UNDERSTANDING AND ADDRESSING STRUCTURAL BARRIERS TO HEALTHCARE ACCESS FOR MAM INDIGENOUS WOMEN IN OREGON

by

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THESIS ABSTRACT

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This thesis explores structural barriers to healthcare access for Mam Indigenous women in Oregon. It provides an overview of structural barriers within the healthcare system and local community and how service providers can address them. From July 2022 to April 2023, I conducted semi-structured interviews with service providers and Mam women in Lane County, Oregon. I also analyzed policies related to healthcare access and observed Mam women at a local support center where I volunteered during a parenting class for Maya and Latino/a/x families. Situating my findings in the literature on health policy and medical anthropology, I argue service providers should practice structural competency to understand and address structural barriers to healthcare access for Mam and immigrant communities. I also provide recommendations to address the structural barriers revealed by this study and a flyer with local health resources that I shared with the community to help improve access to them.

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CHAPTER I

INTRODUCTION

In 1980 the U.S. Department of Health and Human Services commenced the Healthy People initiative to guide national health promotion and disease prevention efforts to improve the health of all people in the United States. The latest iteration, Healthy People 2030, has an increased and overarching focus on social determinants of health (SDOH) and groups SDOH into five domains: 1) economic stability, 2) education access and quality, 3) healthcare access and quality, 4) neighborhood and built environment, and 5) social and community context (U.S. Department of Health and Human Services, n.d.). The nation's focus is on addressing socioeconomic conditions to improve health outcomes in the U.S., considering the worsening wealth gap (Institute for Policy Studies, 2023) and the Black-White health gap (CDC, 2021). In order to achieve health equity in the United States, one must first look at health disparities and structural inequality and understand how they are connected.

Immigrants are a particularly vulnerable group in the United States due to their subordinated economic location and precarious status, which puts them at risk of discrimination and violence impacting their health (Castañeda et al., 2015; Holmes, 2013; Quesada et al., 2011). For this reason, I focus on immigrants in this thesis, specifically Mam Indigenous women in Oregon. Imagine getting dropped off at your doctor's appointment and not knowing how to get back home because you do not have a ride, you do not know how public transportation works in the United States, and you speak zero English and only a little Spanish. Imagine being asked to sign legal documents in a language you cannot read or understand, hoping you understood the Spanish or Mam interpreter correctly. Now imagine it is two weeks after you visit the hospital, and you receive a bill for $5,000 and have no idea how you can afford to pay it because you are

unemployed or work at a low-wage job. These experiences are a reality for Mam women in Oregon due to their immigration status and racial, ethnic, and linguistic background. These issues do not solely exist because they are not from the United States or speak a different language. These issues exist because immigrants' social location places them to experience structural vulnerability, which puts them in a position of limited agency due to forces that constrain decision-making and limit life options (Quesada et al., 2011).

This thesis is aimed specifically at healthcare and service providers in Oregon that work with Maya communities. Although they are the primary intended audience, this thesis is also relevant for anyone working with immigrant communities. I mainly draw from health policy and medical anthropological approaches to examine the health experiences and barriers Mam women encounter in Oregon. Understanding structural vulnerability can help healthcare and service providers better understand factors impacting the health of immigrant communities. By having more structurally competent providers, immigrants and other under-resourced communities can receive improved care and support that considers structural violence and vulnerability.

Immigrants and Healthcare in Oregon

The U.S. Census Bureau estimated Oregon's population at 4,246,155 in 2021. From 2016 to 2020, 9.8%, or approximately 415,000, were foreign-born individuals ("Quick Facts," 2022). This number is likely higher, considering the possible underreporting of undocumented immigrants. Of the foreign-born population, it is estimated that 108,000 are undocumented immigrants. The top two countries of birth for undocumented immigrants are Mexico (68%) and Guatemala (5%), and a total of 77% are from the region of Mexico and Central America ("Profile," 2019). It is also important to note the age breakdown of undocumented immigrants in Oregon. 17% are under 25, 76% are between the ages of 25 and 54, and 7% are 55 and over.

Furthermore, 26% are below the federal poverty level, 32% are below 200% of the federal poverty level, and 47% are uninsured ("Profile," 2019).

In Oregon, Oregon Health Plan (OHP) is the state's primary Medicaid program that offers coverage for eligible low-income adults and families, children, pregnant adults, and seniors. OHP recently expanded to include undocumented immigrants but excluded undocumented immigrants between the ages of 26 and 54, which is almost 76% of undocumented immigrants in Oregon. Other Medicaid programs exist, like Citizen/Alien Waived Emergency Medical (CAWEM) and Medical Assistance for Families (MAF). CAWEM offers limited emergency medical assistance for undocumented immigrants, and MAF is for low-income families with children that qualify under the pre-1996 eligibility rules ("Introduction," n.d.).

Non-citizens and undocumented immigrants are significantly more likely than citizens to be uninsured. In 2020, among the nonelderly population, 26% of lawfully present immigrants and 42% of undocumented immigrants were uninsured compared to 8% of citizens, as seen in Figure 1 (KFF, 2022).

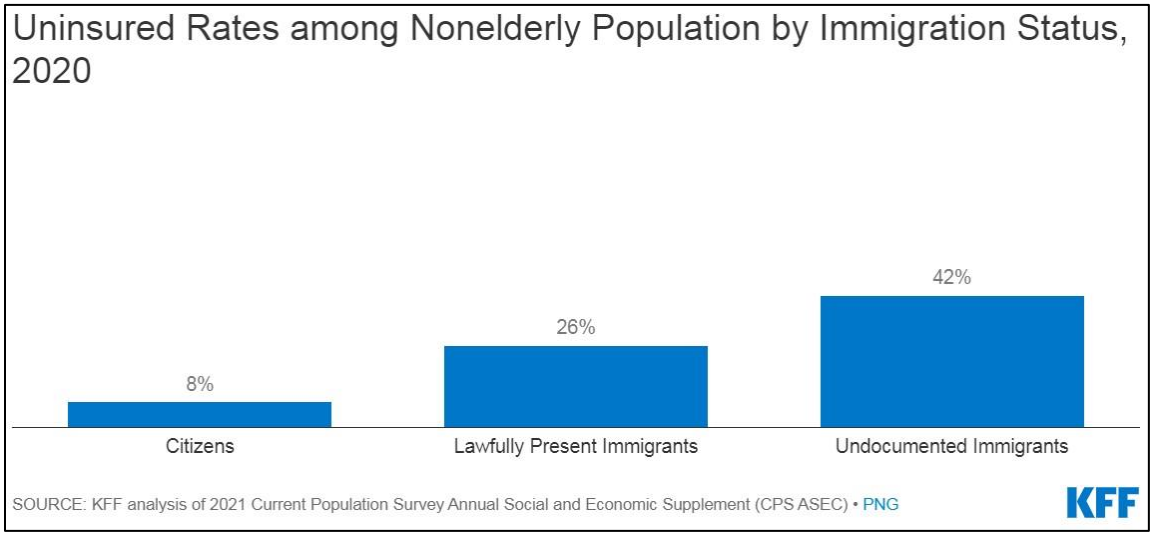

Figure 1. Uninsured Rates among Nonelderly Population by Immigration Status, from Kaiser Family Foundation (2022).

The higher uninsured rate among non-citizens reflects limited access to employer-sponsored coverage; eligibility restrictions for Medicaid, CHIP, and ACA Marketplace coverage; and barriers to enrollment among eligible individuals (KFF, 2022).

There are also differences in the type of healthcare coverage one is eligible for depending on immigration status. Figure 2 illustrates how lawfully present immigrants have similar eligibility to citizens, whereas undocumented immigrants are ineligible due to their immigration status (KFF, 2022).

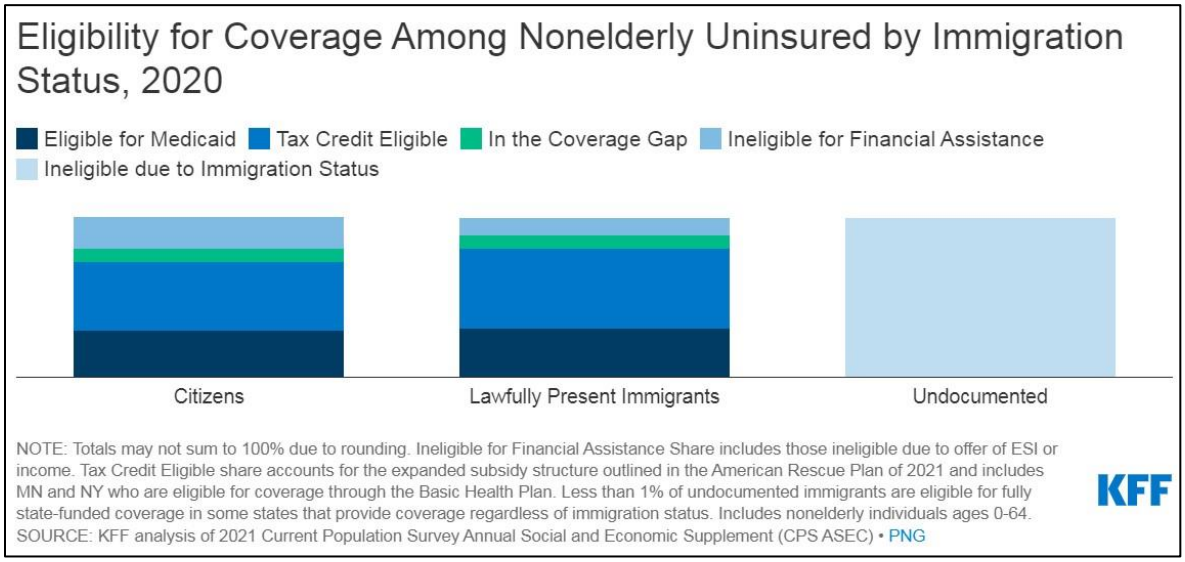

Figure 2. Eligibility for Coverage Among Nonelderly Uninsured by Immigration Status, from Kaiser Family Foundation (2022).

As the figure indicates, undocumented immigrants face more barriers to healthcare access than lawfully present immigrants and citizens. Insurance coverage gaps are one of the many barriers Mam women may experience in the United States when accessing healthcare services.

The Mam Community

The Mam women are a subgroup of Maya Indigenous peoples from the western highlands of Guatemala and southwestern Mexico who speak Mam. Oregon has at least four linguistic and ethnic Guatemalan Maya groups, including Mam, Quiché, Akateko, and Kanjobal.

Beginning in the 1980s, people from Guatemala suffering high levels of political violence related to the Guatemalan Civil War started migrating to the United States to escape genocidal violence targeted at Indigenous communities. Scholars have argued that U.S. foreign policy in Guatemala upheld the military dictators and authoritarian regimes that committed genocide against largely Indigenous communities in the name of eradicating guerilla movements (Stephen, 2017; Sanford, 2003; Moye, 1998). As a result, today, most Guatemalan immigrants in Oregon are Indigenous.

Many Guatemalans fleeing this violence migrated to the United States and settled with Mexican migrants already working in Oregon in agriculture and forestry. Existing migrant communities and work opportunities made settling in Oregon appealing to Guatemalan immigrants. These factors began a history of migration to Oregon for agricultural work and an established community of Mam immigrants. Today, Mam communities' agricultural work includes but is not limited to picking berries, hops, and row crops; planting trees; working for the U.S. Forest Service; and harvesting salal (Stephen, 2017).

The 1986 Immigration Reform and Control Act (IRCA) and Special Agricultural Workers Program (SAW) were crucial resources that allowed Guatemalan immigrants to receive residency for themselves and their family members and build Guatemalan transborder communities in Oregon (Stephen, 2017). According to Lynn Stephen (2017), a Professor of Anthropology at the University of Oregon who has experience working with Mam refugees, the period from 2013 to 2016 marked an increase in undocumented women from Mam and other Guatemalan communities. Many Mam women also came with some of their children, escaping multiple forms of violence and reuniting with family members in rooted transborder communities (Stephen, 2017). Transborder communities are communities that extend historical

bases to other places across national, racial, and ethnic borders and link them through economic and social networks (Stephen, 2017).

Site Justification

For this project, I focus on one of these rooted Mam transborder communities because of their long history there, the feasibility of reaching Mam women and healthcare providers that deliver services to Mam women, and my connections to local organizations. I use a pseudonym, "Alderbridge," to protect the location of an immigrant community and undocumented individuals. Alderbridge is a rural town in South Lane County, Oregon, home to over 350 Indigenous Guatemalan refugees (PeaceHealth, 2022). Alderbridge has a well-known community of Mam Indigenous women and a small network of organizations and people working directly with Mam women and families. Furthermore, Alderbridge is more than 20 miles from the nearest urban area and only has one nearby hospital. Because of the rural location of Alderbridge, local healthcare services are limited, making access to healthcare a challenge for many Mam women. Public health and community-based organizations are aware of this unique community and its needs and have worked together to offer them support.

The Mam community faces a host of barriers in Oregon. Just last year, in 2022, PeaceHealth Medical Center stated, "While these [Guatemalan] families experience a multitude of systemic disparities, language and literacy are two key barriers that make accessing safe housing, food, transportation, employment, education, and healthcare even more difficult" (PeaceHealth, 2022). Additionally, many Mam women are refugees or asylum-seekers due to their fleeing Guatemala due to police, gang, and paramilitary violence and gendered violence that continues to destabilize the country even after the end of the Guatemalan Civil War (Wills, 2022). That means they may experience symptoms of psychological distress, difficulties in

expressing health needs and accessing healthcare, poverty, and social exclusion, all of which negatively impact health (Asgary & Segar, 2011; Burnett & Peel, 2001).

Wanting to understand these barriers to healthcare access drew me to the Mam community. I also have access to the Mam community, specifically Mam women, due to the local community network in Alderbridge that provides services to Mam families. In my experience volunteering at a local nonprofit and food pantry, Mam women often showed up to receive assistance for their families. Though I focus on Mam women in this study, there are also Quiché women in Alderbridge that I met and have experiences similar to Mam women.

Purpose of the Study

Racial and gender inequalities in mental health, physical health, and access to healthcare have been documented in the fields of public health and social science (Rapp et al., 2021; Hicken et al., 2018; Chen et al., 2006; Read & Gorman, 2006). Medical anthropological research also suggests migrant populations in the United States are a particularly vulnerable group susceptible to intersecting forms of structural violence in the United States due to their race, ethnicity, class, and immigration status (Holmes, 2013, 2007; Quesada et al., 2011; Farmer, 2004). Structural violence refers to social systems that harm individuals and communities and keep them from living safe and healthy lives (Galtung, 1969; Farmer, 2006). "The term 'structural violence' is one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people" (Farmer, 2006). As a result, Mam women may face more significant health disparities and barriers to healthcare access compared to other migrant populations.

Barriers to healthcare coverage can result in high healthcare costs, postponing healthcare, and the inability to afford medication, negatively impacting one's health (Kaiser Family Foundation, 2022). Not only may Mam women's identities be tied to barriers they experience, but also extra-individual conditions around them that create added barriers to healthcare access. These added barriers may deter Mam women from seeking care and prevent them from receiving equitable care altogether.

Understanding the experiences of Mam women within a healthcare context can help contribute to a broader understanding of latent issues within healthcare systems in the United States that bring about challenges for marginalized communities like migrant and Indigenous populations. That is why I planned an applied-research project that begins to address the barriers uncovered. I sought to reveal structural barriers within the healthcare system and community that Mam women experience and understand how local service providers can better serve this community. To understand the experiences and unique barriers to healthcare access that Mam women may face and how service providers can better serve Mam women, I address the following research questions:

1. What does healthcare and healthcare access look like for Mam women?
2. What type of barriers to healthcare access exist for Mam women?
3. What knowledge and changes could help service providers provide structurally competent care to Mam women?

CHAPTER II

REVIEW OF THE LITERATURE

Barriers to Healthcare Access

The literature on health disparities and structural inequality is robust and impossible to cover entirely, given the parameters of this project. The main focus of this review is on barriers to healthcare access and structural inequality for women of color and immigrants in the United States. Although limited access to healthcare leads to health disparities among populations like women of color and immigrants, healthcare access is just one of the many drivers of health inequities. Therefore, addressing barriers to healthcare access is just one method of lessening health disparities among women of color and immigrant communities.

