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Pregnant Central American migrant women seeking access to health care in Nuevo Leon and Florida

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Introduction

Migration processes have become one of the main challenges for States worldwide, due to the complexity they represent in various social, political and economic aspects. Organizations and agents working on these specific issues have recognized that it has become a complex issue, since it is not possible to generate a general analysis or produce a homogeneous response. The increase of people within these flows, who go in search of better development opportunities or protection, and the problems that arise as a result of these flows pose a significant challenge for the receiving States. (CNDH, 2021)

The International Organization of Migrants (in CNDH, 2021) defines mixed migration flows as complex population movements that combine forced and economic migration. These flows include people who leave their countries of origin in search for better job opportunities and better health and education services, it also includes people seeking refuge and asylum, fleeing their country of origin due to displacement and violence. In addition, the journey migrants make makes them prone to dangers that can harm their safety and health, both physical and mental.

According to the latest activity report of the National Human Rights Commission, the largest number of people in the context of migration who leave or transit through Mexico have the United States as their destination country. Mexico figures as an important part of the migratory corridor, being this part the most transited by migrants, due to its proximity to the destination country (CNDH, 2021). Central America migration to Mexico began to gain strength in 1980, this being the year in which most displaced persons and applicants for humanitarian protection were received, however, it was not until 1990 that Mexico began to present itself as a transit territory for regular and irregular migrants, mainly coming from Guatemala, Honduras and El Salvador. (Secretaría de Gobernación, 2019)

Currently, 9 out of 10 migrants transit through Mexico in an irregular manner, that or, without documentation, which makes them prone to risk, increases their vulnerability and hinders the exercise of their rights (Secretaría de Gobernación, 2019). Since 2014, there has been an increase in women and minors transiting through Mexico as irregular migrants (Secretaría de Gobernación, 2019). Likewise, it is important to highlight that the US has historically positioned itself as a receiving country for migrants, remaining as the main destination at worldwide level. According to data from the UN Department of Economic and Social Affairs, in 2020 more than 50 million international migrants resided within the region. (Migration Data Portal, 2021)

This phenomenon has opened discussions on the capacity of both States to meet the health need of these population groups. One aspect that should be taken into consideration is that more and more women are leaving their countries of origin in search of security or better social opportunities, and that

more and more migrants are deciding to settle in regions inside one of these states that are not necessarily part of the northern Mexican border.

Migratory flows are diverse and changing, as well as the people who make them up. It is wrong to try to generalize the reasons that lead a person to leave their country in search of better access to health and services that allow them to maintain their physical integrity. It is also wrong to think that the experiences of these people who make up these flows are lived in the same way. The following work seeks to understand how social, cultural, economic and political factors affect migrants' access to health services and to exercise their human right to health, specifically those Central American women who are in one of the stages of pregnancy.

The aim is to learn about the experiences and identify the limitations that Central American migrant women in the period of gestation have experienced when accessing health services. Through the search of information in the different platforms and databases that provide information relevant to the topic of migration, it has been possible to highlight that there is little to no information that focuses specifically on the means of access to health services that Central American migrant women use when they are in any of the stages of pregnancy, so I seek to describe the process and the possible limitations that these women go through when trying to access health services.

General Description of the Problem

Those authors who talk about the relationship and importance of health and migration issues, such as Sánchez Torres (2017), agree on two specific definitions. The first being the definition of health, where they agree that the definition that best interprets the complexity of the concept is that of the World Health Organization; "health is a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity." According to Sánchez Torres (2017), this makes the concept of health not one that is withdrawn or apart from man, but the opposite, health depends on a multiplicity of factors, as are the biological factors of the body, environmental factors, the social relationships we have, and the political and economic factors that modify our environment. (Briceño León, 1999 in Sáncez Torres, 2017)

The second definition, or rather proclamation, in which authors, such as Sotesslé and González Salazar (2018), agree, is the one that stipulates that the right to health is one that is recognized as a Universal Human Right (mainly because it is recognized within Article 25 of the Universal Declaration of Human Rights), which states that "everyone has the right to health protection. If people make use of health services they have the right to obtain timely, professional, appropriate and responsible care."

