El Significado de Salud:
Social Determinants of Health, Public Policy, and Mexican-born Women in Chicago

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Submitted in Partial Fulfillment
of the
Prerequisite for Honors
in the Department of Women’s and Gender Studies

May, 2016

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Acknowledgements

To the nine women who so willingly shared their stories, thank you for taking the time to speak with me in the middle of full days and many commitments. Without their involvement, this project would not have been possible.

To my wonderful thesis advisor, Professor Charlene Galarneau, I am continually grateful for your thoughtful comments and endless guidance. Your attention to detail and willingness to share your expertise, even after reading half-finished drafts, were instrumental to my process. I am so thankful for your patience and belief in me even when my ideas did not seem feasible.

To Professors Rosanna Hertz and Jennifer Musto, thank you for serving on my thesis committee, and Professor Jonathan Imber for acting as my honors visitor.

To Jen Perez and Francisco Echeverria, along with the staff at Heartland Alliance who graciously let me interview students (often during their English classes), thank you for your support in finding participants and for letting me encroach on each of your classrooms. Your kindness and guidance throughout my two weeks of interviews, as well as the summer of 2013, is greatly appreciated.

To Mariya, thank you for catching every word that I did not, and to my thesis buddy, Savi, thanks for sharing your formatting expertise and for always being the smile peeking out of the next cubicle.

To my friends at Wellesley who have made these past four years some of the most special, I cannot imagine this place without you. Thank you for the calming runs, encouraging haikus, and constant friendship. You have made Wellesley home.

To my family who has been unbelievably supportive throughout this process: my grandmother, Seetha, who makes sure that even while thousands of miles away, I am still well-fed; my brother, Shyam, for so often lending a late night ear; and my sister, Shylee, and father, Ram, for continually adding joy to my life. I am forever grateful to my mother, Indira, without whose support I would not be here today. Her kindness, dedication, and intelligence inspire me daily. I cannot capture in words how much her care means to me.
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Introduction

During the summer of 2013, I interned at Heartland Alliance’s division of Refugee and Immigrant Community Services, an English language school for adult immigrants on the border of the Portage Park and Belmont-Cragin neighborhoods of Chicago. While there, I taught an elective conversation class, substituted for daily grammar sessions, and individually tutored the many Spanish-speaking adult students at the school. My internship culminated in a final project where I created a three-part patient advocacy workshop in which students learned medical terms in English, practiced planning for an appointment, and mastered common phrases useful for speaking with a physician. Through these sessions, many students recounted both positive and negative experiences as immigrants in healthcare systems – one woman described being misunderstood in her child’s high-stress emergency room admission when a translator was not present, another recounted her confusion with the out-of-pocket payment systems in the United States, and many students noted the everyday experience of just not being understood.

Outside of the workshop sessions, I also heard about their experiences aside from healthcare systems – one woman who worked three jobs to cover her and her family’s daily expenses, a doctor who came to Chicago illegally and could neither practice medicine nor find a stable job, and a mother of two who was studying to better navigate life in Chicago’s English speaking neighborhoods. While I was unconsciously aware that their good or ill health was influenced by their income level, place of work, or educational background, at the time, I saw their health and the maintenance of it as chiefly a responsibility of modern medical systems. As an aspiring physician, I thought that in order to positively impact health, I would teach them how

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1 See Appendix A for a map detailing these neighborhoods.
2 This estimate is my calculation based on a number of differing metrics known about the population of Chicago. I used the Pew Research Center estimate that 79.2% of the 1,971,000 Hispanics who lived in Chicago in 2011 were Mexican and, the 2000 Census figure that 40% of all Mexicans in Chicago were born in Mexico. The same Census reports that almost half of all Mexican immigrants are women, and thus implies that Mexican-born women comprise roughly 312,206, or about 11.5% of Chicago’s total population.
3 A number of different demographic factors influence self-reported health measures. For one, Latinos are more...
to better engage with medical systems. This thesis is a continued formal exploration of the connections between the social and economic factors that I did not recognize and health.

In order to continue this exploration, I draw upon existing literature and first-hand qualitative interviews. I focus on the specific narratives of nine Mexican-born women living in the Portage Park and Belmont-Cragin neighborhoods of Chicago in order to consider how social determinants manifest in their daily lives. For example, research points to late cancer diagnosis among Mexican women in the United States (Castañeda, Michael, and Vassileios 2014). My interview with Hortencia, a woman who recently had a brain tumor removed, revealed her perceptions about the causes of her cancer, her satisfaction with the treatment she received, and the ways in which cancer still affects her lifestyle today. Furthermore, the qualitative interviews allowed me to contextualize the little existing research on the health of and social determinants of health affecting Mexican-born women in Chicago to this group specifically. Using the words of these nine women, I built upon relevant research conducted at the state or national level that did not analyze Hispanics or Latin@s by sub-ethnic group or account for gender differences.

In some instances, the literature differed from the accounts of the women. For example, a number of articles pointed to social cohesion and neighborhood dynamics as a useful tool for Mexican communities to improve the conditions in which they live (Rios, Aiken, and Zautra 2012). None of the interviewed women, however, reported feeling close to their neighbors or relying on them for help. These two often complementary, but sometimes divergent, sources of information added complexity in answering the question, what are the social determinants of health most relevant to Mexican-born women in Chicago? and together illustrate the utility and effectiveness of mixed-methods research.
Qualitative interviews furthermore reveal the intertwined web of social determinants that affect Mexican-born women in Chicago specifically. Since the women I interviewed reported relatively few health problems, the experiences they spoke of reflected social determinants that often positively affected their health. For example, many note adopting survival strategies in order to afford high-quality food or obtain necessary medical care. On the other hand, the majority of the interviewees are undocumented immigrants without health insurance who came to Heartland Alliance after being unable to attain their desired job with their current English skill level. The words of these women illustrate the multiple, complex facets of their lives that act as both helpful and hurtful social determinants that alternatively maintain or diminish their health.

Like many scholars who do qualitative research, I found that the intent listening a qualitative method calls for enables the reality of experiences to become clear, delineating such information from preconceived assumptions. As Aana Marie Vigen writes in her work about Latin@ and Black women’s experiences in United States healthcare systems, “qualitative research can be a vehicle for honoring the sacred within each person by checking perception and by learning about the intrinsic complexity within each and every person” (2006). By honoring this individual sacred, qualitative research also “can expose problems in perception – whether our own or that of others” (Vigen 2006). As I found in my own interviews, qualitative methods not only elucidate this complexity and enable more nuanced assessments, they also ensure that conclusions and implications are rooted in the words and experiences of those affected.

Along with providing immense information, doing these interviews also came with specific challenges. As someone who is not ethnically Mexican or a native-born Spanish speaker, I come from a community separate from the women I studied. While my brown skin may have initially helped me pass as Hispanic, my American accent and limited Spanish level suggested
that I am not. I did, however, find commonalities with the interviewees as a member of the Heartland Alliance community and as a devoted Chicagoan.

Together, these interviews served as a personal exercise of communicating across cultural and language barriers in order to create a comfortable environment conducive to sharing personal experiences. Furthermore, this work is my attempt, as a student of Women’s and Gender Studies and soon of medicine, to honor the knowledge of a patient as the foremost expert of her experiences and her body. I hope that this thesis will serve as a reminder of how to see the profundity of the everyday and to listen to the complexity of patient experiences – voices often unheard but paramount – in years to come.

My thesis not only calls for physicians and students to listen to voices often unheard, but also for policy-makers whose decisions shape the very social determinants that affect these voices. The framework of social determinants of health, in other words, not only holds a place among medical practitioners, but also is a powerful tool for legislators and other policy-makers. The existing research on social determinants of health and the voices of Mexican-born women in Chicago together illustrate the unique set of social factors important to their health, and further how particular public policies influence the pathway between social determinants and health.

*A Brief History of Mexican Women in Chicago*

Historical accounts of Mexican immigration have largely focused on Southwestern states, but Mexican immigrants have long been a part of Chicago’s diverse population. Due in part to economic and social unrest in Mexico, Mexican immigrants began settling in Chicago at the turn of the 20th century (Arredondo 2008). Most initial migrants arrived from the central and north-central Mexican states of Guanajuato, Jalisco, Zacatecas, Chihuahua, Coahuila, and Nuevo Leon (Valdés and Valdes 2000).
The Mexican immigrant population in Chicago significantly increased between the first two decades of the 20th century. According to the 1900 census, fewer than two hundred Mexican immigrants lived in Illinois. By the 1920s, Mexicans had become a significant ethnic population in Chicago and the United States (García y Griego 1996). This migration to the United States, and particularly to the North, was facilitated by American contractors working for growing railroad and packing-house industries in urban areas like Chicago. Contractors recruited Mexican workers in rural and urban Mexico and once in America, often used the new labor as strikebreakers (García 2003, Valdés and Valdes 2000). In addition, many were itinerant laborers who took winding routes through the Midwest in pursuit of employment on farms. These groups of primarily male migrants continued to spread across the Midwest as they followed the agricultural migrant stream, and settled where they were able to find stable jobs and decent wages (Arredondo 2008, García 2003). During winter seasons when farm work was scarce, Chicago provided diverse employment in slaughterhouses, meat-packing, and manufacturing (Kerr 1976).

In the initial phase of migration, gendered employment opportunities in steel, meatpacking, agriculture, and railroads drew significantly more men than women to Chicago, such that by 1930, women only comprised an estimated one-fourth of the 25,000 Mexicans living in Chicago (Arredondo 2008). While men were driven primarily by employment opportunities, Mexican-born women came to Chicago for both economic and familial reasons. They used kinship networks to come to the United States, and were also encouraged to migrate through the agricultural practice of “hiring entire families and encouraging them to winter in Chicago” (Arredondo 2008).
Migration to Chicago had gendered effects on Mexican-born immigrants. While Mexican men found employment in a relatively diverse set of sectors and positions, Mexican women were limited to a significantly smaller set of choices. For example, in 1928 fifty-eight hundred industries and businesses in Chicago employed Mexicans, but of these, only twenty-five employed Mexican women (Arredondo 2008). Furthermore, novel social and legal norms allowed Mexican immigrant women to obtain procedures like divorce. In addition, some Mexican women did come to the United States without a partner and took advantage of the opportunity to live and work alone without having children until later in life (Arredondo 2008).

Migration to Chicago continued throughout the 20th century, and by 1970, the population of Mexicans in Chicago alone was greater than the number of Mexicans in every state except California and Texas (Hutchinson 1999). Today, many of the ethnically Mexican, US-born grandchildren of the initial Mexican migrants live in Chicago. In addition, new Mexican immigrants continue to arrive in Chicago for reasons similar to the initial migrants and while today’s Mexican immigrant communities in Chicago are now comprised almost evenly of men and women, migration and life in the city continues to be gendered (Departamento de Estudios Internacionales 2005). Whether man or woman, or young or old these groups are a vital part of Chicago’s community.

**Demographics of Mexican-born Women in Chicago**

According to the 2010 Census, Chicago had a total population of 2,695,598 people, about 11.5% of whom are Mexican-born women.\(^2\) Mexican-born women differ by immigration status, such that approximately 138,000 undocumented Mexican immigrants live in Chicago,

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\(^2\) This estimate is my calculation based on a number of differing metrics known about the population of Chicago. I used the Pew Research Center estimate that 79.2% of the 1,971,000 Hispanics who lived in Chicago in 2011 were Mexican and, the 2000 Census figure that 40% of all Mexicans in Chicago were born in Mexico. The same Census reports that almost half of all Mexican immigrants are women, and thus implies that Mexican-born women comprise roughly 312,206, or about 11.5% of Chicago’s total population.
approximately half of whom are women (Tsao 2014). Of all Mexican-born women in Chicago, more than half (59%) arrive from small towns, villages, or rural areas (Departmento de Estudios Internacionales 2005). Contemporary migrants come to Chicago as a first point of entry to the United States: more than 80% of Mexican-born immigrants come directly from Mexico to Chicago. Primary reasons for migration among Mexican-born women living in Chicago in 2005 include finding a job (39%), for a job heard about through family and friends (29%), to be with relatives (59%) or to be with friends (13%) (Departmento de Estudios Internacionales 2005). These reasons for migration are similar to those expressed by early Mexican women coming to Chicago.

According to the 2000 Census, Mexican-born immigrants to Chicago are fairly young. Most Mexican-born women in Chicago are between the ages of 25 and 34 (42%), and the average age of Mexican-born women and men upon migrating (20 years) is comparable between genders. Analysis of the age differences between Mexican-born and US-born ethnically Mexican people in Chicago illustrates that Mexican immigrants are largely settling in Chicago and remaining to raise families. While 70% of ethnically Mexican US-born Chicago residents are below the age of 20, 90% of Mexican-born immigrants are between the ages of 20 and 40. This age difference suggests that Mexican-born immigrants and their US-born children “represent different generations of the same families” (Departmento de Estudios Internacionales 2005).

Family both in Chicago and in Mexico seems to be important to Mexican-born women. While now residents of Chicago, many are still economically connected to family in Mexico, such that 40% of Mexican women send back remittances to family in Mexico in amounts totaling on average $1,800 per year (Departmento de Estudios Internacionales 2005). The majority of Mexican-born women in Chicago are also married (67%), and most also have their spouse
present in Chicago (61%). The majority of Mexican-born women in Chicago also have one or more children under the age of 18 living in the same house (88%) (Departmento de Estudios Internacionales 2005). These indicators illustrate that family ties are key to the experiences of Mexican-born women in Chicago.

While likely supported by kinship networks, a significant proportion of these women do not speak English well. Mexican-born women in Chicago speak English at similar levels to Mexican-born men in Chicago, but speak English at much poorer rates than other non-Latino immigrants. In fact, 24% of Mexican-born women report not being able to speak English at all and “slightly over half (55%) of Mexican-born women speak English poorly or not at all, compared to 23% of non-Hispanic immigrant women” (Departmento de Estudios Internacionales 2005). Low-English speaking ability, in turn, makes navigating Chicago’s non-Spanish speaking neighborhoods difficult and in part results in discrimination.

While I provide a brief demographic snapshot of Mexican-born women in Chicago here, this picture becomes clearer through the next two chapters, where I further explore the relationship between Mexican-born women in Chicago and social determinants of health. This thesis is divided into three chapters, along with an introduction and a conclusion. Each chapter explores different sets of knowledge to determine how three social factors: immigration, socioeconomic status, and healthcare access, influence the health of Mexican-born women in Chicago. Chapter 1 profiles the health of Mexican-born women and provides an overview of how the three selected social determinants of health specifically shape the health of Mexican-born women in Chicago. In sum, Chapter 1 utilizes existing research on Mexican-born women in Chicago and nationwide to answer the question: what is the unique constellation of social determinants of health that affect Mexican-born women in Chicago? Chapter 2 looks to
interviews with nine Mexican-born women living in Chicago to answer the same question and includes the women’s voices in light of the literature outlined in Chapter 1. Chapter 3 illustrates how three public policies, the Immigration and Nationality Act, Personal Responsibility and Work Opportunity Act, and Patient Protection and Affordable Care Act, shape such determinants of health. It draws upon the experiences of the nine interviewed women to concretely illustrate how such policies shape individual lives. Finally, I conclude by highlighting the power of the Health in All Policies movement to improve the health of Mexican-born women in Chicago, and the health of all.
Chapter 1: Health and Social Determinants of Health

In this chapter I consider how existing literature on Mexican-born women in Chicago provides insight into the social determinants of health that affect these women. I first provide a brief overview of the current health status of Mexican-born women based on morbidity, mortality, and self-reported health data. These measures taken alone provide a snapshot of the health status of Mexican-born women in Chicago, and together, illustrate multiple pertinent health concerns facing these women today. I then describe the framework of social determinants of health and how social factors modulate the biological mechanisms underlying ill health. I finally focus on how immigration, socioeconomic status, and healthcare access uniquely influence the health of Mexican-born women in Chicago.

Much research on Mexican women has often been conducted by general ethnic group (i.e. Latin@s, Hispanics) instead of sub-ethnic group (i.e. Mexicans, Puerto Ricans, Cubans). The term “Latin@” refers to people with ethnic ties to Latin American countries, thus excluding people from countries such as Spain, while Hispanic refers to people of Spanish-speaking origin or ancestry, thus excluding people from Latin American countries such as Brazil (Brians 2013). In the United States, Mexican women comprise the largest sub-group within the Latina and Hispanic ethnic designations (Ramos et al. 2010). As this thesis focuses on Mexican-born women living in Chicago, the following section draws on information about the social determinants of health among Mexican, Latin@, and Hispanic groups as indicators of Mexican women specifically.

The majority of data I use comes from two sources: the “Healthy Chicago Survey” and “Mexican Women in Chicago: A Report to the Secretaria de Desarrollo Social de Mexico”. Conducted by the Chicago Department of Public Health, the “Healthy Chicago Survey” is a 2014
phone survey of 2,517 Chicago residents. The authors of “Mexican Women in Chicago,” a group of scholars at the Institute for Latino Studies at Notre Dame, analyzed data from the 2000 Census and the Chicago Area Survey. The US Census is a nationwide survey that systematically acquires a wide variety of population measures. The Chicago Area Survey is a phone survey of metropolitan Chicago, which includes Cook, DuPage, Kane, Lake, McHenry, and Will counties. To obtain the data for the Chicago Area Survey, the NuStats Corporation conducted surveys with 2,326 interviewees (out of 21,750 eligible households) in both English and Spanish. Of these, 397 Hispanic Chicago residents were surveyed.

While these data sources are Chicago-specific and provide useful insight into the health and demographics of Mexican-born women in Chicago, each source has its own limitations. For one, the “Healthy Chicago Survey” combines data into three ethnic groups: Hispanic, non-Hispanic Black, and non-Hispanic White. Doing so eliminates the diversity in health outcomes and experiences of Hispanic sub-ethnicities. Furthermore, the report does not present outcomes based on both gender and ethnicity, instead dividing outcomes using either variable. While the “Report to the Secretaria de Desarrollo Social de Mexico” often includes a sub-ethnicity, gender-based analysis specific to first-generation immigrants, its focus is on social factors, and thus does not provide significant information about the health status of Mexican-born women in Chicago.

In places where I reference other data sources, I make note of the specific demographic of the research group considered. In doing so, I indicate that each statistic should be understood as providing insight on the health status and social factors experienced by Mexican-born women and point to the continued need for research that uses a sub-ethnicity-based, generational, gendered, and local approach.
Health Status of Mexican-born Women

Mexican-born women at the national level experience a higher prevalence of certain diseases. The rate of HIV/AIDS is more than four times higher for Latina females than for non-Latina females, and the prevalence of stroke is 1.3 times higher for Hispanics between ages 35-64 than non-Hispanics at the same age (Castañeda, Michael, and Vassileios 2014). Nearly one out of every four Mexican-born woman in the United States reports suffering from musculoskeletal disorders and almost half (46%) report suffering from an ulcer, either gastric or duodenal, compared to 27% of non-Hispanic White women or 33% of non-Hispanic Black women (Castañeda, Michael, and Vassileios 2014). Mexican-born women are more likely to be overweight or obese than non-Hispanic White women. They are additionally more likely to suffer from a disorder related to being overweight (74%) than non-Hispanic White women, but experience slightly lower morbidities than non-Hispanic Black women (Castañeda, Michael, and Vassileios 2014). These morbidities reflect that Mexican-born women experience significant disease burdens.