I use the terms "Hispanic," "Latino," and "Latinx" for the sake of using the same language used in the health policy papers and studies I reference. Mam Indigenous migrants are often categorized as Hispanic or Latino because they come from Latin America. Although terms like Hispanic and Latino/a/x contribute to the erasure of Indigenous identities, I use the terms to help situate the Mam community in these studies and data. Not all Maya peoples will identify with these categories, but the Mam and Quiché women I worked with did.

Barriers to healthcare access vary by sex and race among individuals in the United States. According to a recent study, Black and Hispanic women reported significantly more barriers to availability, affordability, and overall healthcare barriers compared to White women (Rapp et al., 2021). This study looked at state-level sexism and women's healthcare access in the United States and found that Black and Hispanic women residing in states with a higher state-level sexism score reported more affordability barriers. At the same time, it had no significant impact on White women (Rapp et al., 2021). The state-level sexism index was constructed using the

following indicators: ratio of (1) men's-to-women's earnings, (2) men's-to-women's employment, (3) and women's-to-men's poverty rate; (4) proportion of men in state legislature; (5) absence of a state paid family or medical leave policy; (6) absence of state law restricting gun ownership for domestic violence offenders; and (7) proportion of women residing in a county without an abortion provider (Rapp et al., 2021). This study highlights the importance of using an intersectional lens to view structural inequality. Not only do women face more barriers to healthcare access in the U.S. than men, but also, women of color encounter more barriers than their White counterparts.

Another barrier to healthcare access is health insurance coverage. The Latinx population experiences a significantly higher uninsured rate (27%) compared with other racial or ethnic groups (14% of Black adults, 9% of White adults, and 8% of Asian adults) (AHRQ, 2018). This same study by the Agency for Healthcare Research and Quality also revealed that the Latinx population had worse access to healthcare than White individuals on 70% of other healthcare access measures, such as having a regular source of care. The same pattern follows when solely comparing women with each other (AHRQ, 2018). A recent report found that Latinx women had higher rates of being uninsured (23%) compared to Black women (12%) and White women (8%) (Kaiser Family Foundation, 2021). For this reason, it is imperative to analyze racial and ethnic differences when attempting to understand diverse experiences within healthcare. Understanding racial and ethnic disparities is particularly important in the United States due to the U.S.'s long history of racialization and associated "deservingness" (Horton, 2008) attributed to immigrants within healthcare.

Relatedly, we can look deeper at sociopolitical differences within groups. For example, healthcare access also varies among nationality and immigration status within Latinx

populations. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) gave Cuban and Haitian immigrants access to major federal benefits programs, including Medicaid, due to refugee or asylum status (National Immigration Law Center, 2022). However, immigrants from other Latin American countries, including Mexico, El Salvador, Guatemala, and Honduras, cannot access these benefits (Pew Research Center, 2019). The PRWORA also barred legal residents from accessing federal programs for five years or longer, which led to a significant drop in healthcare coverage within immigrant communities after 1996 (National Immigration Law Center, 2022). This exemplifies the healthcare policies and practices in the U.S. that create categories of "deserving" and "undeserving" immigrants, which ultimately impact the health of tens of millions of people (Castañeda et al., 2015; Horton, 2008). These categories are based on "a neoliberal standard of self-reliance as moral worth," which leads to unmet health needs and poor health outcomes for certain populations when providers deem them unworthy of their resources (Horton, 2008). Deservingness also refers to how some groups, but not others, are considered worthy of attention, investment, and care, and is usually tied to immigration status, language use, accent, perceived ethnicity or race, and many other factors (Castañeda et al., 2015).

Studies have also shown the discrepancies in healthcare access among immigrants based on immigration status. Undocumented immigrants were three to five times more likely to be uninsured compared to naturalized citizens (Sanchez et al., 2017). Undocumented immigrants were also significantly less likely than documented immigrants to have visited a doctor in the past year and had fewer physician visits overall (Bustamante et al., 2012; Sanchez et al., 2017). This is no surprise considering the fear undocumented immigrants may have when interacting with local and state systems within the United States. Non-citizenship status is a substantial

barrier to accessing healthcare because of program ineligibility and fear of stigma and deportation (Castañeda et al., 2015; Perez-Escamilla et al., 2010; Rivers & Patino, 2006). Additionally, barriers exist related to socioeconomic status, language and culture, discrimination, difficulty understanding how the system works, and difficulty navigating public programs (Hill et al., 2021; Hacker et al., 2015; Rivers & Patino, 2006;). These findings highlight the overlapping barriers to healthcare access for undocumented immigrants at policy, system, and individual levels.

Indigenous groups in the United States face unique barriers to healthcare access. A review of disparities in healthcare services among Indigenous peoples revealed that healthcare access and utilization rates are substantially lower among Indigenous populations compared to the general population (Marrone, 2007). Rural location, communication, and socioeconomic status are the main barriers that disproportionately impact access to healthcare services for Indigenous communities (Marrone, 2007). That is because many Indigenous peoples live in rural areas near tribal territories. Similarly, immigrant communities may also live in rural areas where agricultural work is in demand and access to healthcare services is limited. In Oregon, 36% of all residents live in rural communities, but only about 10% of physicians practice there, leaving many areas without primary care providers (“Transforming,” 2020). Significant health disparities exist among Oregon's rural residents, where adults are 36% more likely to report their health status as fair or poor than adults in urban areas (“Transforming,” 2020). Since the Mam women in my study live in Alderbridge, one of Oregon’s rural communities, they have less access to healthcare services and may experience poorer health outcomes.

Structural Violence

Working in agricultural labor is another site where inequality and health intersect for immigrant communities. Many undocumented immigrants are employed in low-wage sectors of the U.S. economy, which directly affects their access to adequate healthcare and insurance since most undocumented immigrants are employed in industries that offer no health insurance to employees (Rivers & Patino, 2006). In an ethnography on migrant farmworkers in the U.S., Seth Holmes (2013) picks strawberries alongside Triqui Indigenous people from Oaxaca, Mexico, in the Skagit Valley in Washington to understand issues of immigration, social and racial hierarchy, and health. Holmes highlights the disparate treatment among workers that are Latino U.S. citizens or residents, undocumented mestizo Mexicans, and undocumented Indigenous Mexicans, and argues that "class, ethnicity, and citizenship form a triply conjugated oppression conspiring to deny undocumented Triqui berry pickers respect and deprive them of their physical and mental health" (2007, p. 51). The pain and illness that the Triqui laborers experience is an example of structural violence becoming embodied in the form of suffering and sickness (Holmes, 2013). I apply Holmes' analysis to understand Mam women and how their socioeconomic status, ethnicity, and immigration status impact their health and access to healthcare.

Structural violence describes economic, political, legal, cultural, and religious systems that harm marginalized groups and manifest as social inequalities, often along categories of race, class, gender, and sexuality (Galtung, 1969; Farmer, 1996, 2004). Structural violence can also be observed along categories of indigeneity and immigration status. Examples of structural violence include disparate access to resources, political power, education, healthcare, and legal standing (Farmer 2004, 2006). Structural violence is closely linked to social injustice and the social

machinery of oppression (Farmer 2004, 2006). Therefore, I underscore structural violence because of its impact on the health of immigrants and other oppressed communities.

Structural and systemic racism have perpetuated widespread unfair treatment and oppression of people of color, resulting in adverse health outcomes (Braveman et al., 2022). For example, by disenfranchising people through limiting voting, their lack of political power results in a lack of access to crucial resources needed to be healthy, such as clean water, pollution-free neighborhoods, well-resourced schools, affordable housing, and access to medical care (Braveman et al., 2022). On top of that, socioeconomic factors such as lower levels of income, wealth, and education among people of color have repeatedly been shown to be significant contributors to racial disparities in health (Williams et al., 2016; Braveman & Gottlieb, 2014). Systemic racism also leads to poorer health among people of color at all economic levels, especially Black people, by persistently exposing them to racism and discrimination that produces chronic stress, leading to increased risks for chronic disease (Geronimus et al., 2005). For immigrants in the United States, racism and discrimination are all too familiar, especially with the rise of anti-immigrant sentiment worldwide. Most of the Mam women I worked with are immigrants and considered low-income, so they may likely be vulnerable to racism, discrimination, and health disparities.

Because of structural violence, systemic racism, and systems that marginalize communities of color, it is imperative to view health and healthcare access through a lens of structural intersectionality. Intersectionality is an analytical framework for understanding how overlapping systems of oppression, such as racism, sexism, classism, and other forms of inequality based on one's social identities, impact individuals (Crenshaw, 1991). The fields of public health and medical anthropology have already begun to use intersectional approaches to

understand inequalities in population health. A recent study highlights this shift and emphasizes the importance of using a structural intersectionality approach for health disparities research (Homan et al., 2021). This approach underscores the consequences of multiple systems of oppression, involving systematic subordination and exclusion of marginalized groups with respect to resources, opportunities, and freedoms in social institutions, which shape health via differential access to economic resources and increased exposure to health risks such as social stressors, toxic living conditions, discrimination, stigma, and relative deprivation (Homan et al., 2021). Fields related to health and equity should be responsible for using a structural intersectionality lens when engaging in their work because one-dimensional approaches fail to capture the unique experiences of marginalized communities and how various forms of oppression impact health. That is why when looking at Mam women, I aim to understand how their gender, race, ethnicity, class, immigration status, and more impact their access to healthcare in Oregon.

Structural Competency

A narrow focus on cultural explanations for health disparities can also lead to missing fundamental causes of health concerns and illness by ignoring the role of social inequality. In recent decades, "cultural competency" has become popular among healthcare professionals and health education programs (Leininger, 2022; Hirsch, 2003). Cultural competence involves acknowledging the importance of culture and incorporates assessment of cross-cultural relations, attentiveness toward dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs (Betancourt et al., 2003). On the one hand, effective cultural competence programs can positively affect patient health outcomes by incorporating cultural health beliefs and practices into healthcare delivery (Bechtel

et al., 2000). On the other hand, looking at immigrant communities specifically, some critical medical anthropologists have long been critical of the concept because the overreliance on cultural explanations for immigrant health outcomes obscures the impact of structural factors on immigrant health disparities (Viruell-Fuentes et al., 2012; Casteñeda, 2010; Hirsch, 2003). Paul Farmer (1999), an American medical anthropologist and physician, calls these misplaced cultural explanations "immodest claims of causality" that mask the social, political, and economic causes of disparate health outcomes and human rights violations. Exclusively focusing on cultural competence suggests that problems with immigrant health are primarily due to a lack of culturally relevant health services instead of acknowledging that immigrants often live in unhealthy conditions, work dangerous jobs, experience everyday racialized discrimination, and have minimal access to health services (Hirsch, 2003).

Furthermore, cultural competence training tends to stereotype patients of varying ethnicities by relying on oversimplified group generalizations while ignoring the intersection between racism, sexism, political violence, immigration policy, and generalized effects of poverty (Farmer, 1999; Castañeda, 2010). Healthcare professionals must walk a fine line when determining how to treat different patients based on their perceived race and ethnicity because assumptions and practices can quickly go from culturally competent care to disparate and discriminatory treatment. That is not to say cultural competence is futile, but that one must understand the socioeconomic forces that impact the health of diverse communities and discern when culture is relevant to addressing health behaviors and when to assess structural barriers. In this thesis, I argue that service providers should primarily scrutinize structural factors impacting patients' health and examine what one considers to be cultural behaviors within a structural understanding of the conditions that lead groups of people to exhibit certain behaviors.

To move health fields beyond cultural competence, *structural competency* (Metzl & Hansen, 2014; structuralcompetency.org) must be learned and practiced to provide equitable and compassionate care to people of diverse backgrounds. Structural competency, as defined by Jonathan Metzl and Helena Hansen, is as follows:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases…also represent the downstream implications of a number of upstream decisions about such matters as healthcare and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health (2014, p. 5).

The Structural Competency Working Group and Structural Competency curriculum emerged from the structural competency framework. Founded in 2014, the Structural Competency Working Group comprises healthcare workers, scholars, public health professionals, students, educators, and other community members to promote the training of health professionals in structural competency around the country and beyond (structcomp.org). Currently, Structural Competency is only taught at a handful of U.S. medical schools, one of which is the Oregon Health and Science University (OHSU). The structural competency framework and curriculum guide my research and efforts to understand structural barriers to healthcare access for this unique community in Oregon.

This recently developed framework aims to teach health professionals how to recognize and respond to disease and its unequal distribution due to harmful social structures, such as policies, institutions, and systems (Harvey & McGladrey, 2019). Structural competency also provides a corrective to the cultural competency framework, which often places responsibility and blame on individuals and communities for structurally generated health inequities (Castañeda et al., 2015; Harvey & McGladrey, 2019). This framework is not meant to replace cultural awareness but seeks to promote skills for recognizing how “culture” and “structure” are

mutually complicated in producing stigma and inequality (Metzl & Hansen, 2014). In response to the need for structural competency in healthcare settings, Metzl and Hansen (2014) propose a five-part model of competencies meant to promote awareness of forces that influence health outcomes at levels above individual interactions. The five core competencies are as follows: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating "cultural" formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility. This thesis focuses on the first and fourth competencies.

Structural competency is imperative to the study of structural barriers to healthcare access because barriers that exist arise from policies, institutions, and systems that adversely impact historically marginalized communities. Structural competency builds on an understanding of the social determinants of health, structural inequality, and structural violence, which I have discussed in this review. By focusing on structural barriers impacting the Mam community, local service providers can better understand and address issues that give rise to inaccessible healthcare since structural competency emphasizes socioeconomic systems, policies, local and state institutions, and social forces that produce and perpetuate barriers to access. For local service providers to become competent in structural barriers that impact the Mam community, one must explore Mam women's experiences of healthcare access in Oregon. This is a central aim of my thesis project: focusing on local service providers to understand and address barriers to healthcare access for Mam women.

CHAPTER III

METHODS

Building Connections

Early in 2022, I contacted a nonprofit in Alderbridge that served the Mam community. They ran a food pantry twice a week for anyone in the community—no questions asked. People who wanted to access the food pantry did not have to provide their address, number, proof of residency, etcetera. Because of this, it was a safe space for the Mam community to get the resources they needed, including food, hygiene products, diapers, clothing, face masks, and more. I wanted to start making connections with people and organizations in Alderbridge and learn more about the Mam community, so I volunteered at the food pantry a few times. While there, I noticed most people coming were Mam women and their young children. I did not see male partners with them, which stood out to me initially but made sense considering the food pantry hours and their partners' irregular work schedules. Unfortunately, I could not volunteer in the spring because my classes interfered with the food pantry hours. I kept in touch with the nonprofit and one of its employees who is Mam. He was accommodating and often shared his knowledge of Alderbridge and the Mam community.

A few weeks later, I learned that the food pantry had shut down, and as a result, I lost my connection to the Mam community. During the summer of 2022, I officially began my research and interviewed service providers in Alderbridge and nearby cities in Lane County. My goal was also to interview Mam women during this time, but with the food pantry closed and the slowdown of certain services during the summer, I could not find opportunities to connect with Mam women. After interviewing several service providers, many told me how challenging it is to do outreach with the Mam community during the summer because their children are out of

school, and many of the services Mam families receive are affiliated with the school. The COVID-19 pandemic also disrupted many services and added another barrier to outreach.

A primary service provider for Mam women in Alderbridge is the Support Center. The Support Center helps families with various services, such as offering parenting classes, connecting families to resources, and assisting families with healthcare navigation, to name a few. The Support Center also provides services in Spanish and has been a safe space for immigrants for several decades. The Support Center would not begin sessions with the Mam women until September 30, 2022. Because of this, I was only able to interview service providers in the summer and had to wait until the fall to begin speaking with the Mam women.

It was a fortunate turn of events because I learned about the Mam community from people who have experience working with Mam women before interacting with them myself. I also built relationships with service providers in the area and gained their trust to work with a vulnerable population they wish to protect. After meeting with four staff members at the Support Center and explaining my research project, they were open to receiving me and allowed me to volunteer and meet the Mam women with whom they work. I volunteered on Fridays and did not start interviewing Mam women until November because I wanted to get to know them first, let them know me, and earn their trust before asking them to be part of my research. Waiting to interview them was crucial to the staff and me at the Support Center because we did not want the women to feel uncomfortable or like I was only there to get their information and leave.