This leads us to understand that health is a multifactorial issue, where social issues: such as culture, traditions, and language, economic issues: such as income per person or family, and political issues: such as health system infrastructure, laws, policies and programs focused on health, bureaucracy, and many other socioeconomic and political factors determine the health status of a person and the degree of accessibility he/she has to health services and programs provided by the State.

According to the WHO (Sánchez Torres, 2017), the right to health encompasses four elements, through which it is guaranteed that public policy is comprehensive and generates a real impact when serving the population: Health services must have availability. This means that there must be a sufficient number of public health facilities, goods and services. They must be accessible: health facilities, goods and services must avoid being discriminatory, they must facilitate physical access conditions, they must be economically accessible, and the necessary information must be provided so that the user understands and can obtain effective care (Sánchez Torres, 2017).

They must have acceptability: all health facilities, goods or services must be respectful of medical ethics and must be culturally appropriate. They must also be sensitive to gender and life-cycle requirements. They must be of quality: that is, health services, goods and facilities must provide care that is appropriate and in a condition adequate to the need of the population. The user must be satisfied with the care received.(Sánchez Torres, 2017).

In Mexico, the right to health is stipulated in Article 4 of the Constitution, which states that "every person has the right to health protection", it also establishes that "The Law will define the bases and modalities for access to health services and will establish the concurrence of the Federation and the federative entities in matters of general health". In view of this, it is relevant to mention that Mexico's Migration Law, in its articles 6 and 8, establishes that "the Mexican State shall guarantee to all foreigners the exercise of the rights and freedoms recognized in the Constitution (...)" and in the treaties and conventions.)" and in the international treaties and conventions to which the Mexican State is a signatory; and that "migrants shall have the right to receive any type of medical attention (...)" and "shall have the right to receive, free of charge and without restriction, any type of urgent medical attention necessary to preserve their lives", regardless of their immigration status.

In contrast, in the United States, the Constitution does not explicitly provide for the right to health or medical care, i.e., the words "right to health" are not mentioned in any article or amendment (Swendiman, 2010). However, although the right is not explicitly stipulated, it is implicitly mentioned that citizens can access health services through their own means (Swendiman, 2010). The U.S. Congress has enabled different tools to have some type of public medical service, such as the Medicare, Medicaid

and Children's Health Insurance Program (CHIP), which establish and define specific legal rights so that certain individuals can receive government health care services (Swendiman, 2010).

Regarding the right to health or medical services for migrants, those under Qualified Non-Citizen status tend to be eligible to seek medical coverage through the Medicaid and CHIP programs. However, this coverage is only obtained if they meet the requirements of: being Legal Permanent Residents or Green Card holders, residing in the country as Asylees or Refugees, being participants of Cuban or Haitian origin, being on parole in the U.S. for at least one year, being a non-citizen showing signs of abuse, being a victim of human trafficking or having a family member with a visa application in process, among others. (U.S. Centers for Medicare & Medicaid Services, 2022).

Even if the migrant falls into one of these categories, applicability is subject to a 5-year waiting list, i.e., one must wait 5 years after receiving "qualified migrant" status before receiving any type of coverage; only those who are listed as asylees or refugees can receive coverage without waiting (U.S. Centers for Medicare & Medicaid Services, 2022).

From the above, we can interpret that the Mexican State is responsible for providing free medical care to all migrants through public or private health institutions, according to the provisions of its laws and regulations, in order to preserve their lives, regardless of their immigration status. On the other hand, the American State is not responsible for providing medical attention or public health services, however, different governmental entities facilitate legislation and social programs that can provide some type of medical attention service, even if it is not completely free of charge.