Cause of death and mortality data additionally provide an indicator of the health of a group, and specifically the illnesses that do not receive attention or are currently incurable. Between 2007 and 2009, malignant neoplasms (22.5-23.1%) and diseases of the heart (17-19.1%) were the two leading causes of death for Hispanic females of all ages in Chicago. The third leading cause was diabetes mellitus in 2009 (6.8%) and cerebrovascular diseases, such as stroke, in 2007 and 2008 (5.6%-7.1%). Among younger Hispanic females (15-34 years old), the three leading causes of death were accidents/unintentional injuries, assault, and malignant neoplasms. With age, cerebrovascular diseases, diseases of the heart, and septicemia increase in incidence (Jones et al. 2013). These data illustrate that similar diseases, particularly
cerebrovascular diseases, such as stroke, affect Mexican-born women during their lifetime, and also often cause their death.

Overall mortality rates furthermore differ between Hispanic and non-Hispanic ethnic groups in Chicago. Analysis of death and birth certificate data sets from Chicago find that while Hispanics comprise approximately 29% of the population of Chicago, they account for 10% of deaths in 2009 (Jones et al. 2013). While such difference in death rates might indicate better health among Mexican-born women in Chicago, this difference may in reality be due to the lower average age of Mexican-born women in Chicago. Thus, while mortality data might not provide an indicative picture of the health of Mexican-born women in Chicago because of their young age, cause of death, like morbidity, suggests ongoing need for attention to diseases that are particularly prevalent in Chicago’s population of Mexican immigrant women.

Latin@s nationwide are more likely to report fair or poor health relative to other ethnic groups. This disparity persists even after accounting for socio-economic status, age, depressive symptoms, and comorbidities (Brewer et al. 2013). The percentage of Hispanics reporting fair or poor health in Chicago (28.8%) follows nationwide differences and is significantly higher than non-Hispanic blacks (20.1%) or non-Hispanic whites (11.7%) (Laflamme et al. 2015).³ If public health or medical measures are to maintain and improve the health of an individual or community, a stakeholder’s perception of her own health is a key indicator of where support is needed. Considering Mexican-born women in Chicago are a young group, their self-reported

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³ A number of different demographic factors influence self-reported health measures. For one, Latinas are more likely to report better self-rated health than Latino men, an outcome often attributed to Latinas’ decreased exposure to occupational hazards (Ramos et al. 2010). Furthermore, self-rated health also differs by age, such that people in Chicago over the age of 45, were more than twice as likely to report poor or fair health compared to those 44 and younger (Laflamme et al. 2015). Length of time in the United States also impacts self-rated health measures, such that self-rated health tends to be higher among foreign-born Hispanics and decreases with increased time in the United States (Huh, Prause, and Dooley 2008).
health is likely higher than nationwide data on Latinitas indicate. Self-report data is an important health metric as it indicates the perceived health of Mexican-born women themselves.

While morbidity, mortality, and self-reported health indicators of Mexican-born women reflect that Mexican-born women experience poorer health than other ethnic groups, some measures indicate otherwise. In a phenomenon termed the Mexican Health Paradox, recent Mexican immigrant newborns exhibit lower prevalence of many mental and physical illnesses when compared to their White counterparts of similar socioeconomic status. For example, first generation immigrants exhibit significantly better birth outcomes than babies born to women of other ethnicities of similar socioeconomic status and or to later-generation Mexican women (Acevedo-Garcia and Bates 2008). The positive health outcomes observed in the Mexican Health Paradox, however, seem to decrease relatively quickly, such that the observed healthier birth outcomes among Mexican immigrants disappear within five years of living in the United States (Horevitz and Organista 2013). Such data implies that first-generation immigrant groups are temporarily resistant to obstacles such as poverty, discrimination, stress of adapting to a new country, language, and access barriers that lead to adverse health outcomes and are typically associated with low socioeconomic status or non-White ethnicity (Zsembik and Fennell 2005, Horevitz and Organista 2013).

At least three hypotheses explain the existence of the Mexican Health Paradox and this positive disparity. The first attributes the phenomenon to “cultural and/or social protective factors, such as social support, strong family or religious ties, and norms related to diet and substance abuse” among the Mexican immigrant community (Acevedo-Garcia and Bates 2008). Factors such as the centrality of family, religiosity, and spirituality are associated with lower levels of drinking, smoking, and sexual-risk taking, and are inherently stress-buffering, thus
resulting in overall better health (Wills, Yaeger, & Sandy, 2003; Aranda, Cantaneda, Lee & Sobel 2001; Bacallao & Smokowski, 2007; Caballero, 2005; Campos et al, 2008). A second hypothesis notes that the advantage illustrated by Mexican immigrants arises due to “healthy immigrant selection” (Acevedo-Garcia and Bates 2008). According to this view, the healthiest immigrants are able to cross the border and remain in the United States, such that the positive health outcomes observed in the Mexican Health Paradox simply follows a migratory selection process.

Finally, the Mexican Health Paradox may arise because of data artifacts such as the “undercount of Latino deaths, inconsistent definitions of Latino identity (e.g. self-identification vs Latino surnames), and underreporting of health problems” (Acevedo-Garcia and Bates 2008). This pseudo-hypothesis posits that the health of Mexican immigrants is in fact not better than other ethnic groups. Instead, the trends reflecting better health outcomes arise due to errors in data collection, data analysis, and medical diagnosis. Following this “hypothesis” the limited access to health care of Mexican-born women in Chicago might contribute to unaccounted diagnoses of disease, resulting in Mexican-born women appearing healthier. For example, while breast cancer is diagnosed about 30% less frequently in Latina women, when diagnosed, it is more likely to be at a later stage (Castañeda, Michael, and Vassileios 2014). In other words, limited access to diagnostic services contributes to the lower reported prevalence of illness, but might not indicate genuinely better health.

While the evidence for and hypotheses underlying the Mexican Health Paradox are contested, it nonetheless holds value as a descriptive term for what is sometimes observed as good health among first-generation Mexican immigrants. In addition, Mexican-born women in the United States experience a number of health problems, including HIV/AIDS, stroke,
musculoskeletal disorders, ulcers, and obesity. Furthermore, heart disease, diabetes, and stroke are common causes of death among Hispanic women in Chicago and a significant proportion of Latinas, including Mexican-born women, are dissatisfied with their health today. These measures elucidate the complex facets of the health status of this group, and illustrate the ways in which the health of Mexican-born women must continue to be considered.

Social Determinants of Health

The health of Mexican-born women is shaped by a unique set of social factors, or social determinants of health (SDHs). SDHs are “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” (World Health Organization, 2008). These social factors have largely been overlooked in biomedical models of health, which instead focus on individuals and individual bodies as acontextual, disconnected units that are considered healthy in the absence of disease.

In agreement with the biomedical model, popular thinking often attributes improvements in lifespan and quality of life to recent medical advances, but critical examination reveals such progress is better explained by advances in fields elsewhere. For example, recent research has shown that medical care is responsible for only 10-15% of preventable mortality in the United States (McGinnis, Williams-Russo, and Knickman 2002). Furthermore, analysis of English and Welsh health records from the mid-19th century include sharp declines in human mortality even before the advent of medical tools like antibiotics and hospital wards. Instead, declines in mortality coincided with improvements in living conditions, such as advances in the quality of sanitation, nutrition and clean water (McKeown, Record, and Turner 1975). Such economic, social, and public health developments are described within what we now call the framework of social determinants of health.
These analyses indicate the limited applicability of a strict biomedical model of health: instead of being only tied to biological mechanisms of disease at the individual level, such evidence illustrates that factors such as environment and living standards critically shape health. Along with downstream determinants like medical care that treat disease and illness, these upstream social determinants of health determine who is at greater risk of becoming sick in the first place (Braveman and Gottlieb 2014). Thus, social determinants of health provide a framework encompassing the multitude of factors that impact health, including conventionally acknowledged factors such as medical treatment and other factors such as immigration, employment, and income.

Such social factors do not remain outside of the body; instead SDHs “get under the skin” and directly modulate biological mechanisms that result in disease through a multitude of pathways (Adler and Ostrove 1999). For example, environmental factors influence genetic expression which modulates disease prevalence in current and future generations. Fetal exposure to poor nutrition or high stress levels while in the womb can “modify developmental biology in offspring in a fashion that elevates their risk of developing diseases like diabetes, hypertension, and cardiovascular disease” as adults (Kuzawa and Sweet 2009). Such connections between social environment and genetic changes have been directly illustrated in humans, where early experiences and environment alter long-term development and modulate bodily functions like the immune response that maintain health (National Scientific Council on the Developing Child 2010; Bharmal et al. 2015).

Social factors also impact health through non-genetic routes. One example of such “life course disadvantage” is the chronic activation of the stress response. Hyper-activation of the stress response is incited by a variety of factors, such as living in perpetually violent
neighborhoods, working in the lower tiers of a workplace hierarchy, or caring for family members and children (Bharmal et al. 2015). Chronic activation results in deterioration of neuroendocrine regulatory bodies (McEwen 2010) and ultimately alters immune function to increase prevalence of chronic diseases such as diabetes and heart disease (Braveman, Egerter, and Williams 2011, McEwen and Gianaros 2010). Thus, chronic stress and resultant physiological activation illustrates one way in which SDHs shape health, whether inter-generationally or within a single lifetime.

Social determinants of health shape human biology through modulation of genetic material and the stress response, in addition to numerous additional pathways. Research has not yet fully elucidated such connections between factors outside of the body and inter- and intra-generational biological mechanisms. However, those ties already substantiated illustrate the tight connections between social factors and the manifestation of disease.

**Immigration**

Immigration is the “process by which non-nationals move into a country for purposes of settlement” (International Organization for Migration 2011). Immigration affects the health of Mexican-born women in three main ways: through the implications of immigration status in the host country, discrimination towards immigrants, and cultural differences between the immigrant and her new home. Following federal categories, immigration status is often divided into four primary categories in research on Latin@ healthcare usage and health status: US-born citizens, foreign-born citizens, legal foreign-born permanent residents, and undocumented residents.

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4 The process of undocumented migration itself also has health effects. Often physically deterred by federal and state governments operating under a policy of “prevention through deterrence” the United States Border Patrol has displaced and diverted undocumented migrant flows to the United States “into more treacherous and dangerous zones to cross, such as deserts, rivers, canals, and rugged terrain.” In 2013 alone, federal agents documented 463 people who died crossing the US-Mexico border (Santos and Zemansky 2013). Undocumented Mexican-born women in Chicago who did not lose legal status after overstaying their visa likely crossed the border via such paths. Finally, unauthorized status causes activation of the stress response due to fear of deportation and traumatic experiences crossing the US-Mexico border and results in detrimental health effects (McGuire and Georges 2003).
(Ortega et al. 2007). The first three categories describe people who are legally authorized to reside in the United States, and the final category, undocumented immigrants, describes people who have either overstayed their visa or have illegally crossed into the United States. 138,000 undocumented immigrants live in Chicago alone (Tsao 2014).

These legal distinctions shape health in three main ways: through access to public aid programs, deterrence from health-protective programs, and the direct threat of deportation. Legal immigration status is associated with specific privileges at the local, federal, and state levels, particularly inclusion in public health insurance and federal aid programs. An analysis of a 2007 nationally representative telephone interview survey of 4,013 randomly selected Latino adults illustrated differences in health-care access based on immigration status. Among all participants, undocumented Latin@s were least likely to have a usual source of health care (58%) or health insurance (37%) (Ortega et al. 2007). This difference in coverage is in part due to major legislation such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which excludes undocumented immigrants and legal foreign-born permanent residents who have lived in the United States for fewer than five years from access to federal aid and programs like Medicaid. The importance of health care access and insurance as determinants of health is considered later in this chapter.

While immigrants are eligible for some programs regardless of immigration status, the threat of deportation restricts undocumented immigrants from seeking needed services. For example, a study of undocumented Latino immigrants in a Midwestern city found that almost 40% of their sample expressed “concern with seeking services for fear of deportation” (Cavazos-Rehg, Zayas, and Spitznagel 2007). Undocumented immigrants often do not seek out services in fear of being detected or deported, even from programs that might provide some social or
economic relief that do not require legal residence (Castañeda et al. 2015). For example, undocumented women who experience domestic violence or abuse are less likely to seek available services in part due to fear of government authorities discovering their immigration status (Moynihan, Gaboury, and Onken 2008).

The threat of deportation similarly discourages health-protective behaviors. For example, undocumented workers face the threat of retaliation and deportation when organizing for better labor conditions or wages. A study of Latin@ restaurant workers in San Jose and Houston illustrated that undocumented immigrants are less likely to make workplace claims often due to two reasons, a fear of deportation that prevents formal confrontation and a “pragmatic and short-term understanding of their working life in the United States” that renders their working conditions “temporary and endurable” (Gleeson 2010). Thus, utilization of inclusive aid programs or organizing actions that are crucial to improving other downstream and upstream determinants, such as direct violence and employment conditions, are shaped by immigration status.

Immigration enforcement by public officials also modulates the health of Mexican-born women as a downstream determinant. Increased presence of Immigration and Customs Enforcement officials in a community leads to an increased fear of deportation among undocumented immigrants (Allen, Cisneros, and Tellez 2015, Hacker et al. 2012, Muñoz et al. 2015). This fear results in higher stress and anxiety levels, factors that shape physical and mental health (Hacker et al. 2012). While not all undocumented immigrants are concerned with deportation or family separation, those who are report feeling as if they are “being hunted” by law enforcement officials, an emotion that directly impacts emotional well-being, and places
undocumented immigrants at “increased risk of experiencing negative mental states” (Cavazos-Rehg, Zayas, and Spitznagel 2007).

In addition to experiencing the health effects of undocumented status, many Mexican-born women experience discrimination and acculturation, processes that also shape health, along with other Latin@s. While discrimination and acculturation are less directly tied to federal immigration categories, they also shape the health of Mexican-born women, specifically through discriminatory stereotypes and language differences. Mexican women in the United States are subjected to a multitude of stereotypes. For example, Mexican women have been termed “immigrant birth mothers” who, as Republican Senator Lindsey Graham of South Carolina noted, cross the border and “go to the emergency room, have a child, and that child's automatically an American citizen.” (Hartry 2012). Graham’s words exemplify the sentiment that Mexicans and Mexican women immigrate to the United States in order to take advantage of current policies that grant citizenship to their children. Graham implies that such women and their children are not deserving of such rights and instead tax the current welfare system. In other settings, Mexican women are portrayed as hypersexual and overly fertile. In popular media, Latinas are often portrayed as the “Harlot” mistress tempting the main white characters. These stereotypes persist among everyday citizens and policy-makers alike and result in pervasive discrimination in care that, at its most extreme, contributed to the forced sterilization of thousands of Mexican-origin women in the late 20th century (Lira and Stern 2014).

In addition to experiencing discrimination in daily life, Latinas are also more likely to report being discriminated against in the American health care systems than their non-Latina White counterparts (Lauderdale et al. 2006). Within health systems perceived discrimination can affect healthcare in two ways: through (1) systemic bias in delivery of care which decreases
quality of care or through (2) patient’s perceptions of discrimination which causes her to be less likely to seek care and adhere to treatment (Lauderdale et al. 2006). Mexican-born women are more likely to experience both of these types of discrimination within healthcare systems, thus resulting in poorer health.

Such discrimination is often facilitated by discordance in language and health beliefs between patient and provider. For example, Spanish-speaking patients are less likely to be satisfied with their care and with the patient-provider relationship (Betancourt et al. 2003). While not all Mexican-born women have limited English communication abilities, those who do experience systemic discrimination in receiving care, as Spanish-speaking patients are less likely to “understand their diagnosis, prescribed medications, special instructions, and plans for follow-up care.” (Betancourt et al. 2003). In such aspects of the clinical visit, Mexican-born women with little English proficiency face increasing obstacles in obtaining high-quality care.

Furthermore, providers and their Mexican-born patients often differ in their conception. A study of Mexican women in Santa Fe illustrated that immigrants who had been in the United States for a longer duration “differed from the recently arrived in their cognitive models of health; their beliefs about how people should behave when sick, about the emotional and physical effects of stress, and about diet and exercise; their knowledge of alternative medicine; and their attitudes toward curanderismo, the traditional healing system in much of Latin America” (Reichman 2006). Such changes in ideology are associated with acculturation, or the “bi-dimensional process in which individuals learn and/or adopt certain aspects of the dominant culture while potentially maintaining some or all aspects of their culture of origin” (Jimenez et al. 2012). These differences in health beliefs due to acculturation suggest dissonance between
Western medical systems and indicate that Western, English-only services might not serve Mexican-born women very well.

The limited number of bilingual and bicultural medical professionals exacerbates the language and culture disconnect between Mexican-born female patients and their physicians (Baig et al. 2014). Furthermore, undocumented immigrants are particularly vulnerable, as they experience the most difficulty understanding their physicians and are most likely to think that they would get better care if they were a different race or ethnicity (Ortega et al. 2007). Such dissatisfaction might be due to limited knowledge of the English language and available health care services, or because of non-Western conceptions of health care provision among undocumented immigrants.

While discrimination and acculturation are experiences common among most Latin@s, these experiences are pertinent for Mexican-born women. Furthermore, for Mexican-born women who are undocumented, immigration status limits their eligibility for aid programs and willingness to seek help for fear of deportation. Fear of deportation and experiences of discrimination may directly increase stress and fear, diminishing health. Finally, pervasive discrimination and cultural differences in everyday and medical settings result in lower quality of care. As Castañeda et al. note, “Being an immigrant limits behavioral choices and indeed, often directly impacts and significantly alters the effects of other social positioning, such as race/ethnicity, gender, or socioeconomic status, because it places individuals in ambiguous and often hostile relationships to the state and its institutions, including health services” (2015). This experience is exacerbated for undocumented immigrants, whose undocumented status “remains a persistent and insidious psycho-environmental stressor” (Cavazos-Rehg, Zayas, and Spitznagel 2007). Immigration status, therefore, is an upstream determinant that influences other upstream
factors, such as income and employment, as well as downstream factors, such as healthcare access and finally, health itself.

Socioeconomic Status: Employment and Income

Existing research uses a variety of metrics to measure socioeconomic status, including wealth, neighborhood of origin, and education level (Braveman et al. 2005). Among these facets of socioeconomic status, I focus on the impact of employment and income on the health of Mexican-born women in Chicago. Irrespective of the measure used, greater socioeconomic status is robustly correlated with better health, such that socioeconomic status itself is the strongest predictor of health status (Rios, Aiken, and Zautra 2012). The factors comprising socioeconomic status are interwoven: those with higher educational levels are typically able to obtain greater incomes and accrue greater amounts of wealth. Income, in turn, also shapes health status.

The tie between socioeconomic status and health manifests in multiple ways. Individuals with low education and income levels are more likely to “lack a job, health insurance, and disposable income for medical expenses” than their better-educated, higher-earning counterparts (Woolf and Braveman 2011). Chicago-level analysis reflects how income directly affects health insurance, such that people living above 400% of the Federal Poverty Line (FPL) are significantly more likely to have healthcare coverage (92.5%) (Laflamme et al. 2015). Limited income also restricts an individual’s access to nutritious high-quality food and ability to engage in healthy behaviors. Low-wage occupations are often at the lowest level of the workplace hierarchy, a position where employees are more likely to experience chronic stress (Heraclides et

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5 In addition to income and employment, education is also an important piece of socioeconomic status. For an educational profile of Mexican women in Chicago, see Departamento de Estudios Internacionales (2005).
al. 2009). These factors both directly influence sickness and disease as well as an individual’s ability to engage in health-promoting behaviors, such as receiving healthcare.