It was and is essential for me not to engage in extractive research practices and instead focus on building community with and learning from the Mam women. Researchers have historically exploited Indigenous and minoritized communities to produce research and academic publications (Tuhiwai Smith, 2021). Because I conducted this research as part of the

requirements for receiving my master's degree, I wanted to ensure I was not exploitative in my research practices. To assuage the moral dilemma I was experiencing from working with an Indigenous community as a non-Indigenous person, I built trust building, community building, and reciprocity into the design of my research project. Though this project is tied to my academic career, I saw it as an opportunity to use my privilege, time, and resources as a graduate student to produce something intentional and valuable for the community.

As a result of moving at a slower pace than planned, my data collection took much longer than expected. Data collection took longer than expected because I did not have access to a group of Mam women until October 2022. I spent over a month building trust with the women before asking if I could interview them because I wanted them to feel comfortable around me beforehand. By the end of December 2022, I had only interviewed one Mam woman when my goal was to interview at least five by that time. However, that is not to say that I did not learn much about Mam women throughout those three months. I learned about the barriers they faced by attending classes at the Support Center, the challenges they had in their personal lives, how difficult it can be to communicate a clear message when Spanish is their second language, and several other challenges that arise with being an immigrant in the United States. I documented what I learned in my field notes and referred to them throughout my data analysis. These field notes allowed me to gain a more extensive understanding of the barriers Mam women experience, even if they did not mention them explicitly in the interviews.

I want to emphasize how important community building is when learning about people and their communities. There is not only one way to learn about people, their culture, lives, successes, hardships, and so forth, as suggested by Western research practices. Linda Tuhiwai Smith, leader of Indigenous education, argues that "the term 'research' is inextricably linked to

European imperialism and colonialism" (2021, p. 1). Throughout history, the West has exerted power over "the Other," like Indigenous peoples and the Global South, and extracted data and knowledge for the researcher's benefit (Tuhiwai Smith, 2021). As a non-Indigenous person working with an Indigenous community, I was cognizant of the power differentials between myself and Mam women. I made it my plan to prioritize the needs and wants of the community and not my goals as a student researcher. This project was not about what I wanted to learn from the community but about what those outside their community should know if we are to address barriers to healthcare access for Mam women. I also shared what I learned, including community resources, with the Mam community and service providers throughout Lane County to put my research to use immediately and provide something in return to the community.

Research Design

Interviews with service providers

Now that I have foregrounded the importance of building connections, trust, and mutual respect, I will outline the study's timeline. My project was an applied, exploratory study with three phases—community-based data collection, thematic data analysis, and presentation to key stakeholders. From July to September 2022, I identified key participants among service providers for interviews. I used purposive and snowball sampling methods; the inclusion criteria were that they must have experience working with Mam women from Alderbridge. I did this by looking up local healthcare facilities and organizations in Alderbridge and perusing online resource guides to develop a list of potential service providers for interviews. I called and emailed these organizations and asked if anyone had experience working with the Mam community and would be willing to speak with me. Some organizations never contacted me or knew little about the Mam community or if they served them. Others knew who to direct me to or were grateful I was

calling and looking to support the Mam community. I interviewed nine service providers from five organizations, including a local PeaceHealth Medical Center, Lane County Public Health, Alderbridge Mental Health (pseudonym), Support Center (pseudonym), and Lane Community College Dental Clinic. I did not use the real names of two organizations to protect the location of this town. I also want to emphasize that the service provider's opinions do not represent the opinions of Lane County Public Health, PeaceHealth, and the other organizations involved. Table 1 further details the nine service providers I interviewed.

Table 1. Participants: Service providers.

Pseudonym	Affiliated organization	Job title	Years at job	Location
Miranda	1) PeaceHealth Medical Center 2)Support Center	1) Community health worker 2) Program coordinator*	*29	Alderbridge
Marta	Support Center	Family support specialist	27	Alderbridge
Gabriela	Support Center	Family support specialist	3	Alderbridge
Adriana	Support Center	Family support specialist	2	Alderbridge
Yesenia	Lane County Public Health	Community health nurse	2	Lane County
Mariela	Lane County Public Health	Community health nurse	2	Lane County
Elena	Lane County Public Health	Disease intervention specialist/ Community health worker	5	Lane County
Phillip	Alderbridge Mental Health	Bilingual therapist	2 (Additional 6 years working with the community at previous job)	Lane County
Vivian	Lane Community College Dental Clinic	Dental assistant	1	Eugene

I conducted semi-structured interviews focusing on understanding barriers to healthcare access for Mam women from the service provider's perspective. The service providers make up a majority of my interlocutors due to challenges recruiting Mam women. As a result, my findings

are primarily based on service provider opinions. Although I interview fewer Mam women than service providers, service providers can offer a broader perspective of Mam women's experiences because providers have interacted with numerous Mam families. Due to COVID-19 precautions and the preferences of my interviewees, I conducted interviews in person, on Zoom, or over the phone. The interview questionnaires consisted of twelve questions. Interviews were audio recorded and lasted anywhere from thirty minutes to one hour. I then transcribed them verbatim before analyzing them.

After learning about resources the Mam community could access from my interviews and research, I compiled a list of local resources in Alderbridge and Lane County and created a resource flyer. The purpose of this flyer was to share the information I learned from the service providers with the Mam community so they could easily access the services and support offered by local organizations. The flyer is in Spanish and contains the organization's name, services offered, whether they speak Spanish or Mam, and contact information. The services listed include medical, dental, addiction, mental health, family, food, transportation, and more. I gave these flyers to the Mam women I met and the service providers I interviewed. I also shared the flyer with other women at the Support Center and service providers I met throughout my research so that they could have it on hand and share it with more Mam families and colleagues. The resource flyer is in the appendix, but I have removed some organization names and contact information to not reveal the town's location.

Observations and interviews with Mam women

From October 2022 to April 2023, I volunteered at the Support Center almost once a week and interviewed three Mam women at the Support Center. In total, I attended twenty classes and volunteered for approximately seventy hours. I volunteered on Fridays because Mam

women and other women attended a parenting class in the afternoon. I met over ten women—most were Mam, a few were Quiché, and one woman was Mexican. As a volunteer, I primarily helped with child care so the women could focus on the parenting class, and I supported the staff whenever they needed an extra hand during class. I also helped the women with things like downloading and navigating an app they needed to receive notification from their child's school, reading their mail to them because it was in English, and coordinating a ride for a Mam speaker because the driver spoke English. After every class, I recorded my field notes of observations and things learned from the women during the parenting classes to supplement the interviews. Several barriers expressed during the interviews became apparent during my time at the Support Center. The findings I discuss throughout this thesis emerge from the data collected through interviews and observations.

For interviews with women, I used convenience sampling to find participants and the following inclusion criteria: 1) self-identify as Mam, 2) live in Alderbridge, and 3) are 18 years or older. I initially had an extended interview questionnaire, but upon meeting the women and talking to a staff member, we agreed it would be best to shorten the interview and simplify the questions. I decided this because the Mam women were shy and did not talk much. I conducted their interviews in Spanish, and although they understand Spanish, they are still not as comfortable speaking Spanish as Mam, so I had to ensure my questions were clear and straightforward. The interview questionnaire had fourteen questions and asked about their conceptualization of health, their experiences accessing healthcare services, and their thoughts on improving access. Unlike service provider interviews, I did not record interviews with Mam women for two reasons. The first reason is I conducted interviews in the room where the class took place, and because we could not be alone, I did not want to record anyone else who did not

consent. The second reason I decided not to record was that some women were hesitant to be interviewed, and being recorded could deter them even more. Knowing how fearful immigrants can be when sharing personal information, I felt they would feel more comfortable being open and honest if they knew I was not recording. With their permission, I took handwritten notes and used them for my analysis.

Table 2 displays basic information about the three participants. I refrained from asking for more personal demographic information due to the possibility of them being undocumented, unwilling, or just uncomfortable sharing personal information with me. I was only able to formally interview three Mam women. In part, this was due to the compressed time conducting interviews due to ongoing interruptions related to the COVID-19 pandemic, and because I was limited to Mam women that could speak Spanish and consented to an interview. Interviews were conducted with a convenience sample of women at the support center who were available to speak with me after their classes. For some women, this was a barrier to participation, as they shared rides to the center and did not have time to engage in my interview due to transportation issues.

Table 2. Participants: Mam women.

Pseudonym	Age	Number of children	Age of youngest child	Health insurance
Carmen	45	6	6 mo.	CAWEM
Alma	42	4	4 yrs.	MAF
Isabel	27	2	5 mo.	Moda Health

Policy and data analysis

In addition to interviewing Mam women and local service providers, I also explored federal, state, and local policies affecting access to healthcare for immigrant populations. This involved reviewing Medicaid, Affordable Care Act, Oregon Health Plan, Financial Assistance

(charity care program), and the Public Charge policy. This online research was critical to understanding the political facet of structural barriers to healthcare access in Alderbridge. I also incorporate interviewee opinions in my analysis of policy barriers.

I began analyzing interviews in December 2022 with Dedoose 9.0, a qualitative and mixed-methods research software program. I continued to analyze interviews as I conducted them with Mam women. I first applied open coding to search for key themes and categories as different barriers appeared as I read the interview transcripts. I then applied focused coding to identify barriers related to policy, socioeconomic status, living in a rural community, and other themes that appeared from the open coding process. I also wrote analytic memos when reviewing interviews and field notes. The prominent themes, primarily consisting of various structural barriers to healthcare access, are the foundation for the findings of this thesis. Part of my analysis included operationalizing "culture" and "structure."

Defining "culture" and "structure" was essential before classifying what constituted a cultural barrier versus a structural barrier. A conventional definition of culture dating back to the 19th century defines culture as a set of knowledge, beliefs, morals, and customs held by a defined group of people (Kim, 2019). A definition of structure relevant to this study is the economic, political, social, and ecological conditions and systems that shape control over and access to material goods and resources necessary for individual and collective life (Kim, 2019). According to the Structural Competency Working Group, structure includes policies, economic systems, institutions, and social hierarchies that have produced and maintain social inequities as well as health disparities, often along the lines of social categories such as race, class, gender, sexuality, and ability (structcomp.org). I use these definitions to categorize barriers raised in the interviews. I also include language, immigration status, and geographic location to expand on the

conceptualization of cultural and structural barriers. Culture and structure are not isolated and are difficult to disentangle; therefore, I attempt to classify barriers into three groups: 1) cultural barriers; 2) structural barriers; and 3) cultural barriers as structural barriers.

Presentation to key stakeholders

Once I completed data analysis and wrote my findings, I shared the results with key stakeholders in the community, including the service providers I interviewed and others throughout Lane County that serve the Mam community. Service providers who have not worked with the Mam community expressed interest in learning about the community and also attended the presentation. The presentation served as an opportunity and method for further understanding service provider opinions regarding barriers to healthcare access for the Mam community. It was a way for me to share my findings with the community, as well as receive feedback about the legitimacy of the barriers I revealed through my study.

The presentation occurred in May 2023, was held on Zoom, and lasted one hour. I presented my findings and recommendations for the first thirty minutes, then spent the remaining thirty minutes discussing comments and questions from the attendees. Approximately thirty-five community members attended, representing organizations including Lane County Public Health, Lane County Health and Human Services, Lane County Developmental Disabilities Services, Lane County WIC (Women, Infants and Children), Community Health Centers of Lane County, South Lane Mental Health, Community Alliance of Lane County, Escudo Latino, Daisy CHAIN, Nurturely, The Arc Lane County, Family Resource Center, Head Start of Lane County, Eugene School District 4J, Friends of the Children Lane County, University of Oregon, and other community members.

Overall, the presentation was well received and created a space for community members to connect and discuss an issue on several people's minds. After the presentation, I received an email from one of the attendees expressing their gratitude and said, *"Abriste muchas puertas donde hacía falta"* [You opened many doors where it was needed]. The meeting allowed disconnected organizations to come together and have a conversation about the challenges they encountered when working with Mam and other Maya communities. Many people expressed interest in the meeting because they knew this community faced barriers but were not sure what steps to take as an organization or community because their conversations about the Mam community were happening independently from the rest. Following my presentation, I emailed the attendees a copy of the presentation, a flyer with local health resources (see Appendix C), and a list of recommendations for addressing the barriers discussed (see Table 5). This presentation and meeting with community members were vital to my project because I did not want my findings to sit idly on a PDF online. I want these findings to benefit the Mam community by helping improve people's understanding of the Mam community, the barriers they experience, and possible solutions to improve their access to healthcare.

Considerations and Positionality

I decided to focus my research on the Mam community because of my interest in supporting immigrant communities and because of a need my advisor, Kristin Yarris, brought to my attention. Before beginning my master's program at the University of Oregon, I worked in Los Angeles at an immigration law firm serving unaccompanied minors from Latin America. Most youth immigrants came from Central America, sometimes from Maya Indigenous communities like Mam, Quiché, Kanjobal, Ixil, and Q'eqchi'. Prior to working there, I was a Peace Corps volunteer in a Bribri Indigenous community in Costa Rica. There I worked with

children and young adults on health-related topics like mental health, sex education, and youth development.

Because of my experience working with immigrant and Indigenous communities, I wanted to continue to dedicate my work to them. I felt I had the necessary sensitivity and trauma-informed approach (Miller et al., 2019) to work with an Indigenous migrant community. Although I have experience working with immigrants and Indigenous people, I recognize my privilege as a U.S. citizen and non-Indigenous person. These positionalities limit my understanding of Mam women's experiences and create power differentials with my role as a student researcher. That is one of the reasons why I spent months volunteering at the Support Center to gain the women's trust and show them that I was not there to conduct harmful or exploitative research.

The time I spent getting the know the Mam and Quiché women allowed me to become someone they trusted and felt comfortable talking to. My identity as a woman of Mexican descent and my Spanish-speaking skills also helped me connect with the women. They knew I was a graduate student, but my position as a volunteer took the forefront. Throughout my time at the Support Center, I was transparent in my roles and research goals and reminded the women that they could speak with me if they wanted to and that it was entirely okay if they did not. I still treated them equally whether or not they agreed to an interview. This approach made them feel safe enough to say no and informed enough to consent. Even after concluding the interview process, I continued volunteering at the Support Center because I did not want to stop seeing the women and offering my support to them and the staff.

CHAPTER IV

POLICY BARRIERS TO HEALTHCARE ACCESS

In this chapter, I discuss federal, state, and local policy barriers to healthcare access impacting the Mam community. The three Mam women I interviewed were Carmen, Alma, and Isabel. I use pseudonyms for the Mam women and service providers. Carmen is 45 years old and has six children, Alma is 42 and has four children, and Isabel is 27 and has two children (see Table 2). I do not want to reduce who they are as individuals to their motherhood, but pregnancy impacts one's access to healthcare in the United States. Due to the challenges of not having a Mam interpreter available during interviews, I spoke to the women in Spanish. Alma and Isabel had little to no trouble communicating in Spanish, whereas Carmen spoke only a little Spanish. As a result, Carmen may not have clearly understood all my questions and had less to say than Alma and Isabel, which the data reflects. I also want to share that I met and learned from Quiché women at the Support Center. As Maya women from Guatemala residing in Alderbridge, Quiché women have similar experiences to Mam women. I did not learn about the Quiché community in Alderbridge until I met a few Quiché women during my time at the Support Center, and I do not want to ignore their presence. Although I cannot say this study 100% applies to Quiché women too, I think its results can also benefit their community. It would be remiss to disregard what I learned from them alongside Mam women.

Federal

The various healthcare policies at different levels of government can make accessing services confusing, even for people who have grown up in the United States. At the federal level is Medicaid which is the United States federal and state program that provides healthcare coverage for Americans, including low-income adults, children, pregnant women, elderly adults,

and people with disabilities ("Medicaid," 2022). States administer Medicaid according to federal requirements. Immigrants in the United States face barriers to healthcare coverage, but barriers differ among 'qualified non-citizens' and 'non-qualified non-citizens.' 'Qualified non-citizens' include lawful permanent residents, refugees, asylees, non-citizens whose deportation is withheld, non-citizens granted Cuban-Haitian Entrant status, and non-citizens admitted to the U.S. as Amerasian immigrants ("Implementation Guide," 2021). 'Non-qualified non-citizens' are also known as undocumented immigrants. Undocumented immigrants experience more barriers to healthcare access than 'qualified non-citizens' in the United States because undocumented immigrants do not qualify for Medicaid. According to Medicaid federal guidelines regarding non-citizenship eligibility, healthcare coverage is only available for 'qualified non-citizens' ("Implementation Guide," 2021). Medicaid guidelines also require 'qualified non-citizens' to wait five years from the date they were granted their immigration status before they can qualify for full Medicaid; however, states can remove this waiting period.