From this, it is necessary to mention an important fact, in both cases there is an obstacle to access to health services. In the Mexican case, the fact that access and entitlement are stipulated in the right does not mean that one has the capabilities or conditions to exercise this right (Stoesslé and González Salazar, 2019). In the U.S. case, the composition of the Constitution is focused on guaranteeing the citizen's freedom from their government, leaving aside the need to guarantee other rights, such as health and access to medical services(Swendiman, 2010). Both cases imply limitations to access to health.

The migration process can be difficult for many people, due to the exposure to different factors that affect the safety, integrity and health of people moving from one place to another. As of today, almost 272 million international migrants in displacement face conditions that affect their physical, mental and social well-being, so moving and relocating outside their country of origin can be a heavy burden for these people. (DESA, 2019 IN IOM, 2022). Still, relocation to an unfamiliar country is not their only problem; access to medical and health care services represents one of the many obstacles they

face. Some factors that affect their accessibility to health services are: their migratory status, language barriers, lack of health policies focused on migrants, etc. (Stoesslé and González Salazar, 2019).

With all this we can understand that health is not only the absence of disease, but the integral well being of the person, that the States (or at least the Mexican State) recognize that it has the obligation to provide medical care to all people in its territory, including the population that moves through it, and that health services must be of quality, that is, optimal and accessible, however, not all people who have ownership of the right to health can fully exercise it.

The migratory phenomenon is not one that can be generalized, since, just as it is recognized that cultural, linguistic, social, economic and political factors affect the degree of accessibility to health services, issues such as age and gender are also factors that affect the degree of medical care that people receive. Migrant groups are not composed of a single type of person; they are made up of multi-diverse individuals. This leads us to think that the characteristics that these people possess are also determinants for access to health services.

When studying migration issues, it is essential to remember that gender is a factor that must always be taken into account when discussing the subject. Many authors, such as Vázquez Quesada (2021), Mata Navarro (2020) and González Arellano (2017) have defended the idea that the experiences and the sociocultural and political context of the migrant affect the way in which he/she copes with the adversities of the mobility process, the way in which he/she adapts to his/her new environment, and the extent to which he/she obtains social assistance from the state. These factors should also be taken into account when evaluating the experiences of men and women who begin the migration process.

The way men and women grow up, the way they are educated, live and develop within society will greatly affect the way they experience migration and how they settle in a place. The way in which men and women are perceived also greatly affects their development, even the roles they play within a new social context will affect their role within the political sphere.(Gonzalez Arellano, 2017)

Women who decide to migrate usually do so due to economic issues, such as the precariousness of working conditions within their country and the lack of infrastructure in the services offered by their country of origin (Moreira Almeida, Casanova, Caldad, Ayres de Campo, and Dias, 2013). According to a study conducted through interviews with Brazilian, African and Eastern European migrant women who were pregnant or had children during their regularization process, recounting their experience with public health services in Portugal, it was identified that women who decide to start this mobility process usually do so before or during the age when it is more common to become pregnant or give birth. Once migrant women face new contexts, they are usually overexposed to biological, environmental and

psychological risks that can affect and even accentuate situations of social vulnerability (Moreira Almeida, Casanova, Caldad, Ayres de Campo, & Dias, 2013).

Even factors such as economic impediments or limitations can increase the state of vulnerability, affecting their access to health care. It is important to note that accessibility is not only determined by personal factors such as income or cultural barriers, but by difficulties with work schedules, medical center opening hours, mobility (in terms of proximity to medical centers), language, the woman's legal status, and the attitude of the medical staff of the centers, have been identified by women in other studies as factors that affect the degree to which they access health services. (Moreira Almeida, Casanova, Caldad, Ayres de Campo, and Dias, 2013).