While Mexican-born women are a critical piece of Chicago’s economy, comprising the largest female immigrant workforce in Chicago, they are often delegated to low-paying, less desirable jobs (Departmento de Estudios Internacionales 2005). Such jobs require little or no experience or skill and are often not protected by unions. Without union membership, Mexican-born women working in Chicago often cannot harness the bargaining power of such bodies to improve working conditions or obtain benefits like health insurance. Positions often occupied by those women are further within only a few sectors of Chicago’s diverse economy, such that over half of all Mexican-born employed women work in two sectors: manufacturing (41.9%), such as production, assembly and fabrication, and machine operation, and food service (11%), such as cooking and serving (Census 2000). These are largely “blue-collar, un-skilled, and semiskilled light industry” positions (Departmento de Estudios Internacionales 2005). Each position is associated with a number of occupational hazards. For example, employees in food service and cooking jobs are more likely to be exposed to allergens, bruises, and burns (Alamgir et al. 2007). In addition, in positions at the bottom of workplace hierarchies, Mexican-born women are vulnerable to increased stress levels that cause “wear and tear” on the body (McEwen 2004).

Since the 2000s, Mexican-born women have been spreading from primarily working in light manufacturing positions into broader industrial sectors, such as food service, health/social service, retail trade, and wholesale trade (Departmento de Estudios Internacionales 2005). Yet Mexican-born women still have not entered high-paying sectors that require high language facility and frequent contact with the public, such as information/communications, public administration, and transportation/public utilities. Both Mexican-born men and women in
Chicago are more likely to not speak English well or at all in comparison to other non-Hispanic immigrants (Departmento de Estudios Internacionales 2005). Since high-paying professional or skilled positions require strong English skills so, many Mexican-born immigrants are not eligible for these higher-paying positions and thus are often unable to benefit from the health improvements associated with better paying employment.

Inability to obtain employment in professional and white-collar sectors contributes to the on average lower income earned per year ($6,100) among Mexican-born women relative to all other immigrant and minority groups in the Chicago female labor force (Departmento de Estudios Internacionales 2005). In comparison, non-Hispanic African American and non-Hispanic White women earn average annual incomes of $12,500 and $17,700, respectively (Departmento de Estudios Internacionales 2005). These income differences indicate that Mexican-born women who are living on their personal income alone are likely limited in their options for healthy living.

Family earnings also shape health behaviors and health status. Foreign born Hispanic families in Chicago earned a median household income of $41,000 in 2011. These earnings are lower than the median household income of all Chicago families ($57,000) and also lower than non-Hispanic Whites ($68,000) and native born Hispanics ($44,900) family earnings. The family income of foreign-born Hispanics in Chicago, however, is still greater than non-Hispanic Blacks ($34,400) (Pew Research Center 2011). In addition to earning below-average personal and family incomes, a significant proportion of Mexican-born Americans live in poverty (16.9%) (Pew Research Center 2011). Since both low-income and extreme poverty predict negative health outcomes, Mexican Americans experience greater risk for ill health outcomes due to earning disparities.
For Mexican-born women in Chicago earnings may be modulated by mental status. The Institute for Latino Studies conducted an analysis of Mexican-born women living in Chicago based on the 2000 Census and found support for three hypotheses describing the connection between marital status and income. First, married women living with a spouse have the lowest median annual income ($5,000). Researchers attribute this effect to a husband acting as the primary breadwinner, which allows women to work part-time or not at all and still attain a sufficient family income. Second, never-married single women earn the second lowest median annual income ($6,400). This may be attributed to being young and finding their first employment with little or no experience. These women might also still live at home or be sharing living expenses, and thus do not require additional income to support children or other family members. The second highest paid sub-group is married women with spouse absent ($8,300), while women who are separated or widowed have the highest income ($10,000). These women are likely older than married women with spouses or single women living in shared situations and likely also the sole breadwinners for their families both in Chicago and abroad. Thus, without additional financial support, even with highest earnings, it is possible that these groups and their families are in fact the most economically vulnerable.

Two-thirds of Mexican-born adults in Chicago are married and marital status seems to shape personal income and employment status, both of which are related to health (Departamento de Estudios Internacionales 2005). Thus, considering the ties between marital status and income for Mexican women, marital status is indirectly tied to health outcomes. Furthermore, income levels for the same women may be moderated by marital status, thus adding complexity to the way in which low income affects health.
The earning disparity between Latinas and other Chicago residents contribute to a nationwide trend where Latinas are “economically disadvantaged, vulnerable to poverty-related health conditions, and often lack health insurance or financial means to access and pay for needed healthcare” (Ramos et al. 2010). Mexican women in Chicago illustrate this disadvantage, as they are often unable to obtain high-paying jobs that would significantly increase their personal and familial income levels, and in doing so, improve health.

Healthcare Access

Access to healthcare is one part of obtaining health-protective medical services, and multiple dimensions comprise access to healthcare itself. According to Gulliford and colleagues, to ‘have access’ services must be available and in adequate supply, but to ‘gain access’ a person must overcome existing “financial, organizational, and social or cultural barriers” that prevent obtaining services (2002). For example, a primary care physician with available appointments may still be inaccessible because a patient who is unable to pay for services, cannot find transportation to the source of care, or does not speak the same language as the physician. While medical care seems to only explain 10% of the variation in health status in the 1990 Surgeon General’s report, for vulnerable populations, such as economically poor communities of racial and ethnic minorities, medical care may have a greater influence on health status by providing protective effects to compensate for occupational and environmental hazards or strenuous employment (Williams 1990).

Access to healthcare not only includes insurance coverage, but also availability of and proximity to acute and preventative services and providers. Health insurance eases the burden of expensive medical coverage and enables visits to primary care and some specialty service providers. Preventative medicine provisioned by a primary care provider can be instrumental to
maintaining the health of vulnerable individuals, and care for acute sickness or injury incurred while in labor-intensive jobs is critical to retaining employment or educational opportunities. Yet many low-income urban neighborhoods inhabited by minority communities such as Mexican immigrants experience an extreme shortage of primary care providers (Woolf and Braveman 2011).

Furthermore, insurance coverage shapes access to a personal doctor, where 89% of those with insurance coverage had a personal doctor, whereas 46% of those who did not have insurance visited a personal doctor. In Chicago, Hispanics are less likely to have a personal doctor (68.4%) than other racial groups (Laflamme et al. 2015). Personal doctors often create a longstanding relationship between doctor and patient and are better able to provide preventative services as well as support patients with serious conditions (Kearley, Freeman, and Heath 2001). In lieu of a consistent family physician, Mexican-born women in Chicago might instead obtain services in free clinics or through subsidized medical programs. Thus, without insurance coverage, Mexican-born women in Chicago face obstacles in obtaining medical care, and especially continuous, high-quality services. Considering the value of insurance coverage, the lower rates of coverage documented among Hispanics in Chicago places Mexican-born women at a disadvantage for maintaining positive health status.

Compared to their White counterparts, Latina women have largely lacked care because of lower rates of insurance coverage and access barriers. In 2011, 359,000 foreign-born Latin@s in Chicago were uninsured (Pew Research Center 2011). In Chicago, 61% of Mexican-born immigrants received insurance through their employer, and more than half also reported that all members of their family were covered by health insurance (Departmento de Estudios Internacionales 2005). Thus, in conjunction with inconsistent access to health insurance,
Mexican women often lack adequate access to both preventative care and treatment, both of which maintain good health.

Regardless of insurance status, access to healthcare systems generally improves with time spent in the United States (Nandi et al. 2008). This phenomenon is especially seen among undocumented immigrants, who with increased time in the United States become more familiar with and integrated into existing health care systems (Nandi et al. 2008). Furthermore, with improved English communication abilities, access also improves (Ortega et al. 2007). While ease of access improves with time in the United States, it does not necessitate formal coverage. Thus, all undocumented immigrants, regardless of length of time in the United States often still seek formal insurance coverage itself. Without such coverage and often living on a limited income, undocumented immigrants frequently forgo visiting a medical professional due to lack of funds (Chavez 2013). When a medical concern become especially serious and the condition is only harder to treat, such groups also might rely on less optimal settings, such as emergency rooms for care (Bustamante et al. 2012). In such cases, insurance coverage would greatly improve access to medical services.

Access to healthcare is a particularly important determinant of health for Mexican-born women, as women generally experience greater healthcare needs than men. In 2000, women comprised the majority of office visits by percentage and visit rate (number of visits/year) compared to men between the ages of 15 and 64 (Woodwell and Cherry 2004). This increased utilization is likely caused by a number of differences between men and women. For one, women generally experience greater lifetime morbidity and longer lifespans than men (Green and Pope 1999, Williams 2002). Furthermore, women have more reproductive health needs, such as care during pregnancy and childbirth (Mustard et al. 1998). Considering the majority of Mexican-born
born women in Chicago are between the ages of 18 and 34 years old (Departmento de Estudios Internacionales 2005), adequate access to reproductive health care is crucial. Finally, gender roles and socialization may cause women to be more responsive to illness and more active in seeking care (Green and Pope 1999). For Mexican-born women who are uninsured, such lack of coverage results in greater barriers to receiving care that all women need.

The above social determinants are intertwined and interdependent. They construct a “web of social and economic conditions” that ultimately acutely and chronically shapes the health of Mexican-born women in Chicago (Woolf and Braveman 2011). Preventing illnesses common among many Mexican-born women, like cancer and heart disease, requires low stress levels, a healthy diet, and exercise, behaviors more accessible with greater socioeconomic status and more attainable when one is not worrying about the repercussions of undocumented status. Furthermore, precautionary screening and long-term management provided by access to health care services is instrumental to prevention. Individuals with legal residence or of higher socioeconomic status or who are eligible for government provisioned coverage are able to obtain medical services necessary for both prevention and treatment, and engage in healthy behaviors to mitigate the development of such disease. In these ways and others, disease prevalence is shaped by the interactions between biological mechanisms and the social factors integral to an individual’s daily life. For Mexican-born women in Chicago and all, these biological and social causes of sickness are not mutually exclusive, but instead, intimately intertwined.
Chapter 2: Women’s Voices

While quantitative information drawn from existing research provides a useful framework to consider the social determinants and health of Mexican-born women in Chicago, individual lived experiences also provide immense and illuminative insight. Thus, the past chapter utilized relevant existing literature to explore how social determinants of health affect Mexican women in Chicago, and the following chapter relies on interviews with Mexican women living in Chicago to re-examine the same question. Their first-hand accounts create a complex portrait of the ways in which social determinants impact their health.

In this chapter, I first present the methodology I used to obtain and conduct nine interviews with Mexican-born women in Chicago. Before delving into the common themes I found among interviews, I include longer-form narratives to introduce the personal histories of three women who exemplify the experiences and perspectives of the women in total. I continue introducing the interviewees through an overview of the health status, health beliefs, and typical responsibilities of all nine. I then examine the social determinants of immigration, socioeconomic status, and healthcare access in the women’s interviews and trace commonalities and differences between each. In these sections, I sample directly from the words of each woman and have preserved the English or Spanish grammar they use in order to provide an account of their experiences that directly reflects their personal ways of conveying them. In the few instances where I changed words where the language was unclear, I indicate the changes in brackets. Finally, I address how these women add complexity to the information included in Chapter 1.
Interview Methodology

I met and interviewed all participants at the Refugee and Immigrant Community Services division of Heartland Alliance, a non-profit organization that provides social services to underserved communities in Chicago. Students at Heartland are adult immigrants who are learning English at a variety of levels from pre-literacy to pre-General Education Development. The students I interviewed attend day classes, which are two-hour long sessions between 9 AM and 3 PM held from Monday to Friday. Most students come from Palestine, Eastern Europe, and Central America.

I visited Heartland Alliance’s English school in November of 2015 for the first time since I worked there as an intern during the summer of 2013. During my visit, I spoke to three advanced English classes about this research project and invited any Mexican-born women currently living in Chicago to participate in my interviews. When I returned to the school from January 4th to 15th of 2016, I conducted nine interviews and two preliminary test interviews. Each interview proceeded for thirty to ninety minutes and was conducted in a combination of Spanish and English in an empty classroom at the school. Each interviewee received a $10 gift card to compensate for their time.

All interviewees gave written consent to participate in the interview and to speak about a broad set of topics, including health, immigration, employment, and education experiences. Interview questions were largely open-ended in order to encourage the participant to explore any facet or combination of social determinants of health particularly relevant to their life. As they were interviewee-driven, every interview differed in the specific combination and order of questions in order to facilitate organic responses about the factors they perceived most important. I also, asked each participant a similar set of questions to touch on the social determinants of

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6 See Appendix B, which includes the English version of the interview consent form.
place, socioeconomic status, and healthcare access that I originally planned to focus on in this project.  

*Gabriela*  

Gabriela came to the United States fourteen years ago in order to join her husband in Chicago. She had originally planned to stay in the United States for only one year, but after having a baby in Chicago, she fell into the rhythm of daily life here and remained. Gabriela now is the mother of three daughters, all of whom were born in the United States. Previously she worked as a babysitter, in a restaurant, and at a fast food joint. After her last pregnancy, she stopped babysitting and is currently not working except for intermittently cleaning houses. She spends the majority of her day taking care of her house and daughters and studying English in order to better help her children with their homework. She attends church with her family weekly.  

Gabriela’s husband works in the construction industry. When I interviewed her in January, she noted that he was having an especially difficult time finding work because of the cold, snowy weather. She also mentioned that work availability limits the income and benefits, including health insurance, she and her husband receive. Gabriela and her husband are undocumented immigrants, so she worries about the fragility of her husband’s work status and the possibility of experiencing discrimination because of her limited English abilities. Even though she is undocumented and cannot vote, Gabriela is following the national presidential election campaign and is very worried about the racism that Donald Trump specifically inspires.

7 After researching existing literature on social determinants of health and Mexican-born women, I expected place, or neighborhood to be a key social factor. Instead, after conducting and analyzing the words of the nine women, I found that each placed a much greater emphasis on their experiences of immigration and often did not even mention place. This realization exemplifies how qualitative interviews challenge pre-conceived notions and reveal more true connections.  

8 Pseudonyms have been used to protect the identities of the nine interviewed women.
Gabriela currently lives in the Chicago neighborhood of Portage Park. Before moving to her current home, Gabriela lived in Albany Park, a nearby neighborhood located across the Kennedy Expressway. She describes Albany Park as much more dangerous, in part because the parents living there were often absent during the majority of the day and the poor quality of the neighborhood public school. She enjoys living in Portage Park because it is “nice and quiet” and a healthy environment for her daughters. Three of her brothers and their families also live in the United States, but she has six siblings who remain in Mexico. Before coming to Chicago, she finished high school and also worked in her family’s supermarket.

Today, Gabriela describes her most pressing medical problem as being overweight. She also notes that she has a family history of high blood pressure and cholesterol, so she aims to live in a way that prevents the onset of these diseases. Gabriela also previously underwent surgery to remove a cataract. While the surgery was covered by her husband’s insurance, she is currently uninsured as her husband lost his coverage when construction work became less available. Her mom is sick in Mexico, and if she were able to safely cross the border and pay for transportation, Gabriela would travel to visit her.

Claudia

Claudia enjoys spending time with children, especially her two daughters, aged 5 and 13. They attend church together weekly. Even though she came to the United States legally, Claudia feels like does not know much about the legal system in Chicago especially as it affects her children. During her interview, she recounted a time when she took her daughter to a hospital after her daughter accidentally burned herself with a flat iron. Her husband, unfamiliar with protocol for Child Protective Services, became very scared that they could take away her child citing “negligencia” or negligence. In addition to worrying about the health of her children, she
is concerned for the well-being of her parents and family in Mexico because of the particularly
dire news castings she sees about Mexico’s current social and economic unrest.

Claudia’s husband applied for a visa to come to the United States when both were young. She immigrated after he received a visa six years ago. Before coming to the United States, Claudia studied administration at the university level and worked as an accountant and sales associate for a wood pallet business. In Chicago, she worked in a laundry factory until her second daughter was born. Claudia is learning English with the hope of working in a field related to her career, such as human resources or, outside of her professional background, in a part-time job with children.

Claudia’s husband currently works in a sweet factory. In addition to his income, their family receives food stamps. In Mexico, her husband owned his own electrical business. While they sold the business before leaving, they still own a two-story home with “la recama de las niñas, la recama de huéspedes, la plata baja, alta, garaje” (a children’s room, a guest room, a lower and upper level, and a garage). In Chicago, Claudia rents the basement of a house near Heartland Alliance’s English school and owns her own car. If she were given $10,000, an indicator of her greatest current need, Claudia would consider buying a house for her family.

While she would not remain permanently in Mexico because of the lack of economic opportunities, Claudia still visits her family yearly. Even though she receives health insurance through Medicaid, Claudia does not often seek care for her asthma in the United States, and instead takes advantage of the cheaper and more familiar medical services on her visits to Mexico. She does not like the idea of taking medicine, so when she gets pains like headaches, she uses alternative methods to help herself feel better. Claudia notes that overall, she feels healthy.
Hortencia

Hortencia is 36 years old. She immigrated to the United States after becoming a single mother and dropping out of university in Mexico. Hortencia hoped to give her son better opportunities than those in Mexico and was not able to afford the cost of her daily expenses, even while working in a five-star hotel. She currently has four kids between the ages of two and fourteen. While her oldest son was born in Mexico, her subsequent children have been born in Chicago.

After coming to the United States fourteen years ago, Hortencia intermittently worked as a waitress in an American diner. She quit her job as a waitress after having her second child, and today, her primary responsibilities involve caring for her family and home. Along with a Polish woman, her husband owns an international “hecho en casa” or homemade food business. He oversees the Spanish division of the business and manages imports to sell in the Chicago community.

Hortencia lives with her family in a home near the English school. They have two cars, and her children attend Catholic school, both of which she describes by saying “no es un lujo” (it’s not a luxury). One of her main worries is the educational success of her children, so she extensively researched the public school system in Chicago. After noting the poor average test scores and frequent strikes disrupting classes at her neighborhood public school, Hortencia decided to send her children to a nearby private one. She recently began learning taekwondo with her husband and children.

While a strong believer in God, Hortencia is no longer religious. She detests the Catholic Church’s discriminatory attitudes towards homosexuality, especially since her oldest son is questioning his sexuality and recently attempted suicide. She still notes her continued faith,
saying, “por de lo más, creo mucho en Dios, mucho, mucho” (at the very least, I believe in God, a lot, a lot). She no longer attends church services, but often turns to God to explain her relationships and everyday encounters.

Hortencia considers herself an extremely stressed person, noting “soy una persona demasiado estresada” (I am a person who is too stressed) and recently underwent surgery to remove a tumor that likely arose due to her chronic stress. She continues to suffer from migraines and is trying to live more calmly in order to alleviate her intense headaches. As the oldest sibling in her family, she looks after her husband and children in addition to her many younger siblings who also live in Chicago. After receiving treatment for her tumor, she has begun to focus on what she notes are her immediate priorities: her own health and the well-being of her immediate family. In addition to stress from her daily responsibilities, Hortencia also worries about the undocumented status of herself, her husband, and her son. She says her greatest wish is to live legally in the United States, but Hortencia also notes that illegally crossing the border has not prevented her and her family from achieving their dreams.

Health Status

All interviewees were asked about their current health status through the general question, how is your health? The women interviewed experienced a number of ongoing health problems and also recounted a number of issues they remembered from their past. The most common problems reported were vision problems (3), self-diagnosed depression (2), and headaches (2). Each noted other health concerns including ear infections, asthma, root canal pain, back pain, being overweight, kidney stones, brain cancer, painful menstruation, and varicose veins. All women had been pregnant at least once. Dani, a young woman in her early twenties, most recently had a baby (a few months preceding our interview) while Elvita, a middle aged woman
with married children, gave birth to her youngest child fifteen years ago. Even considering their
ongoing and past health concerns, four of the nine women also noted feeling “good” or “healthy”
without any question to prompt them to do so.