Although Medicaid is unavailable to undocumented immigrants, states are required to provide limited Medicaid services for the treatment of an emergency medical condition to 'qualified non-citizens' subject to the five-year waiting period and to 'non-qualified non-citizens." This program is known as Emergency Medicaid, or CAWEM, in Oregon. All three Mam women stated that limited coverage is a significant barrier to their access. Carmen and Alma explained that because their coverage is limited to emergencies, they often have to pay out of pocket for doctor visits, the dentist, and medication. Isabel said the lack of complete health insurance coverage had deterred her and others from seeking care because it is too expensive. This reveals the problem of undocumented immigrants only having access to healthcare in the event of an emergency. This limited access can become further complicated when service

providers have the power to determine what is considered an emergency and who is deserving of aid. These decisions can significantly affect the health and well-being of immigrants and detrimentally impact their financial circumstances.

Another policy barrier that may discourage undocumented immigrants from seeking public benefits and services is the Public Charge rule. The 1999 Interim Field Guidance on Deportability and Inadmissibility on Public Charge Grounds defines a public charge as a non-citizen "who has become or who is likely to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense" (USCIS, 2022). Types of assistance considered include Supplementary Security Income (SSI), cash assistance under the Temporary Assistance for Needy Families (TANF) program, state and local cash assistance programs that provide benefits for income maintenance (often called "General Assistance" programs), and long-term care paid for by the government (such as in a nursing home or mental health institution) (USCIS, 2022). In 2019, the Trump administration issued the Public Charge Final Rule, adding public benefits that would count in the public charge test. Those added were federally-funded Medicaid with certain exceptions, Supplemental Nutrition Assistance Program (SNAP), and Public Housing (Section 8). However, this rule was vacated on March 9, 2021, and the 1999 Interim Field Guidance went back into effect.

On September 8, 2022, the Department of Homeland Security announced a final rule that implemented the public charge ground of inadmissibility and went into effect on December 23, 2022. Immigrants can take advantage of benefits such as Medicaid (OHP), reproductive health coverage, Emergency Medicaid (CAWEM), SNAP, public housing and Section 8, WIC, social security retirement, unemployment insurance, and several more (USCIS, 2022; "Know the

Facts," 2022). Now, the public benefits that the U.S. Citizenship and Immigration Services (USCIS) considers when determining whether an applicant is inadmissible under the public charge ground include Supplementary Security Income (SSI), Temporary Assistance for Needy Families (TANF), General Assistance, and long-term care paid for by the government (USCIS, 2022). Confusion and fear about the rules and changes became widespread and deterred many immigrants from seeking critical services they were eligible for due to changes in the Public Charge rule (National Immigration Law Center, 2022). Although immigrants are now eligible for more public benefits, they still may have deep concerns about accessing public benefits and healthcare services for fear of becoming a public charge. Elena, who worked for Lane County Public Health for five years and is an immigrant herself, explains the challenge of seeking support and access to specific programs.

> *Elena*: Immigration [policy], in part, I think, is scary, especially as a refugee. If people are in the process of getting refugee status, they need to be careful with what they apply for. If your hope is to be a refugee one day, which a lot of the Mam families are in the process of, they may be afraid of applying for certain programs. You have to be very careful with what you apply for because at the moment that they call you, and they're like, let's revise your case. If they see that you applied for something that you are technically not qualified for, then that could discredit your case.

Elena's comment highlights the precarious nature of living in the United States as an immigrant and the fear immigration policies instill in undocumented immigrants and refugees. This fear of breaking the rules and risking their chances of naturalization impacts their decisions to apply for resources that could improve their lives and overall health.

State

At the state level, Oregon did not remove the five-year waiting period for 'qualified non-citizens' until July 1, 2022. In July 2022, Oregon House Bill 3352 passed, instituting a program called "Cover All People," now known as "Healthier Oregon," that expands Oregon Health Plan

benefits for residents regardless of their immigration status ("Healthier Oregon," 2022). Oregon Health Plan is also open to all children and teens younger than 19, regardless of immigration status. That includes children and teens with undocumented status or Deferred Action for Childhood Arrivals (DACA) recipients. With the expansion of OHP under Healthier Oregon, undocumented immigrants between the age of 19-25 years and those 55 years and older are now eligible for full OHP benefits. Undocumented immigrants in Oregon between the ages of 26 and 54 do not qualify for OHP unless they are pregnant. Since it was Healthier Oregon's first year, the state had to limit enrollment to stay within the budget for the first program year and said if more funding came, they would add more people ("Healthier Oregon," 2022).

As a result, children and young adults (ages 19-25 years) have more access to healthcare than other young and middle-aged adults (ages 26-54 years). Pregnant adults and older adults (55 years and older) also have more access to healthcare than non-pregnant adults and those between the ages of 26 and 54. At the beginning of this thesis, I stated that approximately 76% of undocumented immigrants in Oregon are between the ages of 25 and 54. This means a majority of undocumented immigrants in Oregon face barriers to healthcare access by not being eligible for healthcare coverage during an almost 30-year period where many health issues and injuries may arise. Phillip, who has been a bilingual therapist in Alderbridge for two years and has additional years of experience working with the Alderbridge community, expressed his concerns with OHP's age restrictions.

> *Phillip*: People who have children, people who work to feed their children, people during their prime child-rearing have been excluded. And in the Mam community, it's a huge maternal health concern, and it's also a concern for parents who do work, or with, you know, women and men, they tend to work in agriculture, which means they're highly reliant on their bodies to do their jobs. And if they get injured at work, I mean they can access healthcare, but it's this patchy problematic system instead of having you know OHP, and you can just go get checked out. Like I said, I'm all about the expansion of

> OHP, and in my mind, it's like an absolute nightmare that someone thought it was okay to do that.

On top of OHP age restrictions, income thresholds limit eligibility. The 2023 annual income threshold for eligibility is $13,590 for a family of one and $32,470 for a family of five ("Combined Standards," 2022). These income limits mean many low-income individuals and families do not qualify for OHP, which is unfortunate since OHP is free and may be the only affordable coverage for many immigrants. During my interview with Alma, she expressed her worry about her and her family losing their health insurance if they were to surpass the income limit. These policies put immigrants and low-income individuals in a delicate situation where being low-income helps them qualify for state assistance, but if they improve their financial situation, they risk losing their aid, and the cost of medical bills could quickly place them back in a financial crisis.

Due to their income, those ineligible for Medicaid in Oregon, or OHP, may apply for healthcare coverage through the Affordable Care Act (ACA) or "Obamacare." The ACA makes coverage more affordable by providing tax credit subsidies to qualifying individuals and families. Those eligible are those whose net income is between 100% and 400% of the Federal Poverty Level ("Affordable Care Act," 2022). Similar to Medicaid, ACA is only offered to 'qualified non-citizens.' According to the Health Insurance Marketplace, most U.S. citizens, U.S. nationals, and lawfully present immigrants are eligible for ACA coverage ("Immigrants," 2022). Undocumented immigrants do not qualify for ACA but may apply for coverage on behalf of documented individuals. This can be an excellent way for undocumented immigrants in mixed-status families to access healthcare coverage; however, paying for health insurance for several family members can be financially burdensome.

Local

At the local level, some service providers offer financial assistance to individuals and families who already do or do not have insurance. For example, the local PeaceHealth Medical Center has a Financial Assistance program (also known as charity care) available for those who make up to 400% of the Federal Poverty Level. Depending on one's income, there is a 65% to 100% sliding scale to help cover medical expenses for free or at a reduced rate. The program is open to everyone, and one does not have to provide a Social Security number to apply, which makes this assistance accessible to undocumented immigrants. However, many immigrants may not know this form of aid exists or how to take advantage of it.

Knowing which providers accept these programs is a challenge to taking advantage of OHP and the Financial Assistance program. Figuring this out can be especially difficult when English or Spanish is not someone's first language, and they are unfamiliar with searching for specific providers. Alderbridge has approximately 40 doctors and clinicians ("Find," 2023). Many accept OHP; however, individuals must still be careful not to assume any provider will take OHP and charge the Medicare-approved amount so individuals can pay less out of pocket. Also, not all providers have a financial assistance program to support uninsured individuals. The Financial Assistance program covers "appropriate hospital-based services provided by PeaceHealth depending upon your eligibility. Financial assistance may not cover all healthcare costs, including services provided by other organizations" ("Financial," 2022). Individuals must be wary of the provider they elect to receive services from because not all providers accept payment through the Financial Assistance program. Although patients may apply for Financial Assistance before, during, or after treatment, there may still be a fear of not being approved for financial support, especially during or after treatment.

Denial of assistance may discourage individuals from seeking healthcare services in the future, which results in delayed treatment or health concerns becoming severe and requiring emergency treatment. No one, including undocumented immigrants, should be forced to wait until their health needs become an emergency to receive timely and affordable care. Policy limitations at all levels prevent undocumented immigrants from equitable healthcare access, which is detrimental to their health and the health of the larger public. Denial of care and treatment to some threatens the general health and well-being of all (Farmer, 2010). Aside from healthcare being a human right, it is crucial to ensure the health of all people because the health of those around us affects us, and no one should be denied care based on their immigration status.

CHAPTER V

HEALTHCARE EXPERIENCES IN OREGON

In this chapter, I provide a glance into the healthcare experiences of the Mam women I interviewed. Because I only interviewed three Mam women, their experiences and views cannot be generalized to the rest of the Mam community. However, they can help us understand what some Mam women experience in Oregon. Where women's experiences align with the insights gained through my interviews with service providers, and with observations made during my research period, we may have more confidence that these experiences are indicative of broader barriers faced by Indigenous women seeking healthcare services in Oregon. Before diving into questions about healthcare access and barriers they have experienced, I first wanted to understand what health means to the Mam women. When asked what it means to be healthy, each Mam woman said it means to be free of illness. Alma said it also means having healthcare coverage which foreshadows the vital role healthcare access plays in these women's lives. Alma also said being healthy means "*el bienestar*" which translates to "well-being" in English.

I then asked the women what type of healthcare is important to them. Isabel and Alma immediately answered, "*Todos!*" [All!]. Isabel went on to elaborate and said physical exams, check-ups, and dental care. Similarly, Alma said medical and dental but also listed vision and mental health as important to her and her family. Carmen answered medical and dental health and talked about food stamps and how access to food has been helpful for her family.

When asked where they seek help regarding their health or a family member's health, they all said the Support Center. Carmen and Isabel said they also go to the doctor, whereas Alma said, "*La escuela y el Centro de Recursos Familiares porque no hay otro lugar adonde ir. Ellos son los que siempre nos han ayudado y son los únicos que hablan español*" [The school

and Support Center because there is nowhere else to go. They are the ones who have always helped us and are the only ones who speak Spanish]. Alma emphasized the support she has received from Miranda and Marta at the Support Center over the past several years. Miranda and Marta have worked with immigrant communities in Alderbridge for approximately 29 and 27 years, respectively. They are well-known and trusted throughout the community and have played a key role in supporting Mam women.

Healthcare Coverage and Experiences

I asked the Mam women to share any positive and negative experiences they have had in Oregon when seeking care to gain a general understanding of their experiences and current access to healthcare. Carmen, Alma, and Isabel have different health insurance plans, including Oregon Health Plan's (OHP) Citizen/Alien Waived Emergent Medical program (CAWEM), Medicaid's Medical Assistance for Families (MAF), and Moda Health, a private health insurance company based in Portland, Oregon. Fortunately, they had more positive than negative things to say. First, Carmen and Isabel expressed their gratitude to the Support Center. Carmen emphasized the support she has received from Miranda, and Isabel highlighted the help she gets from the Support Center with making appointments because of language barriers.

Alma and Carmen shared their gratitude for healthcare access in the United States. Alma explained how she is thankful to have healthcare here and the opportunities she and her family have been given in the United States because, in her words, Guatemala had no healthcare coverage or resources to assist them. Guatemala's constitution states access to healthcare is a human right, but lack of funding and limited services in rural areas of Guatemala exclude Indigenous communities from this fundamental right (Kragel et al., 2018; Bhatt, 2012). Alma reiterated her gratitude for the social programs in Alderbridge and Oregon. Carmen echoed

sentiments similar to Alma's. Carmen said healthcare access has not been difficult for her family, and she likes their healthcare plan because her children are covered through OHP, and she and her husband are covered through CAWEM. She also expressed how healthcare access in Alderbridge is better compared to Guatemala because in Guatemala, her kids were not insured, she and her husband were not covered for emergencies (like with CAWEM), and it was expensive to pay out of pocket.

Though these things are true, and they are grateful for their limited access to healthcare in Oregon, it is crucial to understand that it does not mean healthcare access is perfect for Mam women. It may mean their access to healthcare here is better than a healthcare system that failed them in the country they felt the need to leave. Their negative experiences with healthcare in Guatemala could affect their perceptions and feelings about healthcare in the United States. It could also mean the Mam women felt compelled to perform gratitude because of their immigrant identity and desire to be deserving of aid. For refugees, their legitimacy and access to support are often contained in a language of gratitude and deservingness (Taylor, 2016). Immigrants' feelings of anger combined with gratitude give rise to a complex affective state vis-à-vis the country of resettlement, where they may feel a "fragile obligation" to give thanks for their new life and accept the price of resettlement (Iqbal et al., 2021). Therefore, one should critique any gratitude expressed because better healthcare access does not equate to equitable healthcare access, and expressions of gratitude may be compulsory for immigrants. That is important to consider since the Mam women expressed gratitude despite apparent barriers, and one woman shared a negative experience.

Isabel, Alma, and Carmen expressed that they have had positive experiences with healthcare providers in Oregon. Isabel shared her experience of having a child at PeaceHealth

Sacred Heart Medical Center at Riverbend and said she received good medical attention from the doctor and nurses. In general, Isabel said the medical attention she receives is always good, and the staff is friendly. Alma said everything has been good, she has had no problems, and they have helped her a lot every time she has visited. Likewise, Carmen said the doctors and dentists treat her well and that she had a positive experience giving birth to her last child. She also gave birth at PeaceHealth Sacred Heart Medical Center at Riverbend and had a Spanish interpreter available. It is important to note that these women had increased access to healthcare than undocumented individuals who are not or were not recently pregnant because the Oregon Health Plan provides prenatal care to people regardless of immigration status. Literature on immigration and health has shown that undocumented immigrants are treated as undeserving of care, while pregnant individuals may be deemed deserving of care owing to their pregnancy and concerns for the health of the child (Chase et al., 2017; Ruiz-Casares et al., 2013; Vanthuyne et al., 2013). As a result, the Mam women's experiences with the healthcare system may be more positive compared to interactions regarding other health conditions.

When it came to negative experiences, three main complaints arose. The first is language barriers. Isabel expressed that language barriers have been problematic for healthcare access because few providers speak Spanish, and even fewer speak Mam. As a result, she has had to rely on the Support Center to help her schedule appointments. Isabel also stated that the way billing processes work here is a challenge because she does not know how much services will cost ahead of time. Sometimes she has to wait two weeks before receiving a bill and would prefer to know in advance to see if she can afford the services provided because it is usually costly. Carmen said she had positive and negative experiences but could not remember specific examples of negative ones.

On the other hand, Alma recalled a specific experience she describes as having "left me with trauma" [*me dejó con trauma*]. About five years ago, Alma became pregnant with her last child. When she was around three to four months pregnant, the doctor told her that her baby would not be okay and might be born with health issues. Alma does not recall everything the doctor told her, but she remembers they said she would have to terminate the pregnancy. Confused and in disbelief, Alma went against the doctor's order and continued her pregnancy. Six months later, Alma gave birth to a healthy baby. Although Alma was grateful her baby was born free of illness, she expressed anger and confusion toward the doctor who said something was wrong with her baby and suggested she terminate the pregnancy. To this day, Alma is still unsure why the doctor said those things and what exactly they thought was wrong with her baby. As she recounted this story to me, she kept referring to this incident as trauma. She was confused back then and remains confused about it now because she never received an explanation. Alma said she puts it behind her because her baby is healthy, and she does not want any problems. "*No quiero problemas*" [I do not want problems], she said, referring to why she tries to put the incident behind her. Alma then told me the hospital (which will remain unnamed) solicited her feedback regarding her experience, but she decided not to complain or bring up the incident because, in her words, "*No quiero problemas."*

"No quiero problemas" brings to light many undocumented immigrants' concerns in the United States. Undocumented immigrants may refuse to file complaints or interact with government services out of fear that the interaction could lead to deportation (Castañeda et al., 2015). As a result, immigrants' agency is limited due to systems that discriminate against them and target undocumented individuals even when they are seeking help. This limited agency could

result in immigrants not receiving proper care and remaining in unsafe circumstances due to the fear of speaking up.