Particular Description of the Problem

Mexico

The Mexican case is not very different from the Portuguese case, migrant women crossing from the southern border to the northern border face considerable threats due to the precarious medical care they receive. Those who seek assistance "on the other side" and try to cross due to medical circumstances such as labor, are at the mercy of the customs agents on duty, putting them in a vulnerable state. Pregnant migrant women have testified to feeling rejected at public health centers by Mexican immigration authorities for reasons of nationality, which has led them to seek private medical attention.

According to IOM data, in 2019 Mexico ranked second among countries with the most emigrants, that is, people who leave the country and go abroad. However, the immigration policies of the United States have generated that several migrants, both nationals and foreigners, return to Mexico in order to wait and solve different legal processes. In Mexico, according to figures from the Ministry of the Interior, the numbers related to irregular transit migration increased from 2010 to 2017. In 2010, there were around 112,571 irregular migrants from Central America, where 99,649 were men and 28,719 were women. For 2017, a total of 270,419 Central American irregular migrants were registered, where 206,231 were men and 90,597 were women. From this it can be observed that, although the male predominance in migration remains constant, there has been an increase in the female population that transits irregularly through the country.

Migrants who transit through Mexico or are returned to Mexico to await the resolution of some legal process in the United States tend to settle in the northern region of the country. Nuevo Leon, even though it is not a border state, is one of the states that hosts the most migrants. The main reason that

this state has become a shelter and even an attractive destination for migrants is the economic dynamism, salaries and benefits that the state's labor environment offers workers (Casanicolás, 2021).

Casa Monarca, one of the main shelters in the Monterrey Metropolitan Area, housed a total of 7,437 migrants in 2020, 4,874 men and 2,563 women, both groups mostly minors, with 15% of them being children and adolescents. The people who tend to be housed in this house, and in other shelters run by civil society, tend to be people who come mainly from Honduras, El Salvador, Guatemala and Venezuela, who are migrants, returnees, displaced persons, refugees or asylum seekers (Casa Monarca, 2020). (Casa Monarca, 2020).

One of the main problems faced by the migrant population is access to health services. We cannot ignore the fact that health systems in Mexico have several limitations, which were intensified following the arrival of the SARS-Cov2 virus. In fact, in the face of this phenomenon, the migrant population was one of the most affected, since they had little or no access to the vaccine against the virus at the beginning of the pandemic (Casanicolás, 2021).

The Population Council and the Colegio de la Frontera Norte conducted a survey called Estudio: Necesidades y Atención en Salud Sexual y Reproductiva de Mujeres Migrantes en México (2021), which seeks to provide a descriptive overview of governmental actions, organizations and international agencies that provide health services, and aims to collect the experiences of migrant women transiting through Mexico in the use of these entities. The study was conducted with cisgender adult women of reproductive age (18 to 49 years old), Spanish-speaking, non-Mexican nationality, who had arrived in Ciudad Juarez from the southern border and who had arrived from the United States after being returned to Mexico by U.S. immigration authorities to continue their asylum process.

The study takes into account aspects such as Sexual and Reproductive Health care and preparation before starting the journey, during the journey, pregnancy care during the journey through Mexico and pregnancy care in Ciudad Juarez. In terms of Sexual and Reproductive Health Care and Problems during the migratory journey, in the aspect of Menstrual Life, 62.2% of the respondents mentioned that the recurring problem was constant pain and not having access to medication to counteract the pain; only 20.8% had regular access to pain medication during their menstrual cycle.

They were also asked about their genital health. This section is important because it distinguishes between those who identified one or more genital problems and who sought and received care, those who did not receive care, and those who decided not to seek care. Among the 22.1% of women who identified suffering from these problems and who sought care, it is noteworthy that they found and received care in the place where they sought it, whether in public hospitals, in the shelters

where they were staying or in pharmacies. Those who sought and did not receive care were due to insufficient medical personnel available. It is important to mention that when they did not receive medical attention, women decided to resort to self-medication, natural or religious healing, or waited for it to resolve itself. Those who chose not to seek care highlighted the facts that they did not have information about where to seek care or that there was pressure from the shelters or the people they hired to transport them to not let the women leave the place where they were.