Health Beliefs

All of the women had the opportunity to talk about what they believe is healthy through
the questions, what is health?, what should a person do to be healthy?, and what do you do to be
healthy? All considered eating healthful food an integral part of remaining healthy. They also
agreed on what is healthy, for example, foods without or low in fat and sugar. Two women also
noted not eating red meat. All were responsible for cooking for their families, and except for
Elvita who prepares both American and Mexican cuisine, all described cooking Mexican food
for the majority of their families’ meals. While each recognized that healthy eating is important
to good health, few noted that they thought about health as a primary factor when deciding what
to cook. Women like Yoana, Hortencia, and Luz noted that they tried to cook in ways that they
believed are healthy, but others instead considered the dietary preferences of their family, and
cooked such food. For some, like Sandra whose daughters dislike meat and prefer fruits and
yogurt, preferences and health coincide, resulting inadvertently in healthy eating even though she
does not often consider health in her buying and cooking choices.

While all recognize that exercise is important to good health, they also note a variety of
reasons that they do not exercise. For example, Elvita recognizes that being healthy requires
eating well, sleeping well, having good habits, and exercising. Yet, when I asked her about
exercising, Elvita notes that:

*I want to start to run because the dealer, ayyy all day is walking and walking, too much
exercise. My job has a lot of exercise. Cleaning is a lot of exercise, so I think just I need
to walk, to run.*
Elvita is required to walk significantly in her janitorial job, and is thus tired upon returning home. While she notes that her job requires significant physical effort, she does not directly note that this exertion is exercise. Others also note that there is not enough time in the day to exercise.

Porque a veces ya no tienen tiempo...en casa llegar y hacer ejercicio porque llegan a casi las cinco, comen, se relajan un poquito, después empezamos a hacer tareas. Y bueno ahorita conmigo es un poco más difícil porque mi hija, pues, ya ella lo hace sólo sin que yo le diga, pero con el niño, pues, va en kinder. Empieza a enseñarle números, a leer, es un poco más difícil... Entonces ya no hay tiempo para hacer ejercicio o hacer más cosas.

Because sometimes they don’t have time...they come home and work out because they get home around five, they eat, relax a little bit, and afterwards we begin doing homework. And well, right now with me it is a little difficult because my daughter, well, she does [homework] alone without me telling her, but with the kids, well, they go to kindergarten. They are beginning to teach her numbers, to read, it’s a little bit more difficult...So now there isn’t time to work out or do more things.

Luz notes that her time is now occupied by helping her daughter finish homework and other caretaking responsibilities. With such tasks, she no longer finds time to formally exercise. While considering the reasons that the women interviewed do not exercise, they each note that exercise, along with other factors necessary to be healthy, are a personal choice.

You know, you think you go exercise you go to the gym, but it’s no, you can do exercise, you only have to propose and do it.

Sandra elaborates on how she believes exercise is personal choice that a person commits to if she is invested in good health. Whether due to lack of time or lack of motivation, Luz and Sandra note how they must choose to exercise in order to be healthy. Many believe that their health is dependent on actions that they either choose or do not choose to partake in. Furthermore, the women largely agree upon what each of these behaviors mean. In this way, all seem to subscribe to conventional Western health beliefs within a biomedical model. They further agree that health is dependent on factors such as eating well, exercising often, sleeping enough, and visiting the doctor.
Typical Responsibilities

Each interviewee was asked the events that comprise her normal day. While some of the daily responsibilities differed between women, all noted being responsible for caring for their own children, and often additional grandchildren, nieces, or nephews. Angelica describes her daily schedule:

Oh my god…pues como no he trabajado, siempre estoy atendiendo a mis hijos, siempre…llevarlos a la escuela, recogerlos, darles lo que necesitan, ayudarles en la que yo más puedo, prepararles la que comer, y así se van todo el día.

Oh my god…well since I haven’t worked, I am always taking care of my kids…taking them to school, picking them up, giving them what they need, helping them the best I can, getting them ready to eat, and the whole day passes like that.

Angelica describes how her tasks are centered on taking care of her kids, and all of the women mentioned similar responsibilities. The four women who are both working and taking care of children additionally note that child-care continues to be a significant duty alongside responsibilities associated with employment. Yoana, who is both a mother and a hair-stylist, describes her day:

It is hard, too busy, because I wake at 6:30 and I go to the, I wake my daughters for…vestirse (getting dressed). I wake my baby, her baby bottle the morning, then I go to drop off at school and come to my baby with my mom for care and now I studying, but sometimes I work in my house. It’s a stress because I have to care my baby and work my house, and then, clean the house, go to the doctor, or pay the rent, or pay the bills. Then make the dinner, wash the dishes, then sometimes another work.

Yoana describes the daily stress of taking care of her family and house. She not only transports her children and prepares food for her family, Yoana also earns valuable income for the family and manages expenses.

Women working in less consistent employment illustrate how their job is often considered a trade-off between wages and the cost of finding care-taking opportunities. For
example, Dani, a teacher at Heartland Alliance’s daycare, must consider the cost of taking care of her newborn against her hourly earnings.

*Es bien difícil dejarlo a ella que lo cuida y es difícil para mí porque trabajo pocas horas y pues no me conviene pagar alguien para que me lo cuiden porque solo es por tres horas. Casi me cobran lo que yo gano. Eso es lo difícil, lo que me preocupa, porque no quiero salirme de trabajar, pero si no tengo que irme para cuidarlo, tengo que salir de trabajar.*

*It is difficult to leave [my son] to the girl who cares for him and it’s hard for me because I work a few hours and, well, I don’t like to pay anyone to care for him because it is only for three hours. I barely keep the money I make. This is the difficult thing, the thing that worries me because I don’t want to leave work, but if I don’t have to go to take care of him, I have to quit work.*

Gabriela reiterated her experience considering whether to continue working or whether to take care of her children full-time.

*I have three child, for me, are expensive to pay for the babysitter for me. Or daycare, for two kids, it’s expensive. And I paying thirty [for childcare] and [my employer] pay me forty – what?*

Dani and Gabriela alone are largely responsible for the care of their newborns. As such, it is their responsibility to find care for their babies, and they see the worth of their work in terms of the earnings they keep after paying for care. On the other hand, neither note that their husbands’ income is considered in the same way; his earnings for the family are not weighed against the care his child needs. Determining the value of her work in opposition to her care of her child restricts the ways in which Dani is able to pursue employment for herself and also limits the total family income. Similarly, Gabriela quit her job as a babysitter after the birth of her last child because the cost of childcare depleted her possible income.

The women also consider the trade-off between employment and childcare in terms of the child’s well-being. As Gabriela continued to describe why she stopped working, she noted that time with her children takes precedence over her current monetary needs:
It’s very important see that my daughters...enter in the no problems, their friends
good and their school good and they, cómo se dice, grados [how do you say, grades]
their grades good in the school. For me it’s more important my family, what my money,
because my husband work.

Gabriela believes her husband makes enough money to support the family, but she does worry
about the success and education of her children. All of the women echo Gabriela’s dedication to
her children both in their recount of their daily activities and in passing statements about other
facets of their lives. For some, like Gabriela, Claudia, and Hortencia, this immense devotion also
meant leaving employment opportunities in order to provide their children with more time and
care.

While some women left work behind after having children, others, like Yoana and Dani,
experience added stress due to juggling the dual responsibilities of caretaking and working.

Yoana’s words illustrate the multitude and variety of responsibilities women who work
encounter daily.

_In my house, I need to be ready for the customer to call me, “Are you busy, can you
attend me?” Now okay, stress, but I am fine now. Then to pick up my daughters, and
sometimes I have to go to the store, or to the doctor, and come to my house to help my
second daughter, help with homework. And sometimes another customer come to my
house. And I have to clean my house because, you know, the people come in my
house...when I finish work, my husband tell me, “You no eat?” “No, I want eat.” “Okay,
let’s eat.” I cooking something faster for eat for dinner. And I have to care my baby
because my baby always say me “Mom, mom, mom!”...and tell her, “Go with your
daddy” “No, no, no.” Okay when I am sitting or rest, my phone, and somebody call me to
make appointment for tomorrow or when was free, and another do to wash the dishes and
I arguing with my daughter fifteen years because she doesn’t want to help me about
washing the baby bottle and she doesn’t wants to bañarse [take a bath].

Yoana, who manages her business from her home, further illustrates how being responsible for
the cleanliness of her house compounds the stress she already experiences. Not only is she
responsible for the success of her business, she is also in charge of the well-being of her family
and home. As Yoana noted, these responsibilities, both together and alone, result in immense stress and anxiety.

Not all of the women who both work and care for their children express such high levels of stress. For example, Gabriela cleans houses part-time and Elvita works as a full-time janitor in an auto-dealership. Both did not note experiencing such intense stress. Perhaps, for Elvita, her decreased stress is due to the older ages of her children – her youngest son is 15. For Gabriela, the part-time responsibilities of her work may enable her to have more control over her schedule and devote significant amounts of time to taking care of her children.

Other factors that may cause differences between the stress levels of the women include support from a spouse or other family members. Family members, whether inside or outside an interviewee’s immediate family are crucial to alleviating some of the responsibility. Yoana’s mother takes care of her baby while she comes to the English school and Dani’s husband’s cousin takes care of her baby while she works. Hortencia also notes how her husband has become more willing to help her with tasks traditionally allotted to the matriarch of a family after coming to Chicago.

Aquí me ayuda, allá me decía “yo cambiaron pamper? No, porque mi mama me planchaba, porque mi mama me recogiera plato, porque yo jamás tengo que hacer.” Aquí es obligado por lo mismo porque nos dos trabajamos, entonces a mi no me daba tiempo. Entonces dejó de ser machista *laughs*. Todo que ayudarme. Ahora, baña, cambia a mi nena, todo, él cocina, él barra, él mapea. Entonces creo que cambió para bien todo, todo para bien. Dejamos de vivir en ese ambiente machista que se vive en nuestros países para vivir en un ambiente de...no creo que le pasa a todo el mundo, pero gracias a Dios nosotros aprovechamos la oportunidad estar lejos de todas las influencias para hacer una vida como nosotros queríamos vivir, y estamos tratando de vivirlo mejor que se puede.

Here he helps me, there he told me “I change the diaper? No, because my mom ironed, my mom picked up dishes, because I never have to do it.” Here it’s obligatory for the same because we both work. So, I don’t have time. So he stopped being macho. He helps me with everything. Now, he bathes, changes the diaper for my baby, everything, he
cooks, he sweeps, he mops. So I think that everything has changed for the better. We left behind the macho environment that continues on in our countries for living in an environment...I don’t think this happens to everyone, but thanks to God, we are taking advantage of the opportunity to be far from all of the influences to create a life like we had wanted to live, and we are trying to live in the best way we can.

Hortencia recounts a number of daily tasks that her husband now actively participates in. She contrasts his behavior in Chicago with what she might have expected in Mexico, and seems to be satisfied with his increased engagement in the responsibilities that would have otherwise solely fallen to her in Mexico.

Furthermore, many women received crucial help from family members who were more familiar with the Chicago area when they first arrived. For example, Angelica recounts how her husband’s family members helped them transition when they came to Chicago:

Su tía de mi esposo ha llevado mucho tiempo aquí, entonces ella sí hablaba en inglés, entonces siempre cuando ella tenía tiempo, siempre me llevaba, llegar a me ayudaba. Sí que mi esposo, si él hablaba, pues pero él trabajaba, él cansaba el domingo, y el domingo era cuando hacíamos las cosas.

My husband’s aunt has spent a lot of time here, so she spoke in English, so whenever she had time, she always took me, came to help me. If my husband, he spoke [English] too, well he worked, he rested on Sundays, and Sundays were when we did the things [we needed].

Angelica’s family ties helped her settle into her new home and navigate an unfamiliar and almost entirely English-speaking set of stores, legal agencies, and service providers. Family, whether immediate or distant, is a crucial piece of each interviewee’s support system, and these kinship ties provide support in a multitude of ways, including becoming accustomed to Chicago and taking care of routine activities.

Immigration

All interviewees spoke about their immigration experience either while answering a number of immigration-specific questions or through entirely unrelated prompts. To directly gain
information about the importance of immigration status as a social determinant, I asked open-ended introductory questions such as, “Why did you come to Chicago?” and “How is your life in the United States different from your life in Mexico?” Important information about immigration also arose through questions such as “What worries you?” When speaking about immigration, many women described similar economic and kinship-related reasons for migrating. They also noted the detrimental effects of undocumented immigration status, and recounted experiences of discrimination.

A majority (6) of the women immigrated to the United States without legal papers. These undocumented women crossed the border between 11 and 19 years ago. The other three, Claudia, Elvita, and Dani came with visas. Claudia and Elvita had husbands who successfully applied for a visa. Their husbands later acted as sponsors for the women to obtain legal documentation to come to the United States. Dani likely went through a similar process after marrying an ethnically Mexican, United States citizen two years ago and soon after receiving a visa. Regardless of whether their husband was a legal permanent resident or a citizen, all three women became eligible for a one of the many family visas that allow Mexican nationals to come to the United States, a program established by the Immigration and Nationality Act, a piece of legislation that I discuss further in Chapter 3.

The women came to the United States for a variety of reasons, most often economic or family-related. Hortencia’s account of her reasoning for coming to the United States illustrates many of the common drivers.

Wow, este, tomar la decisión de venirnos fue algo demasiado repentino, demasiado así como...yo tengo mucha familia aquí que estaba aquí hace muchos años y yo estudiaba, estaba estudiando en la universidad en México. Yo decía “Wow, para Estados Unidos se va la gente que no estudia, la gente que no tiene un futuro, yo jamás voy a ir a Estados Unidos” *laughs*. Esta es la situación en lo que me vine, no? Pero las cosas cambian, I mean, yo, este, cuando mi esposo, yo nos juntamos, nos dimos cuenta que, yo dejé en la
escuela porque yo fui madre soltera. Tuve que dejar la escuela. Entonces allí cambió mi vida y entonces ya tuve que buscar un futuro inmediato para mi niño. Este entonces... Y allí cambia mi forma de pensar, y creí que yo la tenía que darle mejor a él. En poco tiempo conocía mi esposo, y se nos ocurrió la idea de venirnos por acá porque la economía estaba dura. Yo trabajaba, yo trabajaba de recepcionista en un hotel cinco estrellas y no nos alcanzaba el dinero para vivir, para pampers, para ropa, era mucho, era demasiado. Y eso que yo ganaba mucho dinero a comparación de lo que ganaba más gente. Entonces este decidimos probar suerte aquí en los Estados Unidos. Nos vinimos, atravesamos el desierto de manera ilegal.

**Wow, this, to decide to come was something too sudden, too like that...I have a lot of family here that has been here for many years and I studied, I was studying in university in Mexico. I had said, “Wow, going to the United States are people who don’t study, the people who don’t have a future, I will never go to the United States” *laughs*. This is the situation in which I came, no? But things change, I mean, when my husband and I got together, we realized that, I left school because I became a single mom. I had to leave school. So there my life changed and so I immediately had to look for a future for my son. And there changed the way I think, and I thought that I had to give the best to him. In a little time, I got to know my husband, and the idea of coming here occurred to us, because the economy was hard. I was working, I was working as a receptionist in a five-star hotel and there wasn’t enough money to live, for pampers, for clothes, it was a lot, it was too much. And what I earned was a lot of money compared to what many people earned. So we decided to try our luck here in the United States. We came, we crossed the desert illegally.**

Hortencia left Mexico for the United States for multiple reasons – to join family, seek a better future for her son, and leave behind the limited economic opportunities in Mexico. Aside from Luz, all of the women recounted similar reasoning. Sandra noted that her sister, who she currently shares a house with, already lived in Chicago and Sandra herself sought a “better life.” Dani emigrated after marrying her husband, an American citizen who already lived and worked in Chicago. Angelica joined her husband who was already in Chicago, and unlike the other women, planned to only stay for one year. After she had a baby, she continued to remain. Claudia left Mexico because of the lack of employment opportunities in her hometown. She saw immigrating as an opportunity to fully learn English. Elvita, finally, came in order to support her sons, who wanted to study in the prestigious educational systems in the United States.
Throughout the interview, the women noted that their immigration status affects three main facets their lives: employment/income, eligibility for federal aid and health insurance, and overall stress levels. Gabriela reflects on the economic implications of her undocumented status:

*One problem, this problem is the papers for the immigration for my family. Because it’s not secure in the job. Maybe one month, three months, they say, I need the social security or I need the citizen and no more job. This is a big problem.*

She notes how her own and her husband’s employment, the family’s primary sources of income, are contingent on their employers not enforcing current laws regarding employment of undocumented immigrants. Because of their status, Gabriela continually worries about losing her family’s source of income, one of the many repercussions of living without legal documents.

Secondly, many of the six women who are undocumented note being ineligible for federal insurance programs like Medicaid that would otherwise provide coverage based on their income and resource level requirements. Further effects of immigration status on health insurance eligibility are discussed later in this chapter in the context of healthcare access. In addition, the same undocumented women are ineligible for aid programs like Temporary Aid for Needy Families and food stamps. These programs provide supplemental support for families earning an income under certain poverty levels. Considering the ties between income and health, undocumented status through ineligibility for aid programs, negatively impacts health.

Finally, undocumented status results in increased stress for some women. For example, Hortencia notes her fear of immigration raids.

*Por anoche sueñe que llegaron las agentes de inmigración y fue algo tan aúntico que le digo a mi esposo, “wow!” Después tuve que despertar, tuve que llorar, y esto le digo a mi esposo. Fue terrible.*

*Last night, I dreamt that immigration agents arrived and it was so realistic that I told my husband, “wow!” After, I had to wake up, I had to cry, and this I told to my husband. It was terrible.*
Hortencia illustrates how her immigration status combined with ongoing government action against immigrants who have illegally crossed the border affects her mental and physical well-being. Through pathways illustrated in Chapter 1, such chronic stress causes wear and tear on stress-regulation systems and vital organs, and through the prospect of immigration raids and deportation, undocumented status increases stress, which in turn negatively impacts health.

Both Hortencia and Gabriela note that they have become increasingly afraid of the implications of their undocumented status because of the current political climate. Hortencia comments:

\[\text{No lo había pensado. Nunca, no era algo que nos preocupaba, pero ahora, con esas noticias...}\]

\[\text{I hadn’t thought of it. Never, it wasn’t something that worried us, but now, with these news stories...}\]

Gabriela echoes Hortencia’s sentiment and additionally points to a specific politician, Donald Trump, who has recently gained significant traction in his bid for presidential election:

\[\text{It’s difficult, it’s difficult. Right now it’s more difficult because right now it’s [racist]. Many people is [racist] and the candidate Trump fomenter (promotes), introduce racism. Talk and talk and different race [he] no like. And the peoples living here or is American [say], “I think this is correct.”}\]

To both Gabriela and Hortencia, the current political climate inspires violence and hatred towards immigrants. Furthermore, candidates like Donald Trump present an increasingly possible reality that is not conducive to their well-being as undocumented immigrants.

While discrimination and racism in the United States worry many of the women, some also note that cultural norms between Mexico and Chicago have made their lives easier. For example, Elvita describes how her life has improved, especially when she became divorced, because of what she perceives as a less “macho” culture in Chicago.
Cambió también porque allá te crean que tú dependes del marido, como tu esposo y él es que manda y dice, decide y, acá, dije no, si yo trabajo, también tengo que tener voz y voto. Ósea, decir que si yo trabajo y yo también aporto dinero, yo también puedo decir que él se puede hacer, no nada más lo que diga él, esto también lo aprendí yo, porque puedo ser independiente también. Yo no necesito tampoco, no más depender de él. Y eso me ayudó mucho, porque cuando yo me divorcé, no me sentí que "ay necesito el marido porque dinero," verdad?