CHAPTER VI

STRUCTURAL BARRIERS TO HEALTHCARE ACCESS

After speaking with the Mam women, I soon realized they were bringing up concerns that the service providers also mentioned to me months prior. The service providers I spoke with had much more to say than the Mam women, and as a result, my findings rely heavier on perspectives from service providers because of the sheer number of barriers they discussed with me and the fact that my research consisted of a greater number of interviews with service providers. However, in several instances, the barriers mentioned by the Mam women I interviewed aligned with themes identified in my corpus of interview data with service providers.

There may be several reasons why Mam women were reluctant to openly discuss barriers to healthcare access in Oregon, such as language barriers, fear, unfamiliarity with being interviewed, or perhaps my questions were not straightforward. This outcome foreshadows a barrier I uncovered that reveals that the Mam community is hesitant to advocate for themselves and relies on the advocacy of trusted community members, which I will discuss later. I believe service providers had significantly more to say than the Mam women for the reasons mentioned.

In this chapter, I provide an analysis of structural barriers to healthcare access that Mam women experience. This overview is not an exhaustive list but underscores the most prevalent barriers revealed. I already discussed federal, state, and local policy barriers and will now discuss barriers related to socioeconomic status, living in a rural community, language, fear and mistrust, unmet basic needs, and additional barriers to consider.

Socioeconomic Status

Service providers and Mam women stressed socioeconomic barriers as key concerns for this population. The cost of services and medication is too expensive to the point where they

refuse to seek care because they worry they may be unable to afford it. Although they have healthcare insurance, coverage is limited, especially under CAWEM, which only covers emergency medical procedures and pregnant individuals. Isabel, Carmen, and Alma emphasized cost as a barrier because they lack comprehensive healthcare coverage. Affording healthcare services is incredibly challenging when most Mam families are low-income and work in low-wage labor like the agricultural sector. Take the following comment by Elena that shows how difficult affording medical services and medication can be.

> *Elena*: An issue among this community is the cost, right? It's determining if they don't qualify for, we saw this when we were signing up people for OHP Plus, even like twenty dollars is a lot. So how to get them covered and which clinic has the funds to say, okay, we won't charge them for anything. And not only that, it is not only the visit, medication. Medication is a huge part…if they don't have insurance. Twenty dollars for medication can be a lot.

Barriers to affording healthcare services are also compounded by unaffordable housing. Miranda, who has worked in the community for 29 years and with the Mam community for over ten years, discusses housing as a socioeconomic barrier to healthcare access.

> *Miranda*: Most of them are unhoused, if we were to use the definition of unhoused that on their own they couldn't pay their own rent. So they have to, you know, partner with other families in order to have a place to live. Because they can't pay $1,200 by themselves, so, they need to have all the people to live in their place. And so that's definitely a barrier.

Miranda explains how the cost of rent forces many immigrant families to share a crowded home in order to afford rent. Consequently, crowded living spaces significantly impacted the health of the Mam community during the COVID-19 pandemic due to difficulties social distancing and quarantining in their homes. COVID-19 disproportionately affected low-income families and put them at a greater risk of infection and severe illness due to adult members working outside the home in essential jobs and having existing comorbidities, limited resources, and a lack of health

insurance (Siegel & Mallow, 2021). Not only does low socioeconomic status impact access to healthcare but also one's health in general, making access to healthcare even more essential.

Additionally, few service providers in Alderbridge can see people at a low cost, limiting the options Mam women have to receive care. Yesenia, a Community Health Nurse with Lane County Public Health, explained that only a few providers accept CAWEM. As a result, there are long waitlists, and Mam women sometimes have to wait up to four months before receiving the care they seek. Yesenia said it is especially tough for them to find dental, vision, and specialist providers that accept CAWEM. Lastly, most Mam women do not drive, which places the burden of transportation on family members at times. Because of the hours healthcare providers' offices are open, their family members may have to take time off work to get them to their appointment, which cuts into the income that they exceedingly rely on. The high cost of health services, medication, and rent, plus limited affordable healthcare options are a few of the many structural barriers to healthcare access for this community.

Living in a Rural Community

Geographic barriers encompass two main challenges for Mam women: transportation issues and lack of local services. As mentioned, many Mam women do not drive or have a driver's license. That means they rely on someone else to drive them places or on public transportation. Many Mam families only have one car at home, and the person that drives may be working, busy, or overburdened by being the sole driver in the family. Yesenia describes transportation-related barriers to healthcare access.

> *Yesenia*: Transportation. That's another big barrier, yes. Many of our Mam [clients] don't drive. They don't have a driver's license, and they live far away in [Alderbridge], and the bus system is not as good…sometimes their lives can become very complicated because then the husband, father, brother, whoever is making sure they make it to the appointment has to take time off that day or a few hours and that takes away from their income, which is another barrier.

As Yesenia stated, the bus system can be confusing, especially for someone from another country and unfamiliar with public transportation in the United States. Taking the bus has many additional challenges, such as bus drivers who only speak English and the cost, especially if Mam women travel with their children. Transportation becomes more complicated when Mam women have to travel outside Alderbridge to access healthcare services not offered in town. An issue with living in a rural area like Alderbridge is that most services are in urban areas like Eugene, Oregon. Mariela, also a Community Health Nurse with Lane County Public Health, highlighted this challenge when I asked her about geographic barriers.

> *Mariela*: I feel like most of the services are in the Eugene local area; they have to travel to Eugene. There are not that many resources in [Alderbridge], and that's just the reality of rural communities. Not just [Alderbridge], but you know, even if you're in [neighboring town], you're still not close enough. So really, I think that's what it is, and like I said, it's like they're lucky if these families have a car that can get them there if they're not having to carpool or use the LTD bus systems, which I don't even know if there's one that can get you from [Alderbridge] to Eugene. So yeah, geographically, I think that is a huge barrier.

Yesenia stressed how most services and resources are in Eugene, more than 20 miles from Alderbridge. One of the principal resources lacking in Alderbridge is family planning. Currently, there are no family planning services available in Alderbridge. There used to be, but the clinic shut down recently, and no plan was put in place to provide continuity of care to this community. The clinic's closure now forces Mam women to travel to Eugene to receive critical reproductive health services during a potentially vulnerable time when they may become pregnant and face an increased risk for major medical issues.

From my observations, transportation was also a challenge for the women trying to attend the Friday class at the Support Center. The women would typically walk, carpool, or get a ride from a local community bus service. The bus service was useful but often had a waitlist and the

driver only spoke English. That meant someone from the Support Center had to call on behalf of the women, and the women would show up late to class because of how long the bus would take. The weather also played a huge part in whether the women would show up to class on Friday. During the winter, several women did not attend classes because the weather was too cold or rainy for them to walk to the Support Center with their young children. Not having a car or license, confusing bus systems, and a lack of local services produce transportation challenges, especially during the long winters in Oregon, impacting access to healthcare services.

Language

Language barriers are the most prominent and perceivable challenge for Mam women regarding healthcare access. Mam women speak a language indigenous to Guatemala that often goes unheard in the United States. Carmen stressed that there are barely any Mam interpreters in the community. She also explained that even when a Mam interpreter is available, effectively communicating can still be challenging because Mam speakers sometimes speak different Mam languages. Northern, Central, and Southern Mam languages exist (England, 1983). Nonetheless, this does not deter Mam women from learning how to communicate with others. Some Mam women already know a bit of Spanish, but many of them are learning Spanish now. Though the women I worked with could communicate in Spanish to various degrees, it was clear that some women were more comfortable, confident, and fluent when speaking their native language, Mam. Consequently, they may not fully understand what is communicated in Spanish since Spanish is their second language.

Communicating in Spanish to some degree is better than being unable to communicate at all. However, even trying to communicate in Spanish is sometimes a barrier because not every service provider has a Spanish speaker. If they do, they sometimes only have one speaker,

limiting when the Mam community can receive assistance in Spanish. Challenges can arise when the one Spanish speaker is busy, at lunch, or out of the office. It is ineffective to rely solely on one Spanish speaker to communicate with a large Spanish-speaking community. Also, getting around can be extra challenging if they cannot read bus schedules or communicate with the bus driver where they need to be picked up and where they need to be dropped off.

Yesenia elaborates on the issue of insufficient Spanish speakers and points out the problem with organizations' phone trees. She said the following when I asked her about a local ride service.

> *Yesenia*: No, they don't speak Spanish and of course they don't speak Mam. But yes, they don't speak Spanish, and it's very hard for the Hispanic community to access this resource. Most places don't speak Spanish, which is really sad, even dental offices, family care providers, and if they do speak Spanish, their phone tree is really hard sometimes. When you press *español* [Spanish], *para español, oprima dos* [for Spanish, press two], and you press the two, and then it just takes you to this loop, and loop, and loop, and then you end up at the front desk anyway.

As Yesenia describes, some offices set up a Spanish option for their callers, but often the Spanish option redirects them back to English, or the person who picks up the line speaks only English. The intention to make services accessible to Spanish speakers is there, but they are not always successful and further complicate things for the Spanish-speaking community.

Almost everything written and spoken in English, and a lack of accurate translation makes communication and healthcare access difficult for immigrant communities. As a result, Mam women must rely on others to interpret for them, which can present a set of other issues. Phillip expands on this dilemma and his concerns as a therapist when his patients need a local interpreter.

> *Phillip*: Interpreters are hard because there aren't very many of them, and they come from the community. So they often know the families that they're going to be interpreting for. So there's a huge loss of confidentiality. And, I worry too about like if someone, if an

> interpreter knows someone's story or has been impacted by it, or they're part of it…trauma injuries can occur or reoccur if we're not mindful.

Phillip's remark underscores two significant risks of relying on a limited pool of interpreters when dealing with sensitive information like mental health and health in general—lack of confidentiality and traumatization. Sometimes Mam women's partners interpret for them because their Spanish is better. Depending on a family member or partner for interpretation can also be a serious concern if domestic violence is involved. It can be very difficult and dangerous for a Mam woman to ask for help or explain her situation if the interpreter is her abusive partner or someone who could put her at risk if the information disclosed does not remain confidential.

Additionally, most Mam women do not read or write, and Mam is not a written language, so communication and information received are always verbal. That can make remembering things, like doctors' orders, prescription directions, and more, challenging and concerning, especially when the information given is in a language they are not fluent in. Mariela describes how tedious and unreliable phone interpretation services can be when reviewing vital information.

> *Mariela*: If there's anything really important that I need them to understand, I need to connect with an interpreter. Legally, I have to, but also, I feel like that is just best practice. So for several reasons, interpretation doesn't always go very smooth. They disconnect all the time, and getting them back on the line is like a 7-to-10-minute ordeal because I have to give my information every time, you know, to the interpretation service, like here's my billing information, this is the agency I belong to. I mean, it's just this tedious, tedious thing so I can see why the [Mam woman] that I work with specifically, chooses to decline interpretation services. I've kind of made it be like, you know, I have to because of my job, that's why we're going to use it. But if it were up to her, she wouldn't, and I totally understand why. Interpretation services don't always go super well.

As you can see, service providers make an effort to find a Mam interpreter, but it is not always possible or practical. Additionally, interpreters can be extremely expensive, and small

organizations may lack funding for interpretation services. When a place can afford or requires interpretation services, the interpretation services are not always pleasant for Mam women, like Mariela and others have described. For example, a local hospital in Alderbridge sometimes uses a computer or phone to offer interpretation services in Mam. However, using a computer or phone is less than ideal when discussing someone's health. Adriana, a Support Specialist from the Support Center, shared how inadequate virtual interpretation services are.

> *Adriana*: I think something that's really missing that's hard with, even though they're getting the interpreting services, there is a difference between interpreting and having empathy and having cultural awareness. That is missing. So like when Mam [individuals] go to the doctor, sometimes there's like a computer that's just translating what they're saying instead of having a person talk to another person and be like, "Where does it hurt?" And giving the patients a chance to actually feel like humans and be like, "Here." Instead of like, "She's saying it hurts there." It's so disconnected. The compassion, because it is, a lot of our families are timid to speak. Not because they're not able to, but because it's kind of like, you just kind of learn to submit, and so, kind of give them a little bit more of a voice to say what they need to say. But you need someone that's able to give them that nurturing, that care that they're really needing as people, not just translating for them.

Adriana highlights how uncomfortable experiences with interpretation can affect how Mam individuals interact and communicate with doctors. Because Mam women tend to be shy, there needs to be a compassionate person speaking with them in person to help them feel comfortable expressing themselves. Elena also shared similar sentiments.

> *Elena*: We would go in with the families into the medical appointments, that's another part of the medical system, to go and translate for them. And that's a problem because as a Community Health Worker, even though you're bilingual, you're not certified to translate for someone…and oftentimes, what we would get as an answer is like, oh, well they can call Linguava, use this translation service, call on the phone. And so, then the doctor will be speaking on the phone and then pass it on to the patient, and that is messed up because that is not patient care one-on-one, and it makes the experience even harder. Maybe the families are getting traumatized, and they don't want to go to the doctor because they don't want to be going through that. Maybe they're talking about something personal with their provider that they don't want a translator to know on the phone.

Elena brings up an important issue regarding traumatic experiences with doctors and how it could affect Mam women returning to the same provider. Negative experiences with doctors and interpretation services could deter them from returning, creating a barrier to healthcare access because Mam women may feel reluctant to return. These complications can discourage Mam women from seeking care or wanting interpretation services, negatively impacting their quality of care and services.

Fear and Mistrust

The story of Alma and "*No quiero problemas"* highlights the fear immigrants may have when voicing their concerns about healthcare or other issues they have experienced. They may fear that filing a formal complaint puts a spotlight on them and may result in people digging into their personal information and immigration status. Mariela describes the challenges of ensuring equitable treatment of immigrant individuals and communities.

> *Mariela*: I can only speak for Lane County; I feel like they're making really good strides as far as reflecting equity and equality in their policies. It's just really hard to enforce it… who's watching out and keeping these agencies accountable to actually make sure they're following the law, using an interpreter every time…Who's going to enforce that these things happen? And really, the only way to bring this to light is if one of the patients complains and says, you know, "This didn't…," but most of these families that this happens to, they don't know how to make a formal complaint, or they wouldn't want to. They're not going to put themselves in a place where the focus is on them when really, they're trying to stay hidden from the government.

Mariela demonstrates how it is challenging to hold institutions accountable when the people experiencing inequitable treatment fear reporting unfair treatment and filing a complaint. As a result, undocumented immigrants have less agency and power over their circumstances due to their vulnerable sociopolitical position as undocumented people in the United States. This could

prevent health services from being improved for the Mam community if the individuals receiving inequitable treatment do not feel safe voicing their concerns.

There may also be fear and confusion when seeking healthcare and public services because of the unclear public charge policy discouraging immigrants from applying for public programs. Fear can also arise if people hear stories of negative experiences their community members have had. Phillip shared a story about an undocumented woman in Alderbridge who was wearing an ankle monitor. Immigration judges and U.S. Immigration and Customs Enforcement (ICE) officers can impose ankle monitoring as a condition of release from immigration detention. Aside from being constantly surveilled by the government, ankle monitors have physical and psychological consequences. These consequences include pain, swelling, bruising, chafing, and burning from heat when it is recharging; social stigma from being seen wearing an ankle monitor; and trauma from being reminded of the circumstances of being an undocumented immigrant in the U.S. (Pittman, 2020). Phillip said a doctor tampered with this woman's ankle monitor at one of her appointments. It was unclear whether or not this was an accident, but it resulted in immigration picking this woman up and scheduling her for deportation.

> *Phillip*: There was a person a couple of years ago, a woman who was being monitored by ICE, and she had an injury from her ankle bracelet, and so she went to see her doctor to get checked out, and I don't know if the doctor removed it or if they tampered with it enough. So the device notified ICE, and immigration did pick her up and scheduled her for deportation…really heartbreaking, and so [she] left Dad with his children here, and then mom is now…in Guatemala. So it's like one story, but it had a big splash in the community. So if you know that happened to your neighbor, you're totally going to be wary of any types of support or institutions.