The women were asked if they had had sexual intercourse during their journey, where it was identified that several had felt abdominal pain and were afraid or worried that they had been infected with a Sexually Transmitted Infection (STI) or had become pregnant. Those women who had had sexual relations and who presented problems afterwards reported having sought medical attention in public centers, pharmacies and within the shelter where they were staying. It is worth mentioning that from this question several problems were identified that go hand in hand when talking about the issue of accessibility.

Several women identified that when they sought medical care, they were also offered psychological care, were explained topics related to the use of contraceptives and the possible risks of contracting an STI. They were also allowed to ask questions and mentioned that the treatment they received was always respectful. However, some women mentioned being ignored by the medical staff when they tried to ask a question or when they expressed concern. They also mentioned being referred to inappropriately because of their country of origin or sexual orientation, as well as having to pay for the care they received. A common problem identified in these two sections was that many women did not seek care because they did not know where to go. Other problems identified in this section were that many did not have the resources to pay for the consultation, medication and transportation to the facility and that they were afraid of being identified as migrants.

The study also distinguishes Pregnancy Care during the Mexico Journey. Among the population surveyed, 15 women were identified as having been pregnant during their journey through the country, as well as women who were already pregnant before starting the journey and those who became pregnant during the journey. Some of these women mentioned that they did not want to become pregnant, others mentioned that they did not seek medical attention due to lack of money. Those who did seek care resorted to private services or public health centers.

The study showed that several women gave birth during the journey, most of the women were attended in public health centers, few were attended in a private clinic, we can assume that monetary resources were the main reason why few women had access to private care. In terms of what they experienced during care, women who did not pay for care had to deal with long waiting times.

It should be noted that some of the women who gave birth during the journey received comments that they found offensive or humiliating, these comments being related to their skin color or appearance. Half of the women reported having a space to ask questions about the care and procedure, while the other half were ignored when trying to ask questions and even identified being scolded. Lack of money or resources to pay for medical services, medications and transportation stood out as the main problem in the study, however, this was not only present before seeking medical care, women who were pregnant expressed concern about not having money or not having something to eat or drink.

United States

More than 50 million international migrants were found within the region, of which 48.2% were men and 51.8% were women. It has been identified that, in 2020, 18% of the migrant population arriving in the country was between 15 and 29 years of age and 29% was between 30 and 44 years of age (IOM, 2022). More and more young people are deciding to migrate in order to seek better development opportunities, as the country has become an important region for receiving asylum and refugee seekers and irregular migrants, specifically from Central America (IOM, 202).

Central American migrants who decide to make the journey to the United States usually do so as a result of different economic, political and social factors, with the objective of seeking refuge, stability and new opportunities for development and security. The Central American population residing in the United States has been growing significantly. In 2019 the 3.8 million Central American migrants accounted for 8% of the 44.9 million foreign-born people (Babich and Batalova, 2021).

The majority of Central American migrants resided in states near the coasts or in states near the southern border, with more than half figuring in California, Texas, Florida, and New York, specifically in Los Angeles (California), Harris and Dallas (Texas), Miami-Dade (Florida), and Prince George's counties in Maryland. It was also identified that the highest concentrations tend to occur in metropolitan areas, such as Los Angeles, Washington or Miami (Babich and Batalova, 2021). This information is significant because, as in the Mexican case, it identifies that the migrant population tends to choose to live in states with metropolitan areas and that generate higher incomes.

Florida has been one of the main migrant-receiving states; one in five Florida residents is an immigrant. In 2018, 2.2 million women, 2 million men, and 247, 316 infants were identified as immigrants, with a significant portion of the population coming from a Central American or Caribbean country (American Immigration Council, 2020). About 57% of the immigrant population had naturalized as U.S. citizens, however, more than 425,000 U.S. citizens living in Florida were identified

as living with an undocumented family member; in 2016, about 4% of Florida's population was living in undocumented status. (American Immigration Council, 2020).