It also changed because there, they believe that you depend on the husband, like your spouse and he is the one who commands and says, decides, and here, I said no, if I work, I too must have a voice and vote. That is, to say that if I work and I also provide money, I also can say what he can do, no more than what he says. This also is something I learned, because I can be independent also. I don’t need it either, no more depending on him. And this helped me a lot, because when I got a divorce I didn’t feel that “ay I need a husband because money” right?

Elvita notes that women in Chicago are able to find employment and contribute economically to the household, and thus hold weight in the family decisions. Furthermore, with such income, employed women are more easily able to follow through with a divorce, as they are no longer entirely dependent on their partner for monetary support.

While Elvita notes that she has benefitted immensely from the gender dynamics in the United States, a number of women also elaborate on how difficult it has been to leave family behind in Mexico. For example, Dani, the most recent immigrant in the group of interviewees, feels isolated as she is only connected to her husband’s family and social sphere in Chicago. However, Hortencia describes how her relationship with her husband has become stronger after being in Chicago, in part because they came to the United States alone.

Este cambió en que nos vinimos, nosotros hacer un poco más, más duros, a vernos solos, a unirnos, mi esposo y yo, a saber que, saber que empezamos algo nuevo, de cero, de nada y este, estamos más unidos que nunca por lo menos porque estamos en otro país que no tenemos papá, que no tenemos mamá aquí. Nos hemos hecho fuertes, más duros.

This change in that we came made us stronger, to see ourselves alone, to bring us together, my husband and I, to know that, to know that we started something new, from zero, from nothing, and we are more united than ever at least because we are in another
country where we don’t have our father or mother here. We have been made more powerful, more strong.

Hortencia notes that in the absence of the familial support she lost after immigrating, her relationship with her husband has grown stronger. Together, they have created a new life in a foreign city. While not all women noted experiencing such a change in their relationship with their partner, Hortencia illustrates one way in which even without extended family, Mexican women in Chicago might lean on immediate family that has come to Chicago along with them.

Regardless of the limitations of their undocumented status, Hortencia notes that she and her family have been able to achieve their dreams. She recounts her outlook on her own and her family’s past and future in the United States.

Hace apenas unas semanas, yo creo que eso no era algo que te impedía realizar tus sueños. Nosotros somos personas bien soñadoras y bien trabajadoras. Mi esposo es una persona que no se para que él quiere siempre. Si tiene alguna meta, lo realiza. Aun sin documentos, ya es dueño de una impresa. Entonces nunca nos detenía el hecho o de pensar en no tenemos papeles.

Just a few weeks ago, I think, that this wasn’t something that stops you from realizing your dreams. We are dreaming and hard-working people. My husband is a person who doesn’t stop doing what he wants. If he has a goal, he does it. Even without documents, he already is the owner of a business. So it never stops us the fact or the thought that we don’t have our papers.

Even without legal documents Hortencia describes how her family has begun to achieve the visions that they have long hoped for. She, like the other women interviewed, has risen above her immigration, social, and economic circumstances and views her success and the success of her family as an outcome that is largely self-determined.

Hortencia’s words reflect the optimism present in many of the women’s narratives. Those who are undocumented acknowledge the ways in which immigration status limits their economic opportunities, causes stress and worry, and eliminates opportunities to receive government aid. These same narratives, however, also illustrate how each woman is willing to and will face such
limitations in order to find success and stability for their families. Through their experiences, the health effects of social factors such as immigration on health become clearer. Immigration status compounded with other determinants like income and occupation create an even more complex portrait of the factors that influence the health of Mexican-born women in Chicago.

*Socioeconomic Status*

Information regarding socioeconomic status was provided without prompting. The women most often described their income levels and employment during their introduction, and later mentioned their husbands’ occupations through the course of the conversation. When any facet of economic status arose, I asked a form of the question, *how does/did your income/employment affect your health?* The nine interviewees noted two main ways socioeconomic status effects their health: through direct occupational hazards of employment and through the limitations their earning level places on adopting healthy behavior.

The women interviewed primarily utilize the income of their partners to support their families. The partners are employed in a number of diverse fields: Hortencia’s husband is the owner of his own business, Gloria’s husband works in construction, Claudia’s husband works in a sweets factory, Yoana’s husband works in a marble factory, and Luz’s husband works in hotel cleaning. Three women, Sandra, Dani, and Angelica are married to men working in the auto industry as mechanics or in auto detail. The only woman not currently with a partner, Elvita, receives income from her former husband through child support payments.

In addition to monetary income from their husbands, many of the women either currently work or have worked previously. Yoana, Elvita, Dani (part-time) and Gabriela (part-time) are currently employed. Yoana works as a hairdresser, Elvita as a janitor in a car dealership, Dani as a teacher at Heartland Alliance, and Gabriela as a maid. All of the women, however, note
working at some point in their lives. Their former jobs include positions as a sales agent, waitress, machine operator, and cook.

Three women, Gabriela, Claudia, and Hortencia recounted that they stopped working once pregnant. Some occupations, however, were more amenable to time off during pregnancy or after childbirth than others. For example, Gabriela continued her job as a babysitter and brought her newborn to work with her until her final pregnancy. While positions like babysitting are often considered light work, Gabriela describes the strenuous nature of her work:

\[ I \text{ help the four childrens, and the house, and cleaning, and very hard, but it's okay for me. } \]

Gabriela notes that she was generally able to handle the difficult tasks and that she was able to continue working after becoming pregnant. Claudia, on the other hand, noted that the strength and weight-lifting ability she needed to continue working in a laundry cleaner became too difficult once she became pregnant.

\[ \text{Solo trabajé una temporada antes que nació mi niña, la más pequeña, en una lavandería de ropa para hospitales como por dos meses, yo creo. Después viajé a México, y porque era un trabajo pesado, decidí ya no regresar... como las sabanas eran grandes, tenías que hacer fuerza de jalarlas de un contenedor grande. Tienes que hacer mucha fuerza. } \]

\[ I \text{ only worked for a season before my baby girl was born, the youngest one, in a laundromat for hospitals for two months, I think. Afterwards, I went to Mexico, and because it was hard work, I decided to not return [to the job] ...like the bed sheets were large, you had to forcefully pull them from a large container. You have to do it with a lot of strength. } \]

Christina notes that she chose to quit her job after becoming pregnant, primarily because of the difficulty of the work. In addition to Claudia, Gabriela and Hortencia also noted quitting their jobs once becoming pregnant or having a baby. In addition to the strenuous work, Gabriela and Hortencia pointed to childcare expenses or concern for their children’s future as reasons to transition to full-time parenting.
While some women left jobs after becoming pregnant or having a baby, some also lost long-standing jobs because of the economic recession of 2011. Elvita and Luz both lost their former jobs due to the lack of work during the downturn. Elvita was let go from her job in a window and door factory and instead began working in her current job as a janitor in a car dealership. With the change in occupation, Elvita saw her income fall significantly, and she notes how she modified her own and her son’s spending habits in order to adjust to her lower earnings:

*My job now is only two checks a month and one check is the same as one week in the windows. So it’s...I need to cut many things, to go out to go to the restaurants, yeah... So I talk to my little son, just for my little son, “now we need to change many things because it is less money, so I can’t go outside to the restaurant maybe one time a month, not frequently.”*

Even though her new job severely limits her income, Elvita did not describe her health being affected by this change. Instead, her decision to eliminate eating outside of her own home might be considered a benefit to her health.

In addition to direct personal earnings and the wages of their partners, women like Gabriela and Elvita are in part supported by adult children who pay for a variety of expenses. In Gabriela’s shared home, her children contribute significantly to the household costs.

*Él y mis hijos trabajan y pues ellos pagan la renta. Y para la comida, como dan estampías, pues, también a él le pido, porque no me alcanza, le pido y pues a veces sí a veces no.*

*He and my kids work and, well, they pay the rent. And for food, like, they give [us] stamps, well and I ask [my husband], because it isn’t enough for me, so I ask and sometimes [he says] yes and sometimes no.*

In addition to her income, Gabriela relies on the wages of the children she lives with for both the rent and smaller daily expenses. Elvita’s son similarly helps her and her younger son by paying for expenses such as their phone bill.
Federal programs also support interviewees in different ways. In addition to income earned by the women or their husbands, Angelica and Yoana both note receiving food stamps for their families. Luz, Dani, Hortencia, and Yoana similarly note receiving supplemental nutrition services through the Women, Infant, and Children government program before, during, and after their pregnancies. I elaborate on policies such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that restrict eligibility for food stamps and other federal aid programs based on immigration status in Chapter 3.

The interviewees elaborate on two main ways in which employment and income impact their health. For one, daily responsibilities of a job alone often directly affect health. Gabriela not only describes her former job as a cook as physically taxing, but also physically harmful. She notes direct connections between her former occupation and her current health problems:

*I work on the hot, and sometimes I go to the freezer, and this is very dangerous. I have in the grill, make the steak, it’s very hot and then I need the more steak and no direct in the little freezer, but to the big freezer. It’s very difficult because later, I hurt my body.*

Gabriela describes how she considers rapid temperature change detrimental to her body and a direct cause of her pain. Other women, like Elvita, note that her job as a janitor requires extensive walking, which often makes her tired upon returning home.

Income also affects health through imposing limitations on healthy behaviors. Limited income, for example, might restrict a consumer to high-calorie, low-nutrition foods. Women like Elvita and Hortencia, however, note how their tight budgets encourage them to develop survival strategies for their families’ spending and cooking habits. They both describe the necessity of being avid planners, especially when trying to make healthy choices while living check-to-check. Elvita says:
I have money, but when I get my check, I need it. Because sometime the people spend a lot of the money, and then when I need to pay the rent “Ayyy, I don’t have no money.” No, me, one check is for the rent, and the other is for my food.

Hortencia notes further strategies that she utilizes in order to support her family’s health on a limited budget:

Si porque es realidad, este, si compras lo que necesitas, creo es como una planeación. Si tú planeas bien lo que quieres comprar, hechas a perder menos, y aprovechas mucho más. Comprar pollo y hacerlo en un, este, asado, ósea hacerlo es más fácil que hacer un mole, porque hacer mole te sale más caro.

Hay que planear lo que vas a comprar, lo que vas a comer porque la mayoridad de nosotros, creo que, este...estaba viendo las estadísticas que tiramos más que 40% de lo que compramos en comida, que nosotros desperdiciamos más del 40% de lo que compramos. Lo terminamos echando a perder o dejando que se echara de perder. Entonces si lo compras, es porque lo vas a usar en ese momento. Si no, no lo compras. Trato de no desperdiciar comida.

Yes because it is the reality, this, if you buy what you need, I think it’s like a plan. If you plan what you will buy well, you will lose less, and you take advantage of much more. You buy chicken and roast it, that is, make it [in a way] that is easier than making a mole, because making a mole ends up being more expensive.

You have to plan what you are going to buy, what are you going to eat because the majority of our food, I think...I was looking at statistics that said we throw away more than 40% of what we buy in food, we waste more than 40% of what we buy, we end up throwing away or leaving it thrown away. So if you buy it, it’s because you are going to use it at that time. If not, don’t buy it. I try to not waste food.

Hortencia and Elvita note how they meticulously plan their expenses in order to keep costs down while still continuing to eat well and afford their basic needs. Utilizing these survival strategies, women like Hortencia and Elvita strive to be resourceful and strategic consumers in order to ensure that their families are able to live healthily.

The women interviewed illustrate a diverse set of income sources both they and their families use. Those interviewees who are not currently employed are supported by their husband’s employment, government aid, and adult children. Only one woman, Gabriela, noted not having enough money and worrying about this concern. While on a limited income, many
noted developing methods and survival strategies in order to ensure that they and their families were able to live in ways they deemed healthy.

Heathcare Access

All of the interviewees knew that this project was related to health, as I described the project as researching the “factors that affect the health of Mexican-born women in Chicago”. Thus, without prompting, most noted their health status as well as recent experiences with healthcare systems. When such topics arose, I asked questions such as “Where did you last receive care?” “Are you currently insured?” and “Were you satisfied with your last visit to a healthcare system?” Many noted that being undocumented excluded them from federal aid programs that would otherwise provide with healthcare coverage. The women each cited various reasons for being uninsured, and both those with and without insurance noted financial barriers to care. The women also note obtaining services through subsidized providers, either at Community Health Centers or through subsidized hospital programs, and while pregnant. Finally, many women were willing to pay for care, especially when subsidized, and otherwise receive free care while pregnant. They are largely satisfied with the care they receive, but prefer Spanish-speaking providers. Of the women who reported experiencing discrimination within medical systems, they only report experiencing discrimination from non-physician professionals. As they illustrated when describing the effects of socioeconomic status on their lives, many of the women note also developing survival strategies to compensate for lack of insurance coverage or financial barriers to care.

Yoana, along with the five other undocumented women interviewed, is not eligible for Medicaid or subsidized coverage through health insurance marketplaces established by the Patient Protection and Affordable Care Act. The interviewees without health insurance are not
covered by private insurance for a number of reasons: they are unemployed, they are not married to their partner and cannot be covered under insurance provided by his employer, their husband does not have a stable job where insurance is guaranteed, or they cannot afford to pay for coverage out-of-pocket.

Undocumented uninsured women note receiving free care largely while pregnant. Women who have only experienced medical problems while pregnant received free medical attention at that time. For example, Dani had kidney stones while pregnant, but received free medical care in order to pass the stones during her first pregnancy. Similarly, some women believe that they are currently healthy because of the check-ups and examinations they received as part of pregnancy care.

In lieu of consistent or pregnancy-related coverage, women like Hortencia pay out-of-pocket for subsidized community clinics, a prevalent provider of care in Chicago. Hortencia recounts an experience going to one of the 71 community health clinics or federally qualified health centers within five miles of Portage Park and Belmont-Cragin:

*When we believe it is necessary, we visit the doctor. Yes, because it is not something expensive to go to the doctor. I don’t go to a doctor who costs two hundred or three hundred dollars. We have our doctor – we talk, and we say, you talk to the nurse and she tells you if it is an emergency.*

Women like Hortencia are willing to pay a subsidized amount in order to obtain services if they perceive such care is necessary.
Other women like Sandra and Yoana illustrate that the cost of care, especially for mental health services is more than they believe they can afford. Sandra notes how she considers obtaining care:

*I think I sad, but I think it is too much money to see a doctor. I like go to see a psychiatrist, but it’s too much money to pay.*

Yoana similarly does not see a mental health professional, even though she believes that she might benefit from the counseling.

*Because sometimes the psychiatrist, you know you are woman, you are sometimes feeling bad, sad, happy. But I saw my daughter “Okay, okay, I am fine, I am fine” .... because I saw in my daughter “no puedo estar deprimida, no puedo,[I can’t be depressed, I can’t]” for my daughters but sometimes I am feeling bad, sad, you know you are the woman, the woman are crazy. Yo misma, me doy borras, yo misma me aliento, yo misma me digo [I myself, I get rid myself, I help myself, I tell myself] “I can, I can, I can” yo mismo. Entonces I don’t have the money to pay the psychiatrist. I don’t have money, okay, I see the mirror “I am good, I am good, I am good, okay let’s go.” Say bye bye to depression, no, no, not for me.*

Instead of seeing a mental health professional, Yoana utilizes her own survival strategies to compensate for forgone care. She leverages her devotion to her family and children along with her determination to dispel the emotions a mental health professional might instead help her control. While Hortencia notes that when she or her family members need care, she will pay the amount necessary, the words of Yoana and Sandra illustrate that all health concerns are not considered equally and not all are deemed serious enough for professional care.

Sandra similarly cites expensive services as a primary reason for not fully following her physician’s recommendation. She recounts her experience visiting a doctor three years ago:

*Yeah, I don’t feel sick but I say maybe. But when they give me the order for the exams, it is too much money, and I don’t did. I didn’t the exams, and I don’t know.*
Sandra did not follow through with her doctor’s recommendations because of the cost of doing so. While she notes that she feels healthy, she is not able to benefit from the preventative medicine provided by such check-ups due to financial constraints.

When describing the factors and behaviors necessary to maintain good health, many women note that visiting a doctor regularly is important. When asked about their healthcare usage, however, many reported not seeing a doctor regularly. Instead they note that they visited the doctor only when experiencing physical pain or intense ailment. For example, Sandra’s words illustrate the difference between what she considers is good behavior and her own tendencies considering medical care:

*My mom is diabetic and she going to the doctor but she don’t, sometimes she don’t take the medicine, or she do more food that is not healthy for her and she feel bad. Right now, she is losing her eyes, her vision and she need to, to use a medicine for her eyes. If she don’t put the medicine, she is going to lose her eyesight and I think basically I told you. You have to listen our body. You know when you feel sick or you feel something hurts, you go to the doctor right now, no wait until be bad. You don’t…que tú no aguantes el dolor [you don’t hold your pain], yeah and then you go to the doctor – no. When the pain is little, we have to go to the doctor. It is easy to say, but not to do.*

Sandra’s words illustrate the difference between what she believes is healthy behavior – seeing a doctor as a first-line of defense or even a preventative measure – and how, in reality, she often sees the doctor only once she experiences an intense problem. While Sandra advises her diabetic mother to seek medical support more often, she notes that she, herself, does not always do so. Like Sandra, many women similarly reported not visiting a doctor regularly when asked about their healthcare usage. Instead, they noted that they visited the doctor only when experiencing physical pain or intense ailment.

Sandra notes that practicing such advice is much harder than giving it, and Yoana further illustrates how practicing such health beliefs is severely limited by income level.
I went to the doctor when I have the money or when I have the time or when the pain is terrible. For example, I had to do two root canal for teeth. It’s too expensive for me because I don’t have insurance. It’s $1,500 for two root canal, I have money, but this money is for the college for my first daughter. But the painful, it hurts, okay I am frustrate, I think, I have to good me for care my baby in the future.

For Yoana, something she considers instrumental to her well-being, seeing a dentist and alleviating the pain of her root canal, is a trade-off between helping to ensure her daughter’s future success. In her case, health insurance seems critically important, as it would allow her to forgo the expense of medical care while still obtaining necessary services.

However, insurance is not the only important piece of healthcare access. Claudia, who is legally in the United States and is covered through public health insurance programs, receives medical care when she is in Mexico instead of seeking services in the United States. She notes the extensive costs of receiving care in the United States.

En una ocasión, pregunté en una consulta que… Trae mi consulta en un ojo y estaba llevando mi hija a sus terapias y entonces pregunté. La pura consulta cuesta como tres cientos dólares o algo así. Dije era mucho y estamos como limitados en el dinero. Y este, y tenía unas lágrimas artificiales y fue lo que me puse.

One time, I asked in an appointment…I wanted to ask about my eye and I was bringing my daughter to her therapy, and so I asked. The consult alone costs something like $300 or something like that. I said that was a lot and we are limited in money. And that, and I had artificial tears and that is what I put.

In addition to the high cost of care, Claudia later elaborates on her unfamiliarity with the medical system in the United States. Without information about the exact costs of visits and medications, she waits until her next visit to Mexico in order to obtain the care for asthma she needs.

Claudia also expresses her preference for Spanish care providers, who are readily available in Mexico.

Lo que pasa es que casi vamos un vez el año, dos veces el año a México. Y aprovecho, y allá es donde más vengo a hacer chequeos. Porque como que…creo que por el idioma. Siento que me entienden allá. A veces aquí necesitan…a veces hay personas que hablan este…tu idioma pero a veces, bueno un intérprete, y siento que no es lo mismo.
What happens is we go almost once or twice every year to Mexico. And I take advantage and there is where I more often go to get check-ups. Because it’s like...I think because of the language. I feel that they understand me more there. Sometimes, here they need...sometimes there are people who don’t speak this...your language, but sometimes, well with an interpreter and I feel that it is not the same.