The story of this incident spread, and along with it, fear that amplified the mistrust this vulnerable community already has toward strangers and unfamiliar organizations. Thus, trust-building takes a very long time. I experienced this firsthand at the Support Center because it took

a long time for the women to feel comfortable with me and willing to participate in an interview. Even though I volunteered for several weeks and feel like the women learned to trust me, some women still declined an interview, which I completely understand.

Because it takes so long to gain the Mam community's trust, few organizations have been as successful as the Support Center in being a safe space for Mam women. Consequently, many Mam women only reach out to the Support Center for help. This is not a problem in and of itself; however, Phillip argues that this results in protective barriers that drive limited engagement with the rest of the community. When the Mam community only reaches out to one organization, there is a higher risk for burnout and less opportunity for them to build trust with other organizations and spread out support and labor. As a therapist, Phillip underscores the importance of expanding their network because having more community connections could benefit their mental health.

> *Phillip*: I think there is some fear or maybe like uncertainty because people don't have connections…sometimes service providers become overly protective, and then they're the drivers of that behavior pattern. So like, an advocate or a person in the community is like, "Well, I'll be the safe person you can come to for help." And that's great, but if they don't actively connect clients or parents to other safe resources, then people are going to continue to be wary. And so, I've noticed that there's some protective behaviors happening in the community that I think is one of the contextual drivers of limited engagement that could be addressed.
>
> …they're good intentions that can also limit our ability to get people connected in efficient ways…so if we can spread the love and broaden the support network then people have more doors they can go to and places that can give support when they need it. And that benefits everybody; it keeps people from burning out, it increases access and connection, and connection is really good for people's mental wellness, so it's kind of like a win on all fronts if we can do that.

On the other hand, Adriana from the Support Center argues that the Mam community cannot just go anywhere for help because not everyone understands the type of support they

need. They must be taken step by step and have things carefully explained because of language barriers. That is why Mam women continue to seek support from the Support Center and are perceived to have limited engagement with the rest of the community.

> *Adriana*: With agencies, something that we definitely struggle with on behalf of them is that everybody wants to empower our [Mam] families. However, there is a disconnect with what the process looks like. So, everyone is like, "Oh yeah, send them to us, send them to us." And we send [Mam families] to them, but they're not ready to receive them in the right way. What they need is someone to hold their hand and actually walk them through the process, not just walk through the front door, and they can just tell them all this stuff to do.

The above quote and quote from Phillip show complementary views that complicate the problem of fear and mistrust throughout the community. These two perspectives make it hard to break the cycle of limited trust and engagement, which keeps Mam women from broadening their network and accessing more available services. That is not just a barrier for Mam women but also for service providers who are constantly busy finding ways to support those in need in the community.

As Phillip mentioned, service providers can experience burnout if they become overburdened by an unequal distribution of demand from the community. During my interview with Miranda from the Support Center, she mentioned how busy they are on two occasions. First, she said, "We are so buried in the everyday needs," then she said, "We're just so swamped." It is challenging for one place to meet the needs of the Mam community, which is why other service providers need to be competent, compassionate, and patient enough to also work with the Mam community. Considering what I have discussed surrounding fear and mistrust, service providers also need to take the time to build connections and trust with the Mam community if they want to support them successfully. Only then can the Mam community feel safe enough to expand their networks.

Additionally, the Support Center staff will have a better chance of not being overworked and experiencing burnout, which, if it occurs, could affect the support the Mam women receive. I also want to emphasize that understaffing can contribute to burnout, which could be making the Support Center feel swamped. There are more structural barriers than fear and mistrust that can create a risk of burnout. I wanted to briefly highlight understaffing because it is not just the fault of Mam women needing support and only going to the Support Center for it. There is a high demand for support in Alderbridge, and Alderbridge should be equipped to meet the demands of its community members. That includes having enough staff to attend to those in need and enough time to build trustworthy relationships with the Mam and other vulnerable communities.

Limited resources and challenges with inter-agency collaboration are topics that were keenly discussed at the stakeholder meeting I held. Service providers from Alderbridge expressed how difficult it is to collaborate with other agencies when it feels like they are competing against each other for funding. Relatedly, a service provider said, “It seems like the passion is there, and then it ends up that there aren’t enough service providers or capacity to do what is truly needed,” which underscores the need for expanding support networks. Echoing Adriana’s quote, another provider stated that it is hard to refer clients to other organizations when they know clients have had negative experiences there. The comments from the meeting reiterated that collaboration among providers is necessary to ensure providers know how to properly assist Mam families, which is essential for broadening trustworthy support networks.

Unmet Basic Needs

Many service providers stressed that they cannot successfully help improve healthcare access and the overall health of Mam women if their basic needs are not met. There have been

times when Mariela had plans to meet with a family and work on medical-related tasks but had to shift gears because of an immediate concern that took priority.

> *Mariela*: This family is like about to be evicted because there's too many occupants in this apartment, and so getting them applications to another apartment has been really hard because they don't have anyone to fill out these applications for them, and they don't understand the process…It's just a lot of explaining like this is how things work. So, it's hard when you have so many medical things because that is really my focus, but then you can't address those things unless you could also address their basic needs such as housing and, you know. So, it's a lot of, "What is the priority today?" Because I came in with an agenda, right? But then they told me like, "Oh yeah, we haven't applied, and we've had this application for two months." I'm like, okay, let's shift gears here. This is what we're going to do today then.

This quote demonstrates how it is not easy for service providers to work on other goals when they direct much of their energy toward ensuring Mam women and their families have a place to live and food to put on the table. Because many Mam families struggle to afford housing and adequate food, service providers in the area often focus on helping them meet their basic needs, in addition to their primary jobs, so families do not go unhoused or hungry.

It was clear how vital providing basic resources for the Mam community was when I volunteered at the food pantry in Alderbridge because most people who showed up were Mam women. When they dropped by, they always left with food and toiletries, sometimes clothing, and almost always asked for diapers and baby wipes. The food pantry was a valuable resource for them, evident by the long line outside the door. Unfortunately, the food pantry shut down and has not reopened since. No other organization has replaced the food pantry, repeating a pattern of lack of continuity of services, like with the family planning clinic that closed. However, other programs are trying to address food insecurity in Alderbridge in other ways.

For a few weeks, there were vegetable drops every Friday at the Support Center, where Mam women could bag as many foods as they wanted to take home with them. The women also

had the option to have vegetables delivered to their homes if they needed help with transportation. The program working with the Support Center is Veggie Rx, a produce prescription program that subsidizes produce at local farmer's markets. Every week, the Mam women that show up to the Support Center for the parenting class receive ten dollars in the form of Veggie Rx vouchers for each family member. While this program is helpful for some, it does not address the more significant structural issue behind food insecurity in Alderbridge.

Additionally, not everyone has access to these produce vouchers. The Mam women only receive them if they attend class and can only use the vouchers at two locations—one of which is closed during the winter. I went to the farmer's market that was open in the winter to see what it was like for myself and was surprised by how expensive the produce was. The space was small, and as a result, the options were limited. There were a lot of local artisanal products and not many culturally relevant foods that Mam families might be interested in. This could explain why the Mam women were not using their vouchers, according to one of the service providers associated with Veggie Rx.

Proximity and transportation could also be why Mam women prefer to go to other local markets to buy food, especially if they are already accustomed to purchasing food from a different market. Visiting an unknown market may be challenging and intimidating if the staff does not speak Spanish. An issue that arose with one Mam woman who went to the farmer's market with her Veggie Rx vouchers was that the person working said they could not accept them. There was a miscommunication with the staff at that farmer's market, which was eventually resolved after the Mam woman informed us of the issue. Still, unfortunately, she was unable to bring home any produce that day. She then shared this information with the other Mam women, which could have deterred them from going to that market and using the vouchers. As

shown, structural barriers like food and housing insecurity make it challenging for providers to improve healthcare access when food and housing take precedence.

Cultural Barriers as Structural Barriers

I hardly found any cultural barriers because, as Structural Competency suggests, cultural formulations should be rearticulated in structural terms. Two cultural barriers that were initially present were the Mam women's shyness and illiteracy. Although these characteristics were common among the Mam women I worked with, I hesitate to strictly call these cultural barriers because there are structural systems behind why these traits exist. The Mam women may come off as shy because they do not feel comfortable speaking in Spanish or because they still have some fear and mistrust around certain people. As for illiteracy, Mam is not a written language, and violence against Indigenous communities has made it nearly impossible for Indigenous peoples to preserve their languages to the extent of Western ones. On top of that, there is a lack of schools and resources in Mam communities in Guatemala, which could contribute to the low literacy rates among Mam women. Also, according to Yesenia, more Mam men than women are fluent in Spanish. This could signify gender inequality in education or access to opportunities encouraging language learning, such as working and socializing outside the home.

> *Yesenia*: Something that is interesting is that usually, the males speak Spanish well, and the females usually are not as fluent, which I found very interesting. I think that it is very cultural, maybe boys go to school, maybe boys do this, maybe boys leave the house. I don't know, I haven't asked, but I noticed that at the hospital, usually, the man of the house was fluent in Spanish, and he helped translate for his wife, his sister, his brother, his mom sometimes.

Another cultural barrier related to language is the variation among Mam languages due to regional differences. Within the Guatemalan highlands occupied by the Mam people, small

towns are isolated, resulting in different Mam languages (England, 1983). As previously discussed, this sometimes complicates the use of Mam interpretation services.

Lastly, Adriana describes how the Mam community has learned to live with their pain, so they do not often seek support.

> *Adriana*: Besides just the, like the cultural norms…educating and just even the need for resources like that. You don't know what you need unless you need them, and sometimes our families have known such a different lifestyle where they're like, "The pain in my mouth, that's just how it is." They don't even know that that's not, there's no other option than that…some of the kids went to the dentist, and they were in pain, and we had no idea because they had just kind of learned to live with that pain. So that's a big thing. It's just that difference of culture, of, you know, growing up in a very different atmosphere than here. And then when they get here, it's like, "Oh, I need to go to the doctor?"

A cultural analysis might suggest Mam individuals have a higher pain tolerance or prefer to seek medical attention only if it is an emergency or if they have already attempted other healing methods. A structural analysis would argue that inaccessible healthcare has forced them to adapt and learn to live with their pain and illnesses. Therefore, requiring service providers to educate and encourage Mam individuals to seek help before health issues become severe. The lack of knowledge of when to seek care can become a barrier to healthcare access for Mam women.

Additional Barriers to Consider

In this chapter, I provided an overview of the structural barriers to healthcare access that Mam women are currently experiencing in Alderbridge, Oregon. I could not cover the full scope of barriers that Mam women experience, but the barriers discussed are the primary ones service providers are aware of and trying to address. Additional barriers that arose in my observations and interviews but did not take the forefront include racism and discrimination, shortage of care, digital divide, bureaucratic barriers, need for child care, overreliance on others, and lack of

attention given to the Mam community. I do not want to ignore these barriers, so I briefly discuss them in the remainder of this chapter.

Racism and discrimination can prevent Mam women from receiving equitable services and deter them from seeking care in the future. Racism and discrimination can be tied to fear and mistrust, but it can also be an entirely separate barrier to access if providers refuse to serve Mam women based on discriminatory beliefs and practices. Thankfully that was not a common issue I came across in my research. However, there was one story where a Guatemalan woman could not take her driver's license test because the driving instructor spoke only English, even though she requested a Spanish speaker for her test. The driving instructor told the Guatemalan woman, "I cannot go with you because I'm sure we're going to crash because I don't understand you, and you don't understand me, and when you know how to speak English, you can come back." Although this story is not directly related to healthcare access, this woman's inability to get her driver's license could result in unintended consequences, such as being unable to get around town or drive to her appointments.

Shortage of care is another barrier because there are few healthcare providers in Alderbridge. It is related to the barrier of living in a rural community but also deserves to be highlighted as a distinct barrier because despite Alderbridge being a rural community, there are not enough providers to serve its community. As previously mentioned, there is no family planning in Alderbridge, and individuals sometimes have to wait four months to see a dentist. That is not solely a consequence of living in a rural community but a result of insufficient service providers that can attend to their unique population in Alderbridge. As a result, Mam women face barriers to healthcare access because of the lack of local service providers in Alderbridge.

The digital divide, or unequal access to digital technology, has also made it difficult for Mam women to access healthcare services. First, most online websites and information are in English. Second, many Mam women are unfamiliar with using a computer or smartphone. At the Support Center, I helped the women download an app on their phones and taught them how to use it because they had trouble doing it independently. It is common for healthcare providers to send information via email or an app which can create a barrier for Mam women if they are unfamiliar with working their phones. It is also challenging to navigate websites to find a provider that accepts your insurance and to make an appointment, especially when all communications are in English. Mariela, one of the community health nurses, told me a story of when a Mam woman accidentally canceled an important appointment via text—"She just responded to it somehow and canceled the appointment, and it was an audiology appointment, and those are really hard to come by, and they're really hard to reschedule." Even though the text message was in Spanish, Mam language barriers and the digital divide combined to create another barrier to healthcare access during a time of increased technology use.

Bureaucratic barriers came to light during my interviews when service providers told me stories of them trying to address barriers we discussed but were blocked by red tape or rules that prevented them from following through with their plans. Elena described a challenge regarding grant funding that limited their ability to support the Mam community in Alderbridge. One year, their team at Lane County Public Health received funding to enroll individuals in OHP, but they knew they had to build trust with the Mam community beforehand. As I have stated, building trust is imperative to successfully working with the Mam community, but this takes time. As a result, the grant funding was eventually pulled because the staff did not meet the expected quota in the given time frame for the grant. Elena said, "What this grant meant to me was not only

about meeting the quota and enrolling people into OHP, but it was about creating a safe spot with the community, a community that lived far away from Eugene and didn't know how to get ahold of Community Health Centers." Because of expectations associated with grant funding, ways to support the Mam community are limited and sometimes dependent on if there is funding for the labor required to help alleviate barriers the Mam community is facing.

Additionally, bureaucratic rules have prevented individuals from becoming interpreters for Mam women. Individuals like Elena and Mariela, who the Mam women trust, have tried to assist them at their doctor appointments but were told they could not help because they were not certified interpreters. As a result, Mam women have no choice but to speak with an unknown interpreter over the phone, which tends to be an unpleasant experience. Miranda from the Support Center also described how difficult it is for Mam speakers from the community to become certified interpreters. Outstanding young Mam leaders in Alderbridge are already supporting their community and have considered becoming interpreters knowing language barriers are a huge challenge. Miranda explained how they would not be able to become certified interpreters because the state-certified interpreter exams are challenging and require them to take classes, study, and be proficient in English. Even though these individuals can navigate conversations in Mam, Spanish, and English, it is not satisfactory enough for the state, preventing them from addressing the lack of Mam interpreters in the community.

"Child care is the next frontier for us," says Miranda when asked about barriers that still need to be addressed. Lack of child care is challenging for Mam women in the community, preventing them from getting where they need to go. They must find someone to watch their children or take them with them if they have an appointment. That becomes a challenge if they do not have a car seat or enough money to spend on public transportation for themselves and

their children. Even if the women get to where they need to go, it is difficult for them to focus on the services they are receiving when caring for their children. For example, a primary reason why classes offered at the Support Center have been successful is that they offer child care. While the women focused on learning and getting the support they needed, the other staff and I played with the children and ensured they did not interrupt the class. Unfortunately, few other places offer child care, making it difficult for Mam women to access services.

Because of language barriers, there is an overreliance on others that Mam women experience. Mam women must rely on others to help them enroll in OHP, make an appointment, find a ride, communicate with the doctor, fill out paperwork, pay bills, and more. The staff and I helped the women with all these things during my time at the Support Center, as well as reading them their mail, explaining the information they received from their children's school, calling an immigration attorney for them, and helping them apply for other programs. All this can be highly frustrating, isolating, and concerning when they cannot take things into their own hands and do it themselves. They have to trust the people they are relying on, which can be terrifying when it has to do with their health. They must relinquish their control and hope the person they are counting on has their best interests in mind and will not cause harm. Not being able to do things on their own can be a barrier to healthcare access, especially if there is no one trustworthy around to offer support.