Although Florida has been recognized by the migrant population as one of the states to seek new development opportunities and feel welcome, rapid population growth and various political controversies threaten the stay of the migrant population within the state (Craig and Paul, 2022). About 50 migrants arrived in September 2022 in Martha's Vineyard, Massachusetts on airplanes sent by the governor of Florida through a program to transport immigrants seeking asylum, as well as truckloads of immigrants to Washington and New York. Such action has been seen by different media outlets as a form of protest towards the growth of the influx of irregular immigrants under President Biden's administration (Mazzei, Tumin and Fawcett, 2022).

Now, within the period from 2019 to 2020, after making known the measures against migration that would be taken within the administration of former President Donald Trump, people who did not have legal immigration status abandoned social protection programs, in order to avoid using public policies that would threaten their stay within the country. The U.S. government indicated that it was going to stop the legalization of immigrants who lived inside the country with legal permission and had used some kind of public benefit (Dickerson, 2020).

The term is known as Public Charge, which is an immigration rule that applies to certain people who apply for lawful permanent residence or some other visa to enter the United States; people who are overly dependent on public benefits are referred to as Public Charge (Keep Your Benefits, 2022). This rule implies that, the authorities responsible for the applications perform an evaluation of health, age, income, family support, education, and as a result of the results declare whether or not the applicant is a Public Charge, affecting the viability of obtaining residency. (Keep Your Benefits, 2022).

One of Trump's anti-immigration measures was the expansion of Public Charge, which, as mentioned before, allowed to stop the legalization of immigrants (Dickerson, 2020). However, the use of Medicaid, Medicare, and CHIP programs do not affect on being categorized as Public Charge (Keep Your Benefits, 2022), and although most migrants living without legal permission are not eligible for most social programs and this population has been shown to make the least use of such programs, the potential threat of deportation. (Dickerson, 2020)

The expansion policy had exceptions for certain vulnerable groups, including pregnant women. However, according to doctors and public officials in the health sector, those women living in the country without legal permission were convinced that using the programs would reduce their chances of legalization and put them in the crosshairs of immigration authorities (Dickerson, 2020). According

to midwife testimonies, there was a significant increase in requests for home births in order to avoid hospital visits, emergency room physicians cited an increase in the number of women coming into the room for labor complications and a decrease in prenatal care appointments. (Dickerson, 2020).

Justification

The current migration phenomenon should be understood as the movement of people from one region to another in search of labor and social security. Although not all reasons are motivated by a problem, the vast majority of migrants are motivated to move by the precarious conditions in their place of origin. According to the International Organization for Migration, in 2019 there were an estimated 272 million international migrants in the world, equivalent to 3.5% of the world's population.(IOM, 2020).

The United States is known as one of the main destination countries for migration flows. According to data from U.S. Customs and Border Protection (CBP), 54,771 people were apprehended between U.S. southern border ports of entry in fiscal year 2020 during the month of September. The figures also reveal that they had encounters at the border with 30,557 minors traveling unaccompanied, 52,230 family units, which are identified as minors under the age of 18 traveling with a parent or guardian, and 317,864 adults. Of the family units, 4,335 were identified as coming from El Salvador, 10,905 were from Guatemala, and 10,485 were from Honduras. (CBP, 2020) The process of mobility of migrants puts them in a situation of vulnerability, as it makes them prone to contracting diseases and enhancing diseases already contracted or developed from their countries of origin, and leads them to face dangers that can put them at risk of mortality.(Stoesslé, 2019)

The study by Stoesslé and González Salazar (2019) has pointed out that some of the limitations faced by migrants when trying to access health services are distances, cultural barriers, long waiting times, lack of information or misinformation, either because they themselves do not know where to get the information or because they are denied access to information (Vazquez Quezada, 2021), lack of follow-up medical appointments, lack of access to medicines, among others.