While Claudia is more satisfied with a Spanish provider, among the women interviewed, those who receive health care in the United States are satisfied with the care they receive. They are most satisfied with physicians with whom they can communicate in Spanish, and those who visit family physicians have found Spanish-speaking providers.

In lieu of a Spanish-speaking doctor, many use professionals or family members as interpreters. Others are also variably confident with their own English language skills. For example, Gabriela describes her experience communicating in a health care appointment:

*Mis hijas no se enferman mucho, este, entonces cuando se han enfermado, la más grande ella ya entiende, ya sabe, todo. Ella me sirve, podría ser el interpreter. Pero no lo he usado mucho, porque yo cuando necesito hablar inglés, yo hablo.*

*My daughters don’t get sick a lot, so when they are sick, the oldest, she already understands, she already knows everything. She helps me, she can be the interpreter. But I don’t use her much, because when I need to speak in English, I speak.*

While the women are satisfied with the services they receive from their physician and their ability to communicate effectively with or without an interpreter, they are less satisfied with other healthcare professionals, like nurses and receptionists. These professionals, they note, are less likely to treat them respectfully and are often unresponsive, forgetful, and unhelpful.

*Me ha pasado por ejemplo se aprovechan que no sabes hablar inglés y a veces te dicen cosas, y tú te quedas callado, no sabes defender. No hablas, o a veces no entiendes esta gente. Otras veces me han pasado. Yo fui con la recepcionista solamente a preguntar que donde podía hacer la cita, que tenía que llamar o podía hacer allí. Me contestó mal, y me contestó muy enojada.*

*It has happened to me, for example, they take advantage of the fact that you don’t speak English and sometimes they tell you things, and you stay silent, you don’t know how to defend yourself. You don’t speak or sometimes you don’t understand these people. Other*
times this has happened to me. I went to the receptionist only to ask where I could have the check-up, if I had to call or if I could have it there. She answered me rudely, she answered me very angrily.

Luz recounts experiences of discrimination within the healthcare system, where a receptionist was openly rude to her because of her limited English proficiency. Luz does not mention how such treatment affected her health, but does recount how her limited English ability is often taken advantage of. While none of the interviewees note discrimination as a barrier to seeking care, such experiences likely do not encourage Mexican-born women in Chicago to seek the care important to their health.

In the absence of private or public coverage, the uninsured women use additional creative survival strategies in order to avoid high costs typical of medical services. Yoana negotiated a subsidized rate for her chiropractic appointments by referring her hair clients to her chiropractor. Luz is considering buying a Walgreens subscription plan that will rebate the medications her and her family need. Other women, like Claudia, who are uninsured but with legal documentation take advantage of trips to Mexico where they are more comfortable with and knowledgeable about the medical systems in place. Almost all seek Spanish-speaking physicians with whom they are better able to communicate, but many are also confident and able to use their own abilities. These survival strategies do not encompass treatment for all ailments, however, and each uninsured women notes forgoing treatment, most often preventative or related to mental health. Instead, most of the women are more likely to receive care when they perceive they need medical attention, as opposed to obtain care in order to prevent the manifestation of a medical illness or for an expensive service, such as psychiatry.
Discussion

The words of the women interviewed provide a complex perspective on how social determinants of health affect Mexican-born women in Chicago. While similar, the interviewees also convey a diverse set of experiences and backgrounds. There are, however, a number of shared experiences and themes that emerge in analyzing their experiences together. In this section, I find commonalities and differences between the women’s recounted experiences with social determinants of health and existing literature that considers the same primary research question.

Health Status

The women interviewed seem to experience fewer chronic and acute health problems compared to rates of prevalence typically reported among Chicago’s Hispanic women. While none of the women interviewed were asked to describe their health using adjective descriptors, four of the nine described their health using descriptors such as “good” without prompting. When considering specific chronic diseases, none of the women interviewed reported ailments such as high blood pressure, high cholesterol, or high weight, while some did note making lifestyle choices in order to prevent their onset. Most women knew they did not have such diseases because of their last check-up with a doctor, and others felt well enough to forgo seeking medical care.

The better health of the women interviewed compared to the community of Hispanic women in Chicago may be due to selection factor. The interviewed women were contacted through Heartland Alliance and attended daily English classes. Each is able to be present at the school for at least one hour daily, and thus are successfully juggling the tasks for which they are
currently responsible. Doing so requires relatively good health, as the narratives of these women have illustrated.

Immigration

The Mexican born-women interviewed, six of whom are undocumented, illustrate three ways in which immigration status impacts their lives: through employment vulnerability, eligibility for federal aid and insurance programs, and stress of immigration raids. The pathways outlined by the interviewed women are also present in the literature on immigration as a social determinant of health included in Chapter 1. With the exception of federal aid programs regarding health insurance, the women do not directly state that these facets of their lives directly affect health. Instead, they note that undocumented status leads to employment vulnerability or that immigration raids leads to bad dreams, secondary factors that they did not connect to health. By drawing connections between immigration and upstream determinants, such as income, or downstream determinants, such as fear, they imply the ways in which immigration personally manifests in their health status.

Socioeconomic Status

The Mexican women interviewed were from a variety of employment backgrounds, but more than half (5) are not currently working. According to the 2000 Census, a similar percentage of Mexican-born women in Chicago (51%) were not in the formal labor force or earning taxed income (Departmento de Estudios Internacionales 2005). The women interviewed also worked in occupations not typical of Mexican women in Chicago, suggesting that they experience differing health effects based on type of work. For example in 2000, only 10.9% of Mexican born women in Chicago worked in food service. The majority worked in production or as assemblers, fabricators, packagers and handlers, machine operators and plastic workers.
Aside from Elvita, who operated a machine in a window and door-making factory in the past, the majority of the interviewees do not represent occupations common in the literature on Mexican-born women in Chicago. Instead, Elvita and Gabriela work in cleaning, Hortencia and Gabriela previously worked in food-service, Luz previously worked as a painter, and Yoana currently is a hair stylist. The women, like existing research, also note that these occupations are associated with different occupational effects on health. Machine-operating, for example, might require heavy lifting or constant use of small movements and computer screens, while food service requires extensive walking and exposure to extreme temperatures, as Gabriela notes. Gabriela and Claudia also reflected on the effect of lifting weighty objects on their bodies.

The extent of current research on the occupational hazards of these jobs differs by type of employment. Janitorial positions, for example, have been relatively well studied. A review of epidemiological studies conducted between 1981 and 2005 found that respiratory and dermatological diseases were the most common direct effects of cleaning positions. The review traces these diseases to exposure to cleaning agents, wet work, and rubber latex (Charles, Loomis, and Demissie 2009). The review also noted that “severe physical stressors” such as awkward posture and prolonged stranding lead to musculoskeletal disorders and monotonous jobs and limited opportunity for promotion lead to “psychosocial disorders” (Charles, Loomis, and Demissie 2009). While Elvita did note the exhaustion she feels after long hours walking in the car dealership, neither Elvita nor Gabriela noted experiencing the chemical or psychosocial stressors of cleaning.

Women saw the effects of employment through income on their health, and noted actively adopting to their circumstances in order to protect their health. Elvita, for example, notes that with her last job change, her income fell significantly. In response, she and her son began
eating at home more often to lower expenses. In addition, in the absence of public or employment-based insurance, the cost of care prevented a number of women from seeking medical services. Even those with insurance still noted the cost associated with co-pays and fees for additional tests and services.

Many of the women noted using survival strategies in order to compensate for limited income. Yoana refers her haircutting clients to a specific chiropractor and receives rebates on his services to alleviate her back pain. Elvita and Hortencia note that by meticulously planning, they are able to provide healthy food for their families even considering their limited incomes. Thus, the perspectives of the women interviewed not only provide examples of the effects of employment-related conditions, low wages, and lack of benefits on health but also how they work to prevent the negative effects of such limitations.

*Healthcare Access*

The interviewed women who were insured (4) obtained coverage through Medicaid (if legally in the United States) or through their husband’s employer. The majority (5) of the women interviewed are not covered by health insurance. Similarly, 57% of undocumented Latin@ immigrants nationwide lack health insurance (Bustamante et al. 2012). Instead of utilizing coverage to pay for the cost care, the uninsured women obtain care in a multitude of ways. All receive medical care while pregnant, and when not pregnant, women and their families seek care in subsidized clinics or in hospitals as they perceive it is necessary. In the face of financial obstacles, however, uninsured women adopt survival strategies in order to ensure that they either obtain or manage their health needs on their own.

Most women report obtaining subsidized services in Chicago through subsidized community health centers, personal connections with care providers, and uninsured patient
discount in hospitals. A few women note paying a small fee to obtain care and that this fee is affordable in times where they perceived care was necessary. Considering that there are 71 community clinics and federally qualified health centers within five miles of Portage Park and Belmont-Cragin, such services are likely accessible when needed. Such predominant usage of community clinics among the interviewees parallels usage of Latin@s nationwide, who account for more than 35% of patients at community clinics and health centers (Ortega, Rodriguez, and Vargas Bustamante 2015, Shi et al. 2004).

A few women also noted utilizing Illinois’s second subsidized service, the uninsured patient discount or receiving financial assistance from hospitals. A number of hospital programs, such as Charity Care and Limited Income Program Services, reduce the cost of services if the patient is able to demonstrate financial need. Three women noted specifically using such programs, but it is likely that all of the undocumented women meet the income criteria to obtain subsidized services when uninsured. Even with options for subsidized services, because of the lack of coverage, most of the interviewees reported not seeking preventative care, instead receiving services only when a health need makes medical help necessary.

Instead of or in addition to care in Chicago, one woman also noted receiving care in Mexico. Legally in the United States, Claudia is able to travel between the countries in order to be attended by a system in which she is more comfortable, familiar, and satisfied. Other instances of circular migration in order to receive lower-cost and more culturally similar healthcare services between Mexico and the United States have been previously documented most often among Mexican immigrants living at the Southern border of the United States (Wallace, Mendez-Luck, and Castañeda 2009). Since the undocumented women interviewed live much farther from Mexico and must cross the border illegally, circular migration in order to
obtain healthcare is an even more time-intensive and dangerous option for Mexican-born women in Chicago.

Whether in Mexico or in the United States, the women overall recount being satisfied with the care they receive. Most receive care from Spanish-speaking physicians, but when seeing English-speaking physicians, the women recount using an interpreter or being able to communicate effectively on their own. Furthermore, the women all seemed to share perspectives on their health with their physician. These two factors lead to a better perception and greater satisfaction with the care they receive. Furthermore, such satisfaction with care and mutual understanding leads to better health outcomes (Timmins 2002, Betancourt et al. 2003).

The women’s positive attitude towards health care systems and providers echoes the words of Latina women receiving pregnancy care in New York City. Alyshia Galvez summarizes her interviews of these women, writing:

None scapegoated the healthcare systems or providers – even those who encountered very disturbing practices. To varying degrees and with different foci, all emphasized their own responsibility, agency, and power to affect their care. They each noted how women themselves need to take the initiative to get checked out, to insist on follow-up, to search out second opinions, and to take risks in sharing their information and personhood with their providers. Their conceptions of self and of survival strategies have a central place for their own agency.

While the nine interviewed women did not recount any “disturbing practices” in their experiences with American health systems, they did hold themselves accountable for receiving high-quality care. Many, like Yoana and Hortencia, further made conscious decisions about when their body needed or did not need care, and from whom they would receive it.

The experiences and perspectives of the women also illustrated a contradiction: while many women emphasized their own ability to know when they needed care, they also noted the importance of finding preventative care. For example, Hortencia noted that she sees the doctor
when *she* feels it is necessary. Others echoed her sentiment, explaining that they had not recently received care because they generally feel well. Yet, most also explicitly noted the importance and their appreciation of healthcare systems. Sandra notes, for example “when the pain is little, we have to go to the doctor.” The women, while noting that they believe they are the foremost experts of their bodies, also are enthusiastic about receiving preventative care from medical professionals who they also perceive as experts of their bodies.

**Stress as a Pathway to Illness**

These accounts illustrate the intertwined nature of stress, responsibilities, and health. The women interviewed experience stress from a number of different sources, including employment prospects or responsibilities, income, childcare, care for partner, and housework. While all noted the stress of these activities, they all differentially emphasized the effects of such stress on their bodies. For example, Hortencia illustrates that stress affects health through likelihood of an accident or the manifestation of a tumor. Hortencia specifically recounts a car accident that happened ten years ago and its direct effects on her body:

*Por el estrés, andar corriendo, haciendo el trabajo chocamos nuestro carro. Me rompí las costillas, me rompí el hígado...estuve en terapia intensiva, estuve sin caminar como unos meses.*

*Because of stress, I go around running, while doing work, I got into an accident in our car. I broke my ribs, I broke my liver...I was in intensive therapy, I was unable to walk for some months.*

Hortencia attributes the car accident to her constant stress, and notes the direct debilitating effects of the accident. She additionally experiences migraines and had a brain tumor removed because of what she and her doctors posit manifested due to her constant anxiety:

*Me operaron de un tumor arriba de mi cerebro y me dijeron que posiblemente se ha provocado por tanto estrés. Todavía, la migraña es una enfermedad que no se cura, solamente se tranquiliza. Entonces, este, todos los doctores siempre me han dicho, “debes llevar la vida más relaxed,” y ahora lo estoy intentando.*
They removed a tumor above my brain, and they told me that it was possibly caused by so much stress. Still, migraines are a sickness that can’t be cured, only calmed. So all of the doctors have always told me “you should live a more relaxed life,” and now I am trying.

Through her poignant narrative, Hortencia illustrates that her stress has direct effects on her health. She further notes how her physician attempts to address the health problems rooted in her increased stress, and how she is trying to hold herself personally accountable for her own stress levels. When asked how she recommends being healthy, Hortencia notes living a balanced life, with priorities in order. Other women like Luz similarly reflect that a person must control her stress levels in order to remain healthy, and together the accounts of many of the interviewees further illustrate that stress is related to their daily responsibilities, factors in some ways out of their control, whether taking care of children, running a business, or both.

While there is literature on stress in terms of allostatic load and resultant “wear and tear” on organ systems, Hortencia illustrates other ways in which stress shapes health (McEwen 1998). Both Hortencia and Luz note the day to day experience of being stressful, and in doing so, suggest that stress increases the likelihood of an accident or other physical harm, events that have happened to each in the past. Furthermore, considering none of the women noted being clinically diagnosed with diseases exacerbated by allostatic load, such as hypertension and diabetes, it is not surprising that none also noted that they conceptualized stress as impacting their medical history. However, Yoana and Elvita experience some level of depressive symptoms, a disease exacerbated by stress, still do not imply that stress might be a factor shaping their mental health. Instead, Yoana points to her hormones and Elvita notes loneliness or cold weather as causes of their sadness. These differing beliefs about the effects of stress on health illustrate where Mexican-born women in Chicago, and likely people and policy-makers at large, should be better educated about novel research tying stress to health.
Considering most women noted that they are able to control the factors, such as diet and exercise, which are important to their health, perhaps greater knowledge of the impacts of stress on health would lead to greater adoption of stress-management behaviors. Hortencia’s story illustrates the utility of such knowledge; after her doctors told her that her migraines and tumor might be caused by her chronic stress levels, she began working towards living a less stressed lifestyle where she only takes care of her primary priorities. As noted in Chapter 1, stress, however, is rooted in a number of external factors, such as position in a workplace hierarchy, living in a violent neighborhood, or continually performing care-taking tasks (Heraclides et al. 2009). Such responsibilities and conditions cannot be managed through conscious behavior alone, and thus must be examined by people other than the women themselves in order to improve health.

The complex, nuanced words of the interviewed woman further complicates and elucidates the question, what are the social determinants of health affecting the health of Mexican-born women in Chicago? The experiences of these women illustrate how each is an active agent working towards good health and also have important implications for improving practice and policy in a variety of sectors connected to immigration, socioeconomic status, and healthcare access. Policy-making bodies must listen to the rich histories and voices of Mexican immigrants, in addition to the data points that represent them, in order to better support their health.
Chapter 3: Public Policy and Social Determinants of Health

Public policy, understood as actions and mandates enacted by federal, state, and local governments through law, have widespread implications for health. Thus, whether considering the social determinants of health affecting Mexican women in Chicago through related literature or first-hand interviews, these social factors are shaped by a variety of legislation. In this chapter, I focus on three public policies that have been implemented in the last half-century: the Immigration and Nationality Act, the Personal Responsibility and Work Opportunity Reconciliation Act, and the Patient Protection and Affordable Care Act. Each influences the social determinants of immigration, socioeconomic status, and healthcare access, respectively, and, thus, the present-day health of the nine interviewed women and all Mexican-born women in Chicago.

Immigration: The Immigration and Nationality Act

The Pew Research Center reports that 5.6 million undocumented Mexican immigrants were living in the United States in 2014 (Gonzalez-Barrera 2015). Chicago alone was home to 138,000 undocumented Mexican immigrants between 2010 and 2011 (Tsao 2014). The United States has passed numerous pieces of legislation that affect the flow of such immigrants and continue to shape how migration influences the health of, often undocumented, Mexican-born women in Chicago. One such legislative piece, the Immigration and Nationality Act, sets limits on the number of immigrants allowed into the United States, in part resulting in the significant undocumented population in Chicago and nationwide.9

In 1965 President Lyndon B. Johnson signed the Immigration and Nationality Act, also known as the Hart-Celler Act, replacing the existing nationality-based quota-system with a set of

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9 Before the Immigration and Nationality Act, the United States utilized a national-origins quota system. For a review of immigration policies influencing immigrant inflow including those pre-1965, such as the national-origins quota system, see Cornelius (2004).
global immigration ceilings. The Immigration and Nationality Act allocated a total of 290,000 immigrant visas to the United States, and set a limit of 120,000 visas for countries in the Western Hemisphere, with no per-country quotas, and exclusive of parents, spouses, and children of United States citizens (Cornelius 2004; 1965). The Act also established seven preference categories, four designated for family reunion, two for professional and skilled or unskilled workers, and one for refugees (Kennedy 1966). Modified versions of these complex immigration categories are still in use today.

Implementation of the Immigration and Nationality Act uniquely impacted the immigration of Mexican women to the United States. Before the Immigration and Nationality Act, there were few restrictions on Mexican migration to the United States, in part because of the symbiotic relationship between Mexican workers and American growers in search of cheap labor (Kennedy 1966). The family-based visas established through category 2 of the Act: a 20% allocation to “spouses, unmarried sons, or unmarried daughters of an alien lawfully admitted for permanent residence,” initially supported the legal migration of many Mexican women (1965). Earlier labor initiatives like the Bracero Program facilitated the immigration of over 5 million Mexican nationals, most of whom were men. After their tenure with the Bracero Program, many of these temporary agricultural workers gained legal residency (Calavita 2010). Through the Immigration and Nationality Act’s preference for granting visas to immediate family members of legal permanent residents, many wives still in Mexico obtained legal permission to migrate to the United States in order to reunite with their husbands (Donato, Kanaiaupuni, and Stainback 2001).

10 In addition to few limitations on migration, federal initiatives such as the Bracero Program, established in 1942, encouraged Mexican nationals to come to and work in the United States under certain conditions and within numerical limits. This program ended in 1964, one year before the implementation of the Immigration and Nationality Act (Massey and Pren 2012).
The other family-based categories, however, require a US citizen as a sponsor, and thus were less helpful to Mexican-born women seeking to migrate.