Lastly, I noticed throughout my research that many people did not know the Mam community existed. When calling different service provider offices, I was often met with confused staff and questions about this community. Some service providers said they had worked with Guatemalan clients but did not know some were Mam and assumed they all spoke Spanish. A service provider I talked to, but did not formally interview told me he had Guatemalan clients

who did not understand the Spanish interpreter, so he assumed they spoke “different Spanish dialects.” He had no idea they were Indigenous and spoke an entirely different language the Spanish interpreter could not understand. Nonetheless, service providers were curious and wanted to learn how to support the Mam community. I was surprised to hear so many had no idea this community needed special support. Immediately I knew that location would present several barriers to Mam women if they attempted to access their services. It illustrated that the lack of attention and services given to the Mam community was inevitable if people did not know they existed and required specific support. If people do not know who needs help, they cannot help them, which is why I wanted to bring attention to the Mam community with this project.

CHAPTER VII

RECOMMENDATIONS

Addressing Barriers

What service providers are doing

In this chapter, I share what service providers are currently doing to address these barriers. I also discuss what service providers and the Mam women I spoke with suggest should be done to improve access to healthcare for this community. The community resources flyer in Appendix C shows services available to Mam women in Alderbridge and around Lane County. These services include free prescriptions for low-income individuals with or without insurance, free dental evaluations, sliding scale fees, cash payments, free classes, help with public services, food and transportation, and more. For example, a bus service in Alderbridge offers door-to-door service, which some Mam women use to come to classes at the Support Center on Fridays. However, this bus sometimes has a long wait time, and not all the drivers speak Spanish. Although these services are not perfect and may be difficult for Mam women to access, I want to bring attention to the work being done to help immigrant and low-income communities like the Mam community. I hope it shows what is possible and inspires change in other spaces, especially those working with undocumented immigrants.

In addition to offering affordable care to all community members, Alderbridge Mental Health helps clients with advocacy, resources, food, housing, paperwork, and more. If anyone needs help picking up food from the food pantry, they can pick it up and drop it off at their house for them. Alderbridge Mental Health also has a YouTube channel with psychoeducation content in Spanish, and they want to create videos in Mam to make their videos more accessible. Lane Community College Dental Clinic has begun to flag Mam speakers in their system and allocate

more time for their dentist appointments so they can spend more time walking them through the process and helping them fill out paperwork. Lane County Public Health helps families connect with a Community Health Center and ensures staff receives training on trauma-informed care. Community health nurses do home visits, meet over the phone or Zoom, and are flexible with meetings to be more accessible and meet the needs of each client. Among the numerous things the Support Center does for the Mam community, they advocate for the women (and men) by calling healthcare providers and getting the financial assistance they need, like charity care or discounts, so the costs do not burden them. These are just some of the actions service providers in the community have taken to help improve access to healthcare for the Mam community.

Suggestions from the community

There were many suggestions from my interviews with service providers and Mam women. All of the suggestions aim to address the barriers discussed throughout this thesis. To organize the suggestions and make them easier to read and share, Table 3 lists the barrier and suggestions related to that barrier. Some suggestions may overlap multiple barriers, but I did my best to sort them out appropriately.

Table 3. Community suggestions to address structural barriers to healthcare access.

Type of barrier	Suggestions
Policy	• Expand OHP to include all undocumented immigrants • Increase affordable housing options • Community-level advocacy to change systems
Socioeconomic	• More charity care programs for immigrants and low-income individuals
Living in a rural community	• Open Federally Qualified Health Centers in rural communities • Bring services (from other cities) to Alderbridge to make them more accessible • Have more transportation options like small buses to help families get around

Table 3. (continued).

Type of barrier	Suggestions
Language	• Have a Mam interpreter and information available in Mam • Hire Spanish and Mam speakers to answer phones • Improve Spanish phone trees • Find interpreters with empathy and cultural awareness instead of virtual interpretation services • Make housing applications and other documents available in Spanish • Make information available through visuals, infrographics, video, etc. • Help Mam individuals with OHP, appointments, doctor/dental visits, bills, interpreter services • Place yourself in their shoes to improve services (Ask yourself: If I was on this website and didn't speak English, how would I navigate it?)
Fear and mistrust	• Take time to get to know the community, make connections, and gain their trust • Help broaden Mam community support network
Unmet basic needs	• Have a pantry with relevant food, formula, and diapers • Affordable housing options
Cultural	• Provide Mam individuals with tools to navigate the healthcare system • Health education for Mam women (e.g., reproductive health, doctors, diagnoses, medications, etc.) • Mam and Latino/a/x representation in more organizations • Flexible services to meet the needs of the Mam community (e.g., help with immigration, children's school, doctor appointments, bills, etc.)
Racism and discrimination	• Equity classes for all employees
Need for child care	• Increase child care assistance
Overreliance on others	• Empower Mam women to be their own advocates
Lack of attention given to Mam community	• Have community health workers dedicated to Mam community • Training for employees to learn about the Mam community

The several suggestions to improve language access show that language barriers take the forefront when considering improving healthcare access for Mam women. Some of these suggestions can be immediately implemented, while others may be harder to accomplish. For example, improving Spanish phone trees and making documents available in Spanish can easily

be done, whereas finding Mam interpreters in the community will take much more time. Service providers can also begin to think about how they can bring their services to Alderbridge (e.g., mobile services) and educate their employees about the structural barriers and needs of the Mam community. Although some of the most significant barriers exist at the federal and state levels, that does not mean local communities and individuals cannot begin to address structural barriers within their communities and organizations. I hope those interested in addressing structural barriers to healthcare access find this thesis helpful in providing valuable information and suggestions for improving equitable healthcare access for the Mam community.

Recommendations

At the beginning of this thesis, I asked, "What knowledge and changes could help service providers provide structurally competent care to Mam women?" First and foremost, service providers should know what structural competency is and why understanding structural barriers is essential to improving healthcare access. In short, structural competency is the ability to discern how health issues and behaviors represent the downstream implications of upstream decisions like policies, healthcare systems, rural infrastructure, and more (Metzl and Hansen, 2014). I aimed to help people understand structural competency and two of the five core competencies outlined by Metzl and Hansen (2014). The two competencies I focused on and now encourage service providers to practice are 1) recognizing the structures that shape clinical interaction and 2) observing and imagining structural interventions. I want to highlight that this also applies to non-clinical interactions. I have stressed that all service providers working with the Mam community should learn to recognize structural barriers and implement appropriate solutions.

Service providers should know the principal structural barriers to healthcare access for Mam women includes barriers related to policy, socioeconomic status, living in a rural community, language, fear and mistrust, and unmet basic needs. Additional barriers are associated with culture, racism and discrimination, shortage of care, digital divide, bureaucratic barriers, need for child care, overreliance on others, and lack of attention given to the Mam community. Service providers should also listen to the suggestions provided by the community in Table 3 and think about how their organization may be creating barriers to access for the Mam community and communities alike. Only then can service providers begin to address structural barriers and improve access for underserved communities.

In addition to what the community has suggested for addressing structural barriers to healthcare access, I have recommendations to help organizations provide structurally competent care to Mam women. Table 4 lists suggestions that add to those offered by the service providers and Mam women I interviewed. A combined list of all our suggestions can be found in Table 5.

Table 4. Additional suggestions to address structural barriers to healthcare access.

Type of barrier	Suggestions
Policy	• Advocate for the inclusion of undocumented immigrants in health and social services eligibility • Educate Mam and immigrant communities on their rights, public charge policy, Medicaid policies, and policies related to healthcare access • Advocate for policies that address the social determinants of health
Socioeconomic	• Help Mam community meet basic needs • Encourage and support income-generation opportunities for Mam and immigrant communities
Living in a rural community	• Help Mam community learn how to use public transportation
Language	• Establish organization-specific best practices for working with non-English and non-Spanish speaking individuals

Table 4. (continued).

Type of barrier	Suggestions
Fear and mistrust	• Increase collaboration between service providers working with the Mam community
Unmet basic needs	• Organize mutual aid efforts • Encourage and support income-generation opportunities for Mam and immigrant communities
Cultural	• Training for employees to learn about the Mam community and their specific needs
Racism and discrimination	• Structural competency training for those working with Mam and immigrant communities
Shortage of care	• Encourage providers to bring services to rural communities • More health services in rural communities (e.g., Federally Qualified Health Centers)
Digital divide	• Make services accessible for those without or who do not know how to use computers or smartphones • Educate Mam and immigrant communities on how to access websites and services online or on the phone
Bureaucratic	• Advocate for systems change that removes the barriers affecting support for the Mam community
Need for child care	• Build child care into the planning and design of programs, events, and organizations
Overreliance on others	• Educate immigrant communities on their rights (e.g., Know Your Rights)
Lack of attention given to Mam community	• Structural competency training for those working with Mam and immigrant communities

Table 5. Suggestions to address structural barriers to healthcare access (Combined list).

Type of barrier	Suggestions
Policy	• Expand OHP to include all undocumented immigrants • Increase affordable housing options • Community-level advocacy to change systems • Advocate for the inclusion of undocumented immigrants in health and social services eligibility • Educate Mam and immigrant communities on their rights, public charge policy, Medicaid policies, and policies related to healthcare access • Advocate for policies that address the social determinants of health
Socioeconomic	• More charity care programs for immigrants and low-income individuals • Help Mam community meet basic needs • Encourage and support income-generation opportunities for Mam and immigrant communities
Living in a rural community	• Open Federally Qualified Health Centers in rural communities • Bring services (from other cities) to Alderbridge to make them more accessible • Have more transportation options like small buses to help families get around • Help Mam community learn how to use public transportation
Language	• Have a Mam interpreter and information available in Mam • Hire Spanish and Mam speakers to answer phones • Improve Spanish phone trees • Find interpreters with empathy and cultural awareness instead of virtual interpretation services • Make information available through visuals, infrographics, video, etc. • Make housing applications and other documents available in Spanish • Help Mam individuals with OHP, appointments, doctor/dental visits, bills, interpreter services, and more • Place yourself in their shoes to improve services (Ask yourself: If I was on this website and didn't speak English, how would I navigate it?) • Establish organization-specific best practices for working with non-English and non-Spanish speaking individuals

Table 5. (continued).

Type of barrier	Suggestions
Fear and mistrust	• Take time to get to know the community, make connections, and gain their trust • Help broaden Mam community support network • Increase collaboration between service providers working with the Mam community
Unmet basic needs	• Have a pantry with relevant food, formula, and diapers • Affordable housing options • Organize mutual aid efforts • Encourage and support income-generation opportunities for Mam and immigrant communities
Cultural	• Provide Mam individuals with tools to navigate the healthcare system • Health education for Mam women (e.g., reproductive health, doctors, diagnoses, medications, etc.) • Mam and Latino/a/x representation in more organizations • Flexible services to meet the needs of the Mam community (e.g., help with immigration, children's school, doctor appointments, bills, etc.) • Training for employees to learn about the Mam community and their specific needs
Racism and discrimination	• Equity classes for all employees • Structural competency training for those working with Mam and immigrant communities
Shortage of care	• Encourage providers to bring services to rural communities • More health services in rural communities (e.g., Federally Qualified Health Centers)
Digital divide	• Make services accessible for those without or who do not know how to use computers or smartphones • Educate Mam and immigrant communities on how to access websites and services online or on the phone
Bureaucratic	• Advocate for systems change that removes the barriers affecting support for the Mam community
Need for child care	• Increase child care assistance • Build child care into the planning and design of programs, events, and organizations
Overreliance on others	• Empower Mam women to be their own advocates • Educate immigrant communities on their rights (e.g., Know Your Rights)
Lack of attention given to Mam community	• Have community health workers dedicated to Mam community • Training for employees to learn about the Mam community • Structural competency training for those working with Mam and immigrant communities

As seen by the list of suggestions, organizations, service providers, and individuals can implement solutions at different levels and in numerous ways to improve healthcare access for Mam and immigrant communities. The Structural Competency Working Group (SCWG) argues that interventions should occur at the individual, interpersonal, clinic, community, research, and policy level (Neff et al., 2020).

Considering the list of suggestions in Table 5, these potential solutions span the levels of intervention mentioned by the SCWG. This project falls into the research level, and the suggestions fall into the other levels of intervention. For example, service providers can learn more about the Mam community and structural competency at the individual level. At the interpersonal level, service providers can exercise empathy by placing themselves in the shoes of Mam individuals to see where barriers to their services may exist. At the clinic level, service providers can train their staff on best practices when working with the Mam community. At the community level, community members can implement mutual aid efforts. Lastly, at the policy level, individuals and organizations can advocate for policies that address the social determinants of health and for the inclusion of undocumented immigrants.

To offer another way of understanding structural competency and recognizing structural barriers, I share a case study from the SCWG. This case study looks at a corn farmer from Oaxaca, Mexico to illustrate one example of the life trajectory of a migrant laborer in the United States. As a result of colonialism, North American Free Trade Agreement (NAFTA), U.S. healthcare and immigration policy, and federal and local policies, this migrant ended up in the emergency department after being found on the street. Figure 3 shows the events in the migrant's life in black and the structural factors that contributed to these events in red.

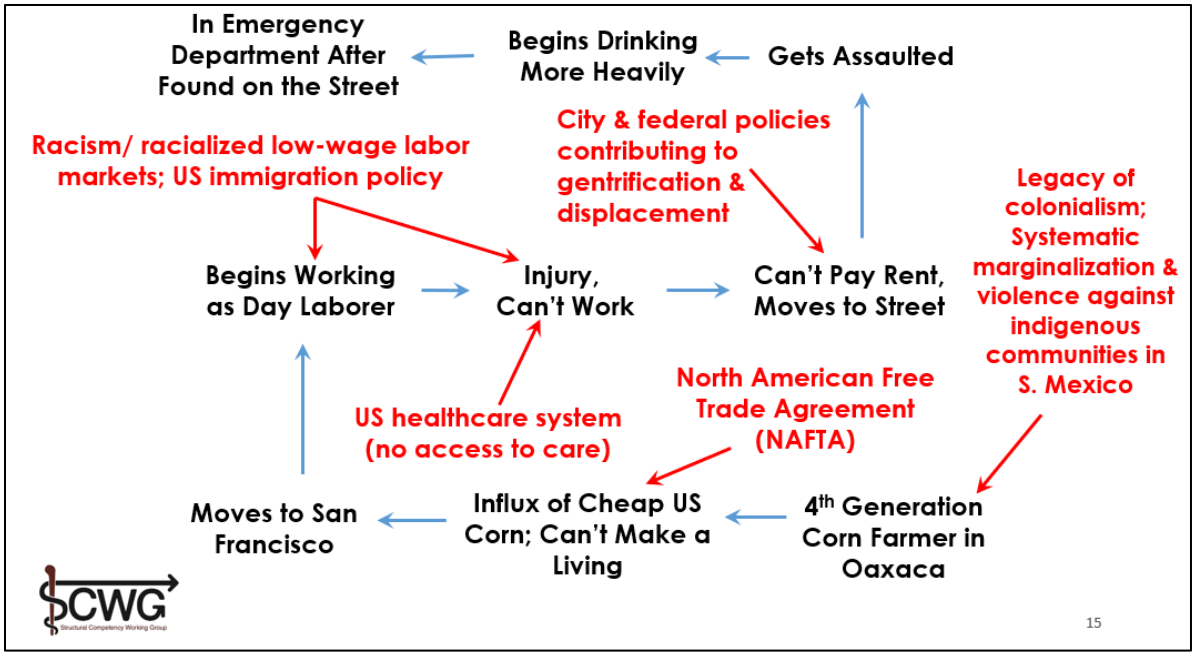

Figure 3. Case Study: Migrant life trajectory and structural forces, from Structural Competency Working Group.

This visual shows how a migrant laborer began drinking heavily and ended up in the emergency department. These events did not transpire solely due to individual behavioral choices or cultural norms but because of structural forces contributing to the migrant's decision to migrate to the United States, work in low-wage labor, live on the streets, and begin drinking heavily. For service providers to understand the structural forces that impact health behaviors and outcomes, like in the case of the corn farmer, they must develop their structural competency skills. Once service providers develop these skills, they can imagine structural interventions for barriers pervading their community. Like the corn farmer, Mam and other migrants can end up in situations where they may have never ended up if structural forces did not limit their agency.

The SCWG also offers examples of interventions to address structural factors impacting the corn farmer's life. Figure 4 outlines the corn farmer's life trajectory and provides interventions at various levels, from the individual to the policy level.