Different articles and research, such as that of Mata Navarro (2020), have mentioned the increase in the number of women who are part of these migratory flows. More and more women are struggling to obtain better opportunities, more and more women are undertaking the journey, alone or with their children, to a different country in search of social and economic stability, there are even women fleeing from domestic or systematic violence in their countries of origin. (Mata Navarro, 2020).

People who migrate are prone to enter a state of vulnerability (Stoesslé and Gonzáles Salazar, 2019), therefore, women who migrate are prone to fall into a state of vulnerability, we can even consider them as more likely to fall into this state taking into account the dangers they live or could live due to the gender under which they identify themselves. These same authors and several international agents have identified the dangerous conditions that women face once they undertake the journey from one country to another, or the difficulties faced by women who are mothers and leave their children in their country of origin, or the difficulties migrant women experience when traveling with their children, there are even studies about the access limitations faced by migrant women when trying to access health services focused on sexual and reproductive rights.

Through the search for information in the different platforms and databases that provide information relevant to the topic of migration, it has been possible to highlight that there is little or no information that focuses specifically on the means of access to health services used by Central American migrant women when they are in any of the stages of pregnancy.

Since there are few studies focused on the experiences of migrant women in the gestation period when trying to access health services in Nuevo León and Florida, it is necessary to mention the importance of a study focused on this subject. While it is well known that women face multiple difficulties when trying to assert their health rights, it could be stipulated that the difficulties experienced by these women during the pregnancy period are little known. The issues of migrant women and pregnancy are of utmost importance, since pregnancy could be a cause of vulnerability, added to other factors such as being prone to violence and sexually transmitted diseases.

The topic that we seek to develop through this research is of utmost importance, since it will allow us to have a more complete picture of the conditions under which migrant women who have transited through Mexico and have chosen to seek shelter in Nuevo León, or have continued their journey and have settled in Florida, find themselves. Specifically those who during their journey have been or are in one of the stages of pregnancy.

This will allow us to know the limitations that they identify as the most difficult to overcome, it will allow us to know if there are health services that allow them to obtain some type of medical attention, if the health services are truly prepared to respond to the demand of this population group, and it will even allow us to know the access limitations that they face after having (or not having) received some type of medical attention or service.

Research Question

How do pregnant Central American migrant women access health services in Nuevo Leon and Florida?

Specific Questions

- What are the means by which migrant women who are or have been pregnant access health services in Nuevo Leon and Florida?
- What are the mechanisms that allow Central American migrant women who are or have been pregnant to access health services in Nuevo Leon and Florida?
- What are the constraints that prevent Central American migrant women who are or have been pregnant from accessing health services in Nuevo Leon and Florida?
- What problems do Central American migrant women who are or have been pregnant face after receiving health care in Nuevo Leon and Florida?

General Objective

To learn how pregnant Central American migrant women access health services in Nuevo Leon and Florida.

Specific objectives

- Identify the means by which migrant women who are or have been pregnant access health services in Nuevo Leon and Florida.
- Distinguish the mechanisms that allow Central American migrant women who are or have been pregnant to access health services in Nuevo Leon and Florida.
- Analyze the constraints that prevent Central American migrant women who are or have been pregnant from accessing health services in Nuevo Leon and Florida.
- Analyze and explain the problems faced by Central American migrant women who are or have been pregnant after receiving health care in Nuevo Leon and Florida.

Theoretical Framework

The following section is intended to compile theories relevant to the topic that will allow us to interpret the experiences of Central American migrant women regarding the medical care they have received during pregnancy, and that will allow us to understand the way in which they have accessed health services before, during and after pregnancy. One of the relevant factors to understand within this topic is the relationship that culture, tradition and values have on the person, since they shape the perception and understanding that the person has about herself and about that which is part of her person, such as the topic of health.

Anthropology has developed four major fields of study, all aimed at understanding the elements that compose and develop identity