The Immigration and Nationality Act also established two 10% categories for employment-based visas, such that 20% of the total number of visas would be allocated to immigrants seeking work (1965). These categories were designated for “qualified immigrants who are capable of performing specified skilled or unskilled labor, not of a temporary or seasonal nature, for which a shortage of employable and willing persons exists in the United States” and “qualified immigrants who are members of the professions, or who because of their exceptional ability in the sciences or arts will substantially benefit prospectively the national economy, cultural interests, or welfare of the United States” (1965). Most Mexican nationals did not qualify for these categories, especially those who migrated in order to respond to dynamic labor needs (Massey, Durand, and Pren 2014).

The modern American immigration system is rooted in the Immigration and Nationality Act. With expanded limits established by the Immigration Act of 1990, the current system grants 700,000 visas in total per year, 480,000 of which are family-based visas. There is no limit on visas allocated to immediate relatives (spouses, unmarried minor children, and parents) of U.S. adult citizens, a continued provision also rooted in the Immigration and Nationality Act (American Immigration Council 2014). Immigration through family-based visas is not just limited by available visas, but also by connections to US sponsors. In order to be admitted through the family preference system, an applicant must have a US citizen or legal permanent resident (LPR) sponsor, who may then petition for the applicant and prove the legitimacy of the relationship, note that the applicant meets minimum income requirements, and finally signs an affidavit of support stating that the sponsor will be financially responsible for their family
member upon arrival in the United States (American Immigration Council 2014). These sponsorship restrictions, in addition to numerical limits on visas, hinder opportunities for Mexican-born women to obtain documentation through the family-based system and legally migrate to the United States.

As specified by the original Immigration and Nationality Act, preference for visas continues to be given to immediate family members of citizens and legal permanent residents of the United States. Two of the three interviewed women who are legally in Chicago noted coming to the United States through family-based visas after their husband had already obtained legal status. Dani falls under the unlimited category for visas granted to immediate relatives of US citizens, while Cristina falls under category 2A as a spouse of a legal permanent resident, a category limited to 87,900 visas annually. Thus, while some Mexican-born women are able to utilize the family-based visa mechanism, many cross the US-Mexico border without documentation and do not benefit from this provision of the Immigration and Nationality Act.

The current immigration system for employment-based visas, a more complex version of the system established by the Immigration and Nationality Act, includes a range of categories and specified quotas for each. Modern employment-based visas are separated into two further categories: temporary and permanent. Temporary workers comprise a variety of sectors, including athletes and entertainers, religious workers, and diplomatic employees. Visas for temporary workers are estimated to be approximately 140,000 when combining the largest temporary visa categories (Lowell 2000). Permanent employment visas are divided into five categories and, in total, also allocated 140,000 visas per year. These categories are divided generally by skill level and years of experience. According to the United States Citizenship and Immigration Services, a non-US national can obtain a visa for permanent residence by presenting
proof of a job offer, investing at least $500,000 certain employment areas, proving that she is an “individual of extraordinary ability in the sciences, arts, education, business, or athletics” or by falling under a number of “special categories of jobs” including religious workers, employees of U.S. foreign service posts, and former U.S. government employees. Among these categories, visas for “other” unskilled laborers are restricted to 5,000 (2013, 2014). Cristina, one of the three Mexican-born women interviewed and legally residing in Chicago reported that her husband had applied for and received a visa to come to the United States. Cristina did not specify the visa type, but did note that her husband was an electrical engineer in Mexico and currently works in a sweet factory.

Given these numerous and restrictive limits both on immigration type and country of origin, the number of Mexican-born immigrants hoping to enter the United States far exceeds the available legal routes of immigration and, in part, results in significant populations of Mexican immigrants remaining in or entering the United States illegally. In addition, by setting a quota on immigrant visas that does not meet the present demand for immigration, the Immigration and Nationality Act in part contributes to illegal border-crossings, especially among Mexican nationals.11

In addition to legislation limiting legal immigration, other legislation not considered immigration policy, such as the North American Free Trade Agreement (NAFTA), shapes the drivers of migration, and, thus, immigration. Passed in 1994, NAFTA increased the number of Mexican nationals looking to migrate to the United States for three primary reasons. First,

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11 In addition to visa limits on the number of legal entrants to the United States, federal and state governments control the difficulty of border crossing in order to control migrant inflows. In recent years, the United States federal government has poured immense funds into keeping undocumented immigrants from crossing American borders by building fences and stationing greater numbers of staff at the US-Mexico border. Recent legislation impacting border security include the Illegal Immigration Reform and Immigrant Responsibility Act and the Secure Fence Act. See Golash-Boza (2009) for a review of border militarization and the effects of such militarization on Mexican nationals and the US economy.
NAFTA allowed heavily subsidized American agricultural products, such as corn, to enter the Mexican market. The cheap competing products devastated the profitability of the Mexican agricultural sector, putting over 2 million farmers out of work (Golash-Boza 2009). Mexican farmers who now found it unprofitable to grow products like corn moved to cities and later crossed the US-Mexico border, often illegally. Secondly, NAFTA created conditions ripe for transnational corporations to move to Mexico, which in turn forced many smaller businesses to close. The potential entrepreneurs who saw little opportunity became new migrants (Golash-Boza 2009).

Finally, NAFTA decreased wages along the Mexican border (Bybee and Winter 2006). Families who subsequently began earning less than subsistence wages were now incentivized to move or to send family members across the border to work (Fernández-Kelly and Massey 2007). While none of the interviewed women mentioned NAFTA specifically, many cited a lack of economic opportunity as a primary motivation for leaving Mexico. For example, Hortencia and Claudia both noted the few well-paying employment opportunities in Mexico as a main reason for deciding to migrate. The lack of economic prosperity they describe may be in part attributed to American policies like NAFTA, and their migration without visa may be in part due to the strict limits currently imposed on visa allocation rooted in the Immigration and Nationality Act.

As Chapter 1 illustrates, immigration status is a key social determinant of health among Mexican-born immigrants in the United States. For the six undocumented women interviewed, immigration status influences their health through ineligibility for the majority of federal and

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12 The increased militarization of the US-Mexico border also directly affects the health of migrants, particularly those who cross the US-Mexico border without legal authorization. Greater border control pushes migrants to more remote areas of crossing, and as construction of the border continues, it is “likely to lead to more migrant deaths, as migrants are pushed into more remote regions of the borderlands” (Téllez and Peña 2007). See Tellez and Peña (2007) for a review of the effects of border militarization on health. Increased militarization also likely increases the stress experienced by migrants and creates divisions between American nationals and immigrants, possibly leading to discrimination, a determinant that further negatively impacts health (Hwang and Goto 2009).
state aid programs. Whether to provide supplemental income, health care coverage, or educational support, these programs enable women to maintain better health. Secondly, stress due to undocumented status, discrimination, and the threat of deportation negatively impacts health (Kaestner et al. 2009). Thus, while the Immigration and Nationality Act and other policies related to immigration were not conceived with regard to their health outcomes, they nonetheless shape both social determinants of health and health itself.

**Socioeconomic Status: Personal Responsibility and Work Opportunity Reconciliation Act**

Public policies also shape socioeconomic status, a key social determinant of health. For example, legislation influences employment opportunities, educational assistance, and taxation and welfare programs. These policies are often connected to other determinants of health. For example, in this section, I focus on the impact of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), a policy that differentially affects Mexican-born women based on immigration status.\(^{13}\)

Passed in 1996, PRWORA is the most recent policy to implement major welfare reform. PRWORA overhauled the existing welfare system by replacing programs such as Aid to Families with Dependent Children with Temporary Aid for Needy Families (TANF) which attempted to “convert welfare into a helping hand, rather than a handout” as a House Report noted (Scaperlanda 1997, 1996). PRWORA’s TANF program primarily provides low-income families with cash assistance, given that the recipient finds employment within two years of receiving aid (1996).

\(^{13}\) While PRWORA shapes who receives public aid, other policies additionally affect employment, another piece of socioeconomic status, for Mexican-born women. For example, the Immigration Reform and Control Act made intentional employment of undocumented foreign workers illegal, punishable by fines and prison sentences. This condition both restricts wages and requires immigrants to obtain fraudulent documents to provide employers (Phillips and Massey 1999).
PRWORA was enacted at a time of deep national disdain towards new immigrants. It was legislated alongside a number of other anti-immigrant laws, including the 1996 Antiterrorism and Effective Death Penalty Act, which limits rights of non-citizens, and the 1996 Illegal Immigration Reform and Immigrant Responsibility Act, which made it easier to deport or report both legal and undocumented immigrants, among other provisions (Fix and Passel 2002). The disdain for immigrant access to public aid could be seen across party lines during the Clinton administration, such that the Democrat-controlled House of Representatives created proposals to limit immigrant access to Social Security benefits, while the Republican Congress wrote “far-reaching restrictions” to immigrant rights into their policy blueprints (Fix and Passel 2002).

Such anti-immigrant attitudes in part resulted in the passing of Title IV of PRWORA, a provision specifying immigrant restrictions. Title IV of PRWORA legislated new eligibility distinctions that directly ties receipt of benefits to citizenship status, shifts the power to determine aid eligibility from the federal to state level, and distinguishes immigrants depending on whether they arrived before or after the enactment of PRWORA (Fix and Passel 2002). These changes directly affected the income of Mexican-born women in Chicago both at the time and currently.

Under Title IV of PRWORA, undocumented and legal immigrants residing in the United States for less than five years became ineligible for large public aid programs like TANF. Before the implementation of PRWORA, legal immigrants, regardless of citizenship status or length of residence in the United States, were able to receive selected public benefits if they met income requirements. PRWORA’s stipulations ensure that the PRWORA restricts eligibility for almost all federal public aid programs for many immigrants, including those who are Mexican-born (Watts and Astone 1997).
Title IV also granted states authorization to offer their own substitute programs for immigrants no longer eligible for aid programs because of immigration status, but also required states to pass a law describing undocumented immigrant eligibility for public aid if deeming such immigrants eligible (Fix and Passel 2002, Borjas 2003). Illinois decided to not provide substitute welfare programs, a decision that continues to affect undocumented Mexican-born women today.

Illinois has obtained eligibility for (1) lawful permanent residents (2) refugees or asylees (3) persons granted withholding deportation or removal (4) persons granted conditional entry (5) trafficking victims (6) certain battered spouses and children with pending or approved applications for legal status and (7) natives of certain ethnic groups, such as Haitians, Cubans, and Hmong/Highland Laotians. These stipulations do not include the majority of Mexican immigrants arriving in Illinois, who are thus ineligible to receive such benefits.  

Of the nine women interviewed, none reported receiving aid through programs like TANF, and only two reported receiving food stamps. Their limited participation in these public aid programs is likely due to six of the women being ineligible to receive services as undocumented immigrants. Two of the undocumented women, Yoana and Angelica, do receive food stamps, but do not report who in their family is eligible. Thus their families may receive aid based on the eligibility of their children, who were born in the United States and thus meet the immigration status eligibility requirement for food stamps. By supplementing income or providing additional funds for food goods, these programs compensate for a family’s otherwise

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14 In addition to meeting immigration requirements to receive public benefits, all recipients must meet specific income and work requirements. For example, to receive Supplemental Security Income, a qualifying immigrant must be able to document that they have 40 credits of work in the United States. To earn credits, an individual must work in taxable employment. Credits are determined based on the taxes paid and attached to their Social Security Number. For example, in 2016, a person earns one credit for every $1,260 of earnings, but the maximum number of credits a person can earn in a year is 4 (Social Security Administration 2016). This complicated system further limits the number of people able to access public benefits, irrespective of immigration status.
low earnings or level of resources, and by excluding many Mexican-born immigrants based on immigration status, such programs do not support their health.

While PROWRA dictates eligibility based on whether a person is be a legal citizen or resident who has been in the United States for more than five years, there are federal aid programs that include undocumented immigrants as eligible participants. The federal government offers the Supplemental Food Program for Women, Infants & Children (WIC). WIC is a federal food assistance program for women, infants, and children that supports pregnant women, new mothers, and young children. Enrollees are eligible for supplemental foods, health care referrals, and nutrition education. Undocumented immigrants in Illinois are also eligible for most non-means tested programs and provisions such as child and adult protective services, violence and abuse prevention, mental illness or substance abuse treatment, short-term housing or disaster assistance, soup kitchens and community nutrition programs (Illinois Coalition for Immigrant and Refugee Rights 2009). Such programs, particularly WIC, seem to be utilized by Mexican-born women in Chicago. Four of the nine interviewed women reported receiving WIC while in Chicago. These services, open to individuals regardless of immigration status, might provide additional assistance to mitigate the ways in which limited income negatively affects health.

Use of public aid programs impacts health in two ways. Firstly, limited income, as a piece of socioeconomic status, is detrimental to health. In 1999, half of all immigrant families lived below the poverty line, but analysis of public aid enrollment and income among immigrants after the implementation of PRWORA illustrates a significant decline in usage of public aid between 1994 to 1999 (Fix and Passel 2002). Thus, while many Mexican-born women might benefit from aid through such programs, they are nonetheless ineligible to receive such.
supplemental help. Secondly, exclusion from aid programs results in greater chronic stress levels, which directly impact health. For example, a study of the 1999 National Survey of America’s Families data found that parents of immigrant children were more likely to be worried about having enough food than were the parents of citizen children” (Capps 2001). When present over extended time periods, such worry can lead to activation of stress pathways outlined in Chapter 1 and, in doing so, negatively influence health.

These pathways illustrate the multi-dimensional way in which public aid, and accordingly public aid policy, impacts health. Socioeconomic status shapes more intermediate social determinants, such as access to health care, high-quality food, and health-protective stress levels. Furthermore, public aid programs compensate for low income by providing health insurance, supplementary income, and greater access to food, all of which affect health. These social determinants and intermediary factors are noted by the Mexican-born women when considering their own health, and are further expanded upon by literature about health and the social determinants of health. Thus, PRWORA and restrictions on access to public aid programs based on immigration status shape public aid eligibility for all immigrants, and furthermore, impact Mexican immigrants specifically, a large part of whom are undocumented or recent legal permanent residents.

Healthcare Access: The Patient Protection and Affordable Care Act

As noted in Chapter 1, access to health care is measured on multiple dimensions, including the availability and supply of services that are not hindered by “financial, organizational, and social or cultural barriers” (2002). Health insurance policy shapes access, as health insurance diminishes the cost of care and thus enables greater access. The Patient Protection and Affordable Care Act (PPACA) is the most recent large-scale reform to the
American healthcare system. I focus on the effects of three primary provisions of the PPACA on Mexican-born women in Chicago: its expansion of Medicaid, establishment of healthcare exchanges, and support for community health initiatives. I also include Illinois-specific legislation that works to provide services to point to the aid available to undocumented immigrants and legal residents who have been in the United States for fewer than five years and are, thus, not eligible for formal programs included in the PPACA.

The PPACA is a federal statute signed into law by President Barack Obama in 2010. It includes an “individual mandate” which requires all individuals to be covered by an insurance policy or pay a penalty. The PPACA also established public health insurance exchanges, where individuals and small businesses can compare policies and to choose their own. The exchanges include subsidies for people living between 100% and 400% of the federal poverty level. The PPACA additionally gave states the option to expand Medicaid programs to a chosen income level (2010b). Illinois is a state that has opted for Medicaid expansion, a decision that has significant implications for the population of uninsured Latin@s currently residing in Chicago.

These provisions hold the potential to immensely improve the rates of coverage among previously uninsured Latin@s, such that if all states opted to expand Medicaid coverage through the PPACA, 95% of eligible uninsured Latin@s would qualify for Medicaid, Children’s Health Insurance Program, or public healthcare exchanges. Even without full adoption of program expansion, 4.2 million uninsured Latin@s became covered through the PPACA. While the PPACA has largely improved care for Mexican-born immigrants, as approximately one in every four uninsured people who are eligible for the expanded Medicaid program or the health insurance marketplaces is Latin@, many of its provisions do not apply to Mexican-born women depending on their immigration status (U.S. Department of Health and Human Services 2012).
Receiving Medicaid and/or subsidized premiums provides individuals and families that would forgo care due to cost another option, and further allows the same groups to utilize money that would otherwise pay for needed care for other necessities.

While the PPACA provides new coverage for some, the 138,000 undocumented Mexican immigrants in Chicago are ineligible for coverage through the PPACA because of their immigration status (Tsao 2014). The PPACA specifically excludes undocumented immigrants, and further limits, if not eliminates, options for legally authorized immigrants who have been in the United States for fewer than five years, an eligibility criteria rooted in PRWORA. Such eligibility criteria leaves these groups ineligible to receive Medicaid and with limited options in the healthcare exchanges. Thus, while Illinois expanded Medicaid in order to provide coverage to residents living near the poverty level, only some Mexican-born women, regardless of income level, are able to take advantage of this change.

In the absence of insurance coverage, undocumented Mexican-born women in Illinois are still able to obtain publically funded care in two ways. Firstly, the state government coordinates the Moms & Babies program, which provides care to pregnant women regardless of immigration status. Eligibility is based on income level, such that a family of four must earn less than $4,304 per month. Pregnant women are eligible for the program while they are pregnant and 60 days after the baby is born, during which a newborn may receive checkups, well-baby care, and vaccinations. The program further provides coverage for labor and a variety of medical services including prenatal checkups and vitamins (State of Illinois All Kids 2015). In addition to the Moms & Babies program, Illinois, in conjunction with the federal government, provides the Medicaid Presumptive Eligibility Program (MPE), which “offers immediate, temporary coverage for outpatient healthcare” while pregnant. MPE only covers care from designated approved
providers, and like Medicaid at the federal level, MPE uses income level as the primary criterion for eligibility (State of Illinois All Kids 2015).

Even though these state and combination state-federal programs support women solely while they are pregnant and immediately afterwards, such coverage enables women to obtain care both related and unrelated to their pregnancy. For example, in addition to prenatal care, the Moms & Babies program covers primary care visits, lab tests, specialty medical care, vision and dental care, emergency room care, mental health support, and substance abuse services (State of Illinois All Kids 2015). Four of the Mexican-born women interviewed reported receiving a majority of services while pregnant, presumably through such state- or combination state-federal funded programs. For example, Dani noted using such services to pass kidney stones while pregnant, and Susana noted that the last time she received medical services was when she had a baby five years ago. Their stories illustrate the utility of the Moms & Babies and Medical Presumptive Eligibility programs in maintaining health, especially among undocumented Mexican-born women who might otherwise not receive care.

In addition to the effects of the PPACA on insurance coverage, two policies directly shape the services that are available for people without insurance. All women, regardless of immigration or pregnancy status, can additionally obtain care in community clinics and health centers (CHCs). With over 8,000 delivery sites nationwide located within the low-income communities that need services most, CHCs diminish financial barriers and eliminate logistical obstacles to care. While CHCs are not insurance itself, they offer comprehensive primary and

15 Community Health Centers address transportation barriers to access through deliberately operating in the communities they serve. Illinois also attempts to reduce logistical barriers to access through the Family Case Management program, which provides enrollees with bus passes in order to attend their health care appointments. While Illinois and federal programs do not comprehensively address the multitude of complex barriers to access, CHCs and programs like FCM nonetheless work to improve care regardless of immigration status.
mental health care services at a subsidized rate based on ability to pay (Ortega, Rodriguez, and Vargas Bustamante 2015). Research indicates that CHCs provide high-quality services, such that insured patients (with Medicaid, Medicare, or private insurance) receive comparable care at CHCs compared to patients who receive care in non-CHC settings (Shi et al. 2003, Forrest and Whelan 2000).