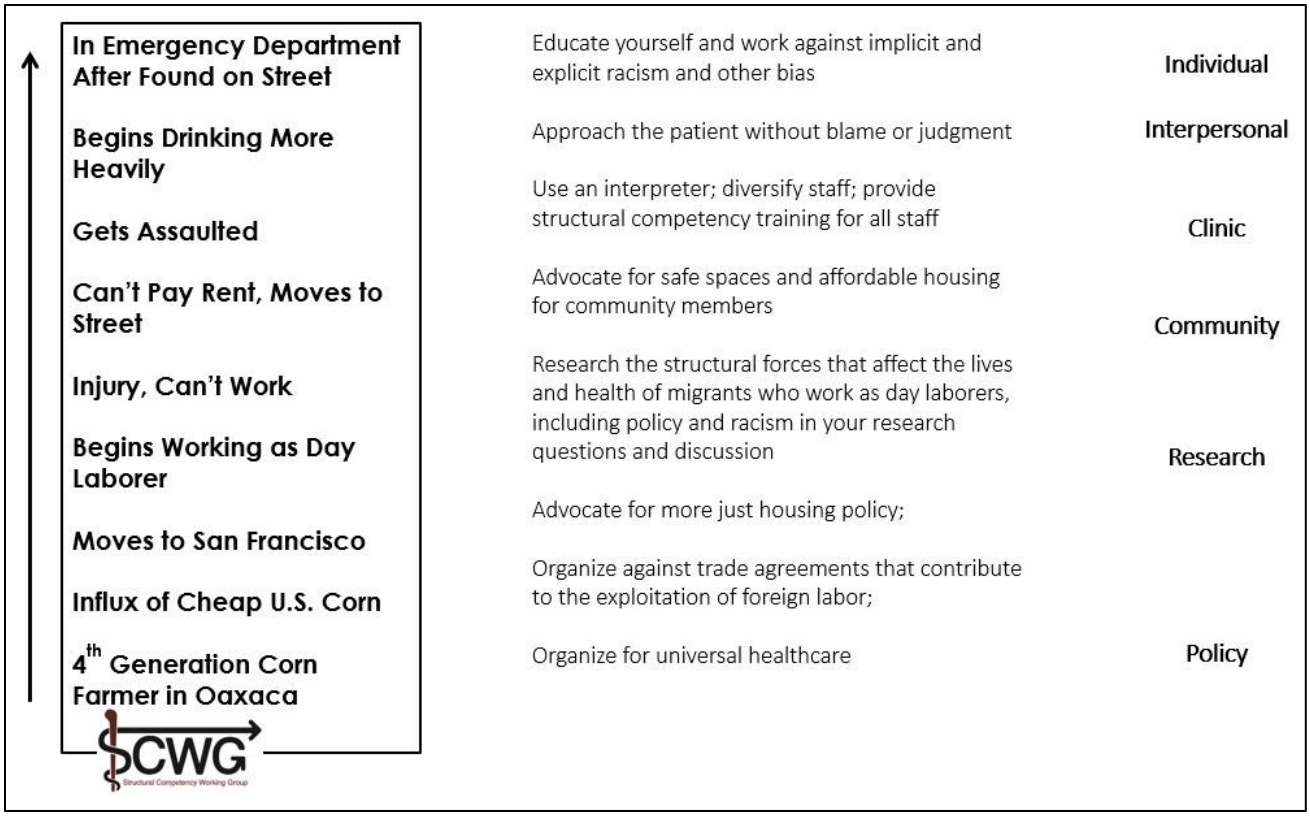

Figure 4. Case Study: Levels of intervention, from Structural Competency Working Group.

Although this is just one case study, one can see how these interventions can improve the health and well-being of immigrants throughout the United States. Education, understanding, structural competency training, researching structural forces, advocating for just housing policy, and organizing for universal healthcare are all actions reflected in the suggestions for addressing structural barriers for Mam women and the corn farmer case study. It is no coincidence that these structural interventions overlap because systems in the United States are built in ways that harm immigrants, like the Mam women in this study and the corn farmer from Oaxaca.

I hope the SCWG case study helps people draw connections with the stories of the Mam women and better understand the ways structural forces impact access to healthcare for immigrant communities and how structural interventions are necessary for addressing barriers. I also hope service providers working with Mam women in Oregon find the list of suggestions

useful, along with the structural competency framework and case study from the SCWG. Lastly, I hope this project successfully highlights structural barriers to healthcare access for the Mam community in a way that benefits them and improves their access to equitable healthcare in Oregon. If service providers take the time to understand the structural barriers Mam women face, the structural competency framework, and the suggestions offered, I think service provider efforts to address these barriers will be fruitful.

CHAPTER VIII

CONCLUSIONS

Limitations and Areas for Further Research

This study offers valuable information about working with the Mam community. Although the lessons learned may apply to Quiché women and similar populations, one cannot assume all Indigenous migrant women's experiences are the same. Therefore, future studies should seek to understand how other Indigenous and migrant populations experience healthcare access in the United States. This study also only looked at women and did not highlight the experiences of Mam men in Alderbridge. It would be valuable to look at the experiences of Indigenous migrant men because of gender-specific barriers that may impact men more than women. For example, migrant men have less access to healthcare than migrant women who become pregnant. Moreover, due to gender roles and norms, men may be more likely to work outside the home. As discussed, this work is often agricultural labor which is harsh on the body. Consequently, men may become injured and ill more than women, highlighting their disparate health experiences. The experiences of Indigenous migrant men should be understood further to improve access to equitable healthcare for all in Oregon.

I was only able to interview three Mam women, limiting the range of experiences I could uncover. I also interviewed these women in Spanish because it was difficult to have a Mam interpreter available during the interviews, which occurred at unpredictable times. Conducting interviews in Spanish could have limited the women's abilities to express themselves since they are more fluent in Mam. Moving forward, listening to Mam women's experiences and suggestions in their native language will be necessary to understand barriers to healthcare access in Oregon further.

Lastly, this study briefly offers suggestions for addressing structural barriers to healthcare access. An in-depth analysis of the suggestions offered, their viability, and how to implement them would be beneficial and provide a valuable guide for those looking to take action in addressing structural barriers to healthcare access.

Conclusions

Improving the health of diverse immigrant communities requires structural and community-based solutions that address structural barriers and the social determinants of health. With this study, service providers from all professional areas can start to see their community's health outcomes and behaviors in structural ways and practice structural competency. Structural competency should not be limited to medical schools and professionals and should expand its reach to public health, social work, and other service providers. With this knowledge, I hope service providers can better understand their clients' experiences and implement changes to improve healthcare access for their most vulnerable populations.

I encourage service providers and researchers to learn more about other communities' needs. There are different ways to do this, but I argue we should move away from demanding time and knowledge from marginalized communities and push ourselves to use more of our time to get to know their communities better, be patient with them, gain their trust, make sure research is relevant and beneficial to them, and give back to their community so the relationship is not one-sided. Ensuring these will require more time on both sides. Still, I believe it will offer a richer understanding of the people one is working with and foster more robust and even relationships between provider and client or researcher and participant.

Lastly, I would like to highlight the significance of this study at the global level. Although this study looked at a small local community in Oregon, the lessons learned can be

carried to other communities around the world. We are living in a time of increased globalization and migration, which means providers are interacting with communities that are more diverse than ever. People in Oregon and around the world should learn how to work with these communities that have different life experiences, privileges, access or lack thereof, historical marginalization, systemic oppression, and vulnerabilities, that others might not. My study highlights that if we, providers, want to serve our communities, then we need to get to know our communities at a personal level like I got the chance to with the Mam women. Only then can we improve access and the health of diverse immigrant communities.

APPENDICES

APPENDIX A

INTERVIEW QUESTIONNAIRE FOR SERVICE PROVIDERS

Demographics

1. What is your job title?
2. Can you tell me about the type of work you do?
3. How long have you worked with Mam women in [Alderbridge]?
4. How does your work relate to healthcare and/or healthcare access for Mam women?

Barriers to Healthcare Access

5. Do you perceive any barriers to healthcare access for Mam women?
6. Do policy barriers exist for Mam women?
7. Do geographic barriers exist for Mam women?
8. Do socioeconomic barriers exist for Mam women?
9. Are there any other barriers you can think of that we have not discussed?

Addressing Barriers

10. Is there anything currently being done at your place of work to address these barriers?
11. Do you have any suggestions for addressing these barriers?
12. What services do you or can you offer Mam women?

APPENDIX B

INTERVIEW QUESTIONNAIRE FOR MAM WOMEN

Spanish

Preguntas demográficas

1. ¿Cuántos años tienes?
2. ¿Tienes hijos? ¿Cuántos? ¿Cuántos años tiene el más joven?
3. ¿Tienes seguro médico? ¿Cuál tienes?

Conceptualización de la salud

4. ¿Qué significa para ti estar saludable?
5. ¿Qué tipo de atención médica es importante para ti?
6. ¿A dónde vas o con quién hablas cuando tienes preguntas sobre tu salud o la salud de tu familia?

Acceso a la atención médica

7. ¿Cómo han sido tus experiencias al buscar atención médica en [Alderbridge]?
8. ¿Hay algo positivo o difícil en buscar atención médica en [Alderbridge]?
9. Pensando en el momento en que estabas embarazada de tu hijo menor, ¿cómo fueron tus experiencias con la atención médica?
10. ¿Crees que ser mujer Mam afecta tu acceso a la atención médica? ¿Por qué o por qué no?

Preguntas finales

11. ¿Puedes pensar en otras cosas que puedan afectar tu acceso a la atención médica?
12. ¿Cuál es tu mayor preocupación de salud para ti o tu familia, si la hay?
13. ¿Qué crees que podría ayudar a solucionar los problemas que has compartido conmigo? ¿Hay algo que deba hacerse de manera diferente?

English

Demographic Questions

1. How old are you?
2. Do you have any children? How many? How old is your youngest?
3. Do you have health insurance? Which one?

Conceptualization of Health

4. What does it mean to be healthy for you?
5. What type of healthcare is important to you?
6. Where do you go or who do you talk to when you have questions about your health or the health of a family member?

Healthcare Access

7. What have your experiences been like when seeking healthcare in [Alderbridge]?
8. Is there anything positive or difficult about seeking healthcare in [Alderbridge]?
9. Thinking back to the time you were pregnant with your youngest child, what were your experiences like with healthcare?
10. Do you think being a Mam woman affects your access to healthcare? Why or why not?

Concluding questions

11. Can you think of any other things that may affect your access to healthcare?
12. What is your biggest health concern for you or your family, if any?
13. What do you think could help fix the challenges you have shared with me? Is there anything that should be done differently?

APPENDIX C

COMMUNITY RESOURCES FLYER

Note: Some information has been removed to preserve the anonymity of the town's location.

Guía de Recursos Locales de Salud/ Local Health Resources Guide
[Alderbridge] & Lane County

Agencia/ Agency	Servicios/ Services	Idioma/ Language	Contacto/ Contact
Médico ⊕			
Centro Médico Comunitario de PeaceHealth/ PeaceHealth Community Medical Center	-Clínica sin cita, departamento de emergencias las 24 horas, hospital, médicos -OHP, Programa Bridge para atención gratuita y con descuento	Español: sí Mam: interpretación puede estar disponible	[removed]
Voluntarios de Medicina/ Volunteers in Medicine	-Servicios médicos, salud mental, recetas gratuitas para adultos de bajos ingresos sin seguro/ con OHP pero sin proveedor	Español: sí Mam: no	2260 Marcola Road, Springfield **541-685-1800**
Planificación Familiar/ Planned Parenthood	-Embarazo, ETS, pruebas de VIH, control de la natalidad, tratamiento, vacunas, atención médica para hombres y mujeres, anticoncepción de emergencia, servicios de aborto -OHP, escala de tarifas ajustables, algunos seguros	Español: sí Mam: intérprete por solicitud	3579 Franklin Blv., Springfield **541-344-9411** 793 N. Danebo Dr., Eugene **541-344-9411**
Departamento de Salud Pública del Condado de Lane/ Lane County Public Health	-Pruebas de ETS, vacunas por cita -OHP, escala de tarifas ajustables, algunos seguros	Español: sí Mam: intérprete por solicitud	151 W 7th Ave. #310, Eugene **541-682-4041**
Seguro médico/ Medical insurance	Oregon Health Plan (OHP) -Para todos los niños y adolescentes menores de 19 años y personas embarazadas independientemente de su estatus migratorio Oregon Más Saludable -Para los que no califican para OHP debido a su estatus migratorio	Español: sí Mam: no	Sitio: **one.oregon.gov** Para ayuda con la inscripción: [removed]

	-y tienen entre 19 y 25 años o 55 años o más		
Dental			
Clínica Dental del Colegio Comunitario de Lane/ Lane Community College Dental Clinic	-Rayos-X, limpiezas, rellenos y extracciones dentales Evaluación gratis, bajo costo, OHP, acepta efectivo -Financiamiento para la atención específica del VIH	Español: a veces Mam: no	2460 Willamette St., Eugene **541-463-5206**
Clínica Médica de White Bird/ White Bird Medical Clinic	-Citas dentales -Clínica sin cita: lunes y miércoles 7:30am -OHP, escala de tarifas ajustables	Español: a veces Mam: interpretación puede estar disponible	1415 Pearl Street, Eugene **541-344-8302**
Adicción			
Centro Latino Americano	-Apoyo a la adicción para adultos y adolescentes hispanohablantes -Servicios sociales y salud mental -Escala de tarifas ajustables de $10-25, OHP	Español: sí Mam: a veces	944 W 5th Ave, Eugene **541-687-2667**
Salud Mental			
[removed]	-Consejería individual, familiar e infantil, manejo de medicamentos, respuesta a crisis, manejo de la ira, vivienda asistida, programa de recuperación para mayores de 14 años -OHP, escala de tarifas ajustables	Español: sí Mam: a veces con un intérprete	[removed]
Familia			
Centro de Padres/ [removed]	-Educación para padres, ayuda con la tarea/tutoría, referencias a recursos comunitarios -Martes y jueves 8:30am - 4:30pm	Español: sí Mam: a veces con un intérprete	[removed]
Departamento de Servicios Humanos/ DHS	-Asistencia de cuidado de niños para familias elegibles -SNAP (cupones de alimentos) para familias e individuos elegibles de bajos ingresos -Defensor de la violencia doméstica	Español: sí Mam: intérprete por solicitud	[removed]
Alianza de Esperanza y Seguridad/	-Para sobrevivientes de violencia doméstica y sus familias -Apoyo de pares, defensa, planificación de seguridad,	Español: sí Mam: intérprete por solicitud	1557 Pearl St., Suite 400, Eugene **541-485-6513** (oficina)

Hope and Safety Alliance	intervención en crisis, casa segura, apoyo legal, transporte de emergencia, grupos de apoyo, defensa bilingüe		**800-281-2800** (línea de crisis 24 horas)
Para Recursos de Salud Maternoinfantil: https://www.lanecounty.org/cms/One.aspx?portalId=3585881&pageId=4078569 **Solicitud de Recursos de Apoyo para el Embarazo y Padres de Familia:** https://www.cognitoforms.com/LaneCountyTechnologyServices/SolicitudDeRecursosDeApoyoParaElEmbarazoYPadresDeFamilia O llame **541-682-8720** y pregunte por MCH Services (Servicios Maternoinfantil)			
Alimentación, Transporte y Mas			
Banco de Comida/ Food Pantry	-Cajas de comida cada jueves de 9:30am - 12pm	Español: no Mam: no	[removed]
WIC del Condado de Lane/ Lane County WIC	-Educación nutricional, apoyo a la lactancia y acceso a alimentos saludables.	Español: sí Mam: intérprete por solicitud	[removed]
[removed]	-Asistencia con medicamentos recetados, asistencia con servicios públicos, cajas de alimentos, leña, duchas, lavandería y propano -Ayuda para evitar el desalojo/ ejecución hipotecaria	Español: sí Mam: no	[removed]
Servicios de la Comunidad Católica/ Catholic Community Services	-Ropa, pases de autobús, pañales, certificado de nacimiento/ asistencia con identificación, artículos de cuidado personal, inscripción en SNAP	Español: sí Mam: no	1464 W 6th, Eugene **541-345-3628**
RideSource para personas con OHP	Transporte para personas que no pueden viajar en el autobús LTD debido a una discapacidad u otras circunstancias	Español: no Mam: no	240 Garfield St, Eugene **541-682-5566**
[removed]	Transporte público con servicio puerta a puerta	Español: a veces Mam: no	[removed]

Para obtener más recursos de la comunidad, visite https://reliefnursery.org/for-our-families/ o visite [removed]

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