The findings in this report do more than demonstrate failures of reproductive health policy—they establish violations of women's fundamental reproductive rights, including the rights to life and health, non-discrimination and equality, and freedom from ill treatment.

TO THE STATE OF TEXAS

Expanding Access to Health Coverage, Services, and Information

- Ensure that funding for women's preventive health services through the expansion of primary care is allocated in an effective and efficient manner to health care providers that offer women's health care services throughout the state, prioritizing women most in need of low-cost services and supplies.

- Repeal the "affiliate rule" to allow renewal of the 90 percent federal match of state dollars through the Texas Women's Health Program and encourage broad participation of specialized family planning providers in all state funding streams for reproductive health.

- Participate in the Medicaid expansion program of the Affordable Care Act (ACA), increasing coverage for 1.7 million Texans at a cost to the state of $15 million over 10 years in exchange for $100 million in federal funding.

- Satisfy the substantial unmet need for affordable contraception among low-income women in Texas by increasing state funding for family planning programs far beyond current levels and ensuring the availability of a wide range of contraception to meet women's individualized needs.

- Expand Medicaid access to immigrant women and families to the maximum extent possible, including extending health coverage to immigrant children and pregnant women through Medicaid, CHIP, and other state-financed programs.

- Develop and fund programs to address geographic barriers to reproductive health care for women living in rural and underserved areas, including: funding mobile reproductive health clinics; increasing funding for *promotora* outreach workers and for materials on comprehensive sex education designed for immigrant and Spanish-speaking communities; incorporating reproductive health services into health fairs offered in medically underserved areas; expanding programs to reimburse low-income women for transportation to doctor visits; and ensuring family planning clinics are easily reached by public transportation.

Monitoring and Evaluation

- Conduct an evidence-based assessment of the impact of the 2011 family planning cuts to the Texas family planning safety net, to be completed prior to the commencement of the 84th session of the Texas legislature in January 2015.

- Monitor the distribution of state family planning funding through the primary care expansion program and evaluate—prior to the commencement of the 84th session of the Texas legislature—whether the current funding scheme is adequately and efficiently meeting the family planning needs of Texan women, especially those in the most underserved areas such as the Lower Rio Grande Valley.

- Monitor the capacity of providers accepting patients through the Texas Women's Health Program to increase service delivery in order to absorb the women who formerly fulfilled their family planning needs at Planned Parenthood health centers. Ensure that the list of providers promoted by the Texas Health and Human Services Commission website provides women's health care and family planning services.

- Improve state data collection methods to record reproductive health indicators and outcomes. Such methodology should ensure up-to-date, county-specific data on incidence and death rates of cervical cancer, breast cancer, and sexually transmitted infections such as chlamydia, and account for differences based on race, ethnicity, immigration status, country of origin, gender, and age.

Capacity Building and Training

- Conduct trainings for workers at state-funded health facilities on eligibility criteria for women seeking family planning services in order to ensure that administrative requirements, such as producing a government-issued identification or proof of income, are reasonably interpreted and do not serve as barriers to service.

- Ensure that providers contracted through the primary care expansion program are trained to provide a full range of contraceptive services and supplies to their clients, including hormonal methods, long-acting reversible methods, and sterilization.

TO CONGRESS

- Eliminate the five-year bar on eligibility for federal health benefits under Medicaid, CHIP, and the Affordable Care Act for immigrants who are lawfully present in the U.S. and otherwise meet income eligibility requirements.

- Eliminate eligibility barriers in Medicaid, CHIP, and the Affordable Care Act that prohibit low-income, undocumented women from accessing affordable health insurance coverage.

- Restore full funding to the Community Health Centers Trust Fund in order to expand capacity of community health centers to meet the need for comprehensive primary care in rural and underserved communities.

- Fully fund the Title X Family Planning Program to help frontline family planning clinics meet the unmet demand for affordable contraception and other preventive women's health services.

- Enact just and humane reforms to immigration policies that advance the health of immigrant communities, including eliminating eligibility barriers to affordable health insurance for immigrants on a path to citizenship.

- Enact and fully fund all provisions of the Health Equity and Accountability Act, to address health disparities faced by immigrant women, Latinas, and women in rural communities.

TO THE OBAMA ADMINISTRATION

- Repeal the U.S. Department of Health and Human Services (DHHS) regulations that exclude those granted temporary relief from deportation under the Deferred Action for Childhood Arrivals program from eligibility for affordable health care under the ACA, or enrollment in Medicaid and CHIP, and use administrative discretion to extend access to health care to the widest net population possible.

- Ensure that DHHS family planning guidelines expected to be released in 2013 are appropriate for community health centers (which are increasingly the principal source for family planning services in underserved communities) and include recommended-practice approaches for providing comprehensive family planning goods and services to immigrant women and other hard-to-reach populations.

- Halt detention, deportation, and immigration enforcement practices that create a climate of intimidation and fear and deter immigrant women from seeking needed care for themselves and their families.

TO CIVIL SOCIETY

- Develop and distribute, in collaboration with *promotoras* and local community groups, medically accurate and linguistically and culturally appropriate educational materials on sexual and reproductive health matters for underserved communities. Information should be comprehensive, including sex education, family planning, and safe and legal abortion services.

- Support policy initiatives and community-based efforts to improve transportation systems to reproductive health facilities for residents of *colonias* and other rural communities.

- Conduct further research on the outcomes and implications of self-administered medication, including long-acting reversible contraceptive methods.

Alma, from Brownsville, with two of her five children. She was not able to get affordable contraception and is now pregnant with her sixth.


CONVERSE
ALL★STAR
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