However, considering many Mexican-born women are uninsured, the care they receive from CHCs often might not be comparable (Hicks et al. 2006, Zhang et al. 2009). In order to receive a health professional’s full-recommended regimen, a patient might need to pay for ordered tests, referrals, and medications, which often require additional services. This difference in coverage might explain why “physicians caring for high proportions of Latin@ patients,” many of whom are Mexican-born women, “report more barriers to providing high-quality care and more challenges in obtaining timely specialty referrals for their patients” (Hargraves, Stoddard, and Trude 2001; Bustamante and Chen 2011). Primary barriers to receiving such care include financial constraints and fear of deportation when providing information to receive services. Thus, while these patients are able to receive basic primary care services, they are often unable to pay for referrals and examinations that are not included in the subsidized cost of a visit. Angelica reported this barrier to care, citing that the tests her physician ordered were too expensive, so she did not follow his orders. Other women, however, note that the subsidized prices at a CHC are affordable enough to ensure that they obtain their full regimen.

The PPACA recently increased funding for CHCs through an $11 billion Community Health Center Fund. The new money supports CHCs in increasing patient volume, and since the fund was established, the number of patients receiving care from CHCs has increased by almost 3 million people (The White House 2012). The Obama administration furthermore added $101
million to the Community Health Center fund in May of 2015 (U.S. Department of Health and Human Services 2015).\textsuperscript{16} Illinois alone received $134,798,795 for capital development, one of four uses for the newly allocated money (The White House 2012).\textsuperscript{17} Thus, while the PPACA might not directly improve insurance coverage for undocumented Mexican women, the PPACA does support the subsidized services that they are able to access.

While I focus on how the PPACA influences public insurance and CHCs, it also impacts private insurance, whether provided through an employer or paid for out-of-pocket. The PPACA prohibits insurers from denying coverage to individuals with pre-existing conditions or dropping policyholders when sick and established minimum standards for all policies. These provisions improve coverage for all American citizens, and some legal and undocumented residents with insurance coverage. None of the women interviewed, however, reported currently using private insurance. Thus like the PPACA in general, these provisions do not to improve access or quality of care for uninsured undocumented Mexican-born women and legal residents who have lived in the United States for fewer than five years.

Finally, Mexican women regardless of immigration status are able to obtain care through the Emergency Medical Treatment and Labor Act (EMTALA). Enacted in 1986 as part of the Consolidated Omnibus Reconciliation Act, EMTALA mandates that any hospital receiving federal funds is required to provide an “appropriate medical screening examination” and to “stabilize or appropriately transfer patients” (Regehr 2008, Fields et al. 2001). The cost of care is then covered through a combination of government, hospital, and patient funds. While this law

\textsuperscript{16} In addition to the PPACA, the American Recovery and Reinvestment Act, commonly known as the Stimulus or the Recovery Act, also significantly finances the construction, renovation, and maintenance of CHCs and their services through $2 billion provided in both 2009 and 2010. The Recovery Act invested across a variety of sectors, and thus did not invest as significantly as the PPACA in CHCs alone (White House Office of the Press Secretary 2009).

\textsuperscript{17} Other uses of these funds include creating new access points for care, increasing capacity of existing CHCs, and improving CHCs through addressing immediate facility needs (2012b).
provides undocumented people a source of care, without regular coverage, undocumented immigrants often forgo preventative, well-body measures and instead seek care to address medical concerns once acute (Ortega, Rodriguez, and Vargas Bustamante 2015).

While opportunities to receive care do lie in CHCs and emergency departments, insurance coverage is important for maintaining and improving health. Mexican-born women and all people with “limited access – or no access – to a usual source of care tend to delay seeking services and tend to be diagnosed with chronic conditions at a later disease stage or remain unaware of their disease” (Ortega, Rodriguez, and Vargas Bustamante 2015). When such patients finally do receive care, their conditions are more likely to require aggressive, invasive, and costly treatment, if they are able to be treated at all (Zuckerman, Waidmann, and Lawton 2011). These factors together can result in overall deteriorating health (Chen, Rizzo, and Rodriguez 2011).

Considering the low rates of coverage among Latinos and the benefits of health insurance, the PPACA has likely benefitted the health of US-born and legally authorized Latinos (Ortega, Rodriguez, and Vargas Bustamante 2015). However, like most publically funded programs, undocumented and recent legal immigrants are not eligible to take advantage of the health gains. While Illinois provides a number of state-run programs in order to compensate for a lack of coverage during pregnancy, the lack of overall coverage through state and federal programs leaves undocumented Mexican-born women vulnerable to preventable and treatable illnesses.

Health is affected by social determinants, and factors such as immigration status, socioeconomic level, and healthcare access, are further determined by existing policies. While the policies outlined here are chosen in part by their relevance in first-hand interviews with
Mexican-born women, there was also merit in the pieces that these women do not mention. It is likely that these programs, such as Temporary Aid for Needy Families, went unmentioned likely for two reasons. Firstly, because the women did not meet eligibility criteria (most often because of undocumented status), they might not think of such possible programs as active factors influencing their health. Secondly, many women conceived health according to a biomedical model and described their health as affected by behaviors such as eating healthily and exercising often, in addition to seeing a physician regularly. This reliance on the biomedical model of health does not recognize the impact of social determinants like income, a determinant shaped by public aid programs, on health.

Policy-makers similarly often do not consider the connections between disparate policy areas, social determinants, and health itself. More recently, however, legislators have begun to think about health in terms of a focus on the upstream determinants, such that there is “broad based appreciation of the imperative to prevent illness and injuries before they arise” (Somerville et al. 2012). These determinants and the policies that shape them have the power to together promote individual and community health. Yet, consideration of social determinants of health, especially as they affect undocumented Mexican-born women has yet to be satisfactorily considered in policies outside of those with a direct impact on health within a biomedical framework.
Conclusion: Towards Health in All Policies

The title of this thesis “El Significado de Salud” comes from the Spanish translation of the interview question, what does health mean to you? I asked all nine interviewees this question in an attempt to begin to understand their viewpoints: what do you believe is important to be healthy, and what do you believe you lack in order to maintain or improve your health? In response, each made reference to their current conception of health, one that relies heavily on biomedical conceptions of health. All noted the importance of eating well, living a lifestyle with low stress levels, and regularly visiting a physician. In other moments of their interviews, however, they made clear the impact of upstream determinants, such as their personal immigration or socioeconomic status, that do not fit into the biomedical model of health, as well as downstream determinants, such as healthcare access on their health.

Their vignettes and the literature together illustrate that health is not solely affected by injury and disease but is a complex state of being that is shaped by the conditions in which a person lives. Undocumented immigration status dictates eligibility for public aid programs, diminishes usage of health-protective programs, and instills chronic fear of deportation in the approximately 138,000 undocumented Mexican immigrants in Chicago (Tsao 2015). The experience of being a non-White immigrant with poor English-speaking ability results in discrimination both inside and outside of healthcare systems and discordant health beliefs between patient and provider reduces quality of care. Policies such as the Immigration and Naturalization Act are at the root of America’s current complex immigration system, one that imposes a limit on legal immigration at a level much lower than the number of Mexican immigrants seeking to migrate to the United States.
Socioeconomic status, through employment and income, similarly shapes the health of Mexican-born women. Employment in strenuous, labor-intensive positions lacking traditional benefits results in occupational hazards that adversely impact the health of Mexican-born women while the lack of extensive English-skills in part prohibits them from obtaining well-paying positions higher in the workplace hierarchy. Furthermore, these low-paying positions result in restricted incomes that stunt their ability to engage in healthy behaviors, such as cooking with nutritious foods or paying for private health insurance. Legislation such as the Personal Responsibility and Work Opportunity Reconciliation Act dictates that undocumented immigrants and legal permanent residents present in the United States for less than five years are ineligible for public aid programs, such as Temporary Aid for Needy Families, Medicaid, and subsidized healthcare exchanges. These programs might compensate for the otherwise often low earnings of many Mexican-born women.

Healthcare access, specifically when facilitated by insurance coverage, ideally enables Mexican-born women to obtain preventative services and further provides assistance when in need of acute care. Yet, Latin@s, including Mexican-born women in Chicago, experience significantly lower rates of coverage compared to other ethnic groups. Furthermore, undocumented immigrants are ineligible for the subsidized or free programs established by the Patient Protection and Affordable Care Act, which otherwise could reduce barriers to access through insurance coverage. In lieu of insurance coverage, many Mexican-born women obtain free care while pregnant, in emergency rooms, or through subsidized community health centers. Others additionally note forgoing care due to its cost, and none of the interviewed women without health insurance recounted obtaining preventative care.
While Mexican-born women in Chicago are often undocumented, earn low overall family income, and are uninsured, the nine interviewed women note developing survival strategies in order to personally maintain their own health in the face of such obstacles. Elvita meticulously budgets her family’s expenses in order to ensure they maintain a healthy diet within their finite income. Yoana refers her clients to her chiropractor in order to receive rebated services, and Claudia takes advantage of her frequent trips to Mexico to obtain care. While describing her perception of being an undocumented immigrant, Hortencia summarizes how the interviewed women actively overcome existing obstacles, saying “nunca nos detenia” (it never stops us).

The women’s vignettes illustrate how social factors, in reality, shape the health of Mexican-born women in Chicago and suggest ways in which those determinants are influenced by public policy. While politicians and practitioners often rely on health care in order to improve health, numerous researchers and the Mexican-born women interviewed illustrate that good health is affected by a wide variety of policymaking bodies typically considered distinct from healthcare.

The connections between policy and health imply that such sectors should consider the multifaceted impact of their programs and that improving and maintaining health requires a multi-sectoral approach at the federal, state, and local levels. This sentiment is embodied in the Health in All Policies (HiAP) movement, a framework that encourages policymakers to consider health, regardless of whether their area is conventionally a part of the healthcare sector.

According to the World Health Organization:

Health in All Policies is an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity. A HiAP approach is founded on health-related rights and obligations. It emphasizes the consequences of public policies on health determinants, and aims to
improve the accountability of policy-makers for health impacts at all levels of policy-making (2013).

HiAP recognizes that the health of communities and individuals is not only dependent on activity in the healthcare sector but also is shaped by other social and economic factors such as immigration and socioeconomic status. At the core, HiAP “examine[s] determinants of health, which can be influenced to improve health but are mainly controlled by policies of sectors other than health” (Sihto, Ollila, and Koivusalo 2006). Thus, it calls for participation of all sectors in order to maintain and improve health.

While the term “Health in All Policies” is relatively new, the approach has been present among public health communities and policy-making bodies since the late 20th century. For example, the first International Conference on Health Promotion in 1986 noted that assessment of the “health impact of a rapidly changing environment – particularly in areas of technology, work, energy production, and urbanization” is increasingly essential for the health of the public (World Health Organization 1986). Similarly, the Adelaide Recommendations drafted at the Second International Conference on Health Promotion by the World Health Organization in 1988 used a similar framework called “healthy public policies” and “intersectoral action for health” (Sihto, Ollila, and Koivusalo 2006). Since these international meetings, both global and national legislative bodies across sectors have gradually begun to use such methods in key decisions.

The Health Impact Assessment (HIA) is one tool increasingly utilized by policy-makers in areas typically considered unrelated to health to implement the analytical framework of HiAP (Kemm 2006). Like the more common Environmental Impact Assessment, the HIA provides a framework where a proposed policy is considered in terms of its potential health effects and rated using HIA’s outlined criteria (Collins and Koplan 2009). The HIA framework involves five stages: (1) screening to determine how HIA might be needed and the potential value of
performing an assessment, (2) scoping to identify which health impacts to evaluate and the analytical tools best for performing the evaluation, (3) assessment and recommendations to provide a profile of existing health conditions, an evaluation of the potential health impacts of the proposed policies, and strategies to manage adverse health impacts, (4) reporting to compile and communicate the findings and recommendations, and (5) monitoring to provide an opportunity for researchers to track the impact of the HIA on the decision-making processes, final decisions, and health determinants (World Health Organization 2016). Through this framework, HIA might consider, for example, how road design influences physical activity and obesity in addition to effects such as air pollution and injury prevention. By considering health, decision-makers are more likely to advise the addition of pedestrian and bicycle facilities to create a transportation plan to “contribute a built environment that promotes the public’s health” (Collins and Koplan 2009).

While utilizing a metric like the Health Impact Assessment improves and maintains health, it does not necessarily ameliorate existing health inequity. For example, poor communities of color have often been overlooked when considering sustainable development that does not encourage gentrification. While the Health Impact Assessment might illustrate how the construction of a new road would impede or enable resident walking and biking, it does not necessarily encourage a focus on communities typically forgotten. Considering inequity in determinants is an important piece of improving health for all, but a systematic review of health impact assessments found that most, but not all, HIA frameworks consider health disparities in their analyses (Mindell, Boltong, and Forde 2008). Explicitly recognizing such inequality is critical, as “tackling determinants of health does not automatically tackle determinants of health inequalities” (Sihto, Ollila, and Koivusalo 2006).
While Chicago does not explicitly use the HIA framework, it has recently adopted the HiAP approach. In 2011, Mayor Rahm Emmanuel and the Chicago Health Commissioner, Dr. Barbara Choucair, unveiled “Healthy Chicago,” the City’s public health improvement plan. The City also simultaneously launched the Chicago Interagency Council to enact the plan and “leverage all city agencies’ missions to improve public health, work collectively on policy change, allow for project-specific partnerships, and stress the public health impacts of each agency’s work” (Polsky et al. 2015). Together, these initiatives established Chicago’s interest in positively shaping health through a multi-sectoral approach, a trademark of the HiAP framework.

Chicago is currently in the second phase of the Healthy Chicago plan, called Healthy Chicago 2.0. Released on March 29th, 2016, Healthy Chicago 2.0 is a “four-year plan to improve health and well-being throughout Chicago communities” (Dirksen and Prachand 2016). Like the original plan, Healthy Chicago 2.0 uses the framework of social determinants in order to shape health. At the core of the plan is a chapter called “addressing the root causes of health” that focuses on built environment, economic development, housing, and educational improvement in Chicago. It also addresses downstream determinants through another chapter dedicated to “increasing access to health care and human services” (Dirksen and Prachand 2016).

In addition to harnessing the power of social factors, Healthy Chicago 2.0 emphasizes health inequity. Its vision includes an “underlying goal of achieving health equity and a commitment to reducing health inequities” in Chicago (Dirksen and Prachand 2016). The plan additionally notes that the City administration welcomes community participation in actions related to the plan. In order to encourage community involvement, the City administration is planning events and public meetings for stakeholders to offer comments and help the City “continually gather feedback” (Healthy Chicago 2.0). By including forums open to Chicago’s
diverse residents, Healthy Chicago 2.0 works to ensure that all voices are heard. In combination with the social determinants of health framework at the core of the plan, Healthy Chicago 2.0 has potential to significantly improve the health of all Chicagoans, including Mexican-born women.

For Mexican-born women, attention to inequity is especially important. For example, Chicago neighborhoods inhabited by Hispanic-majorities are not maintained and improved at the same rate as more affluent and predominantly White neighborhoods (Jargowsky 1997). Healthy Chicago 2.0 explicitly notes a focus on improving such inequities but does not address determinants specific to many Mexican-born women. For example, the plan does not include any proposals to take immigration or immigration status into consideration, a key determinant for the many undocumented Mexican-born women in Chicago. In addition, while the plan utilizes an ethnicity-based dataset, it does not provide any information on the many sub-ethnicities that comprise Hispanic. Still, in addressing a variety of other determinants, the plan will likely help improve the health of Mexican-born women in Chicago in addition to targeting health disparity among other ethnic groups.

A HiAP approach is also useful at the federal level, especially as the United States is at a critical moment in enacting immigration policies that are particularly applicable to the health of Mexican-born women in the United States. President Obama’s recent immigration reform proposal from 2013 includes a number of provisions that could improve the health of Mexican-born women if enacted. For one, the proposal includes a pathway to citizenship, where undocumented immigrants would be able to obtain citizenship after paying a fine and passing qualifications like background and tax checks. If this “earned” citizenship comes with the same benefits granted any American citizen, many currently undocumented Mexican-born women
would be newly eligible for federal aid programs. Furthermore, the same group would no longer experience chronic fear of deportation.

While the novel proposal might positively affect current undocumented immigrants, it also would likely negatively affect future waves of undocumented Mexican-born women entering the United States through its provision to “crack down on illegal immigration”. This piece of the legislation effectively increases militarization of the US-Mexico border. Higher levels of border control would not decrease the social and economic motivation for Mexican-born women migrating to the United States. Instead, greater difficulty crossing would directly diminish the health of undocumented migrants who cross in the face of greater physical harm. Thus, such legislation should not just be considered in terms of its economic and migratory impacts but also its health effects on often forgotten groups, like undocumented Mexican-born women.

Whether considering policies related to immigration, socioeconomic status, or healthcare access, HiAP provides a useful structure to understand health impacts of a wide variety of policies. HiAP is rooted in the premise that “good health is fundamental for a strong economy and vibrant society” (Rudolph et al. 2013). It recognizes that such health outcomes are dependent on the social determinants of health, and that these factors are, in turn, shaped by decisions made both inside and outside of health sector (Rudolph et al. 2013). Through this approach, HiAP inherently expands El Significado de Salud to embody social determinants including and in addition to those described by the biomedical model of health. As major cities like Chicago begin and continue to implement HiAP alongside a perspective that captures the narratives of Mexican-born women, they not only redefine salud, they also improve health for Mexican-born women and for all.
Appendix A: Chicago Neighborhoods

Navy box indicates neighborhoods of Portage Park and Belmont-Cragin. The Refugee and Community Services division of Heartland Alliance is located on Belmont Avenue, the border between the two neighborhoods. All interviewees resided in one of the neighborhoods (Fitzgerald 2012)
Appendix B: Participant Consent Form

SOCIAL DETERMINANTS OF HEALTH AND MEXICAN AMERICAN WOMEN
Study Consent Form

You are being asked to take part in a research study of how social factors influence the health of Mexican women. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What the study is about: The purpose of this study is to learn how Mexican women in the United States are affected by social determinants of health. You must be a woman who has moved from Mexico to the Chicago area and willing to speak about your experiences with health.

What we will ask you to do: If you agree to be in this study, I will conduct an interview with you. The interview will include questions about your health status and life experiences. The interview will take about 1 hour to complete. With your permission, the interview will be recorded.

Risks and benefits:
There are no atypical risks associated with participation in this study.
There is the benefit of participating in a guided exploration of your health and life history.

Compensation: You will earn a small gift for your participation in this interview.
Your answers will be confidential. The records of this interview will be kept private. In the final report, I will not include any information that will make it possible to identify you. Recorded interviews will be destroyed after each interview has been transcribed, which I anticipate will be within two months of taping.

Taking part is voluntary: Taking part in this interview is completely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, it will not affect your current or future relationship with Heartland Alliance, Refugee and Community Services. If you decide to take part, you are free to withdraw at any time.

If you have questions: The researcher conducting this study is Nikita Saladi. Please ask any questions you have now. If you have questions later, you may contact Nikita at nsaladi@wellesley.edu or (630) 802-1945. If you have any questions or concerns regarding your rights as a subject in this study, you may contact Joan Butler, IRB Administrator of Wellesley College Institutional Review Board (IRB) at (781) 283-2498.

You will be given a copy of this form to keep for your records.

Statement of Consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in the study and my interview being recorded.

Your Signature ____________________________ Date ____________________________
Your Name (printed) __________________________________________________________

Signature of person obtaining consent __________________________ Date __________
Printed name of person obtaining consent __________________________ Date __________
This consent form will be kept by the researcher for at least three years beyond the end of the study.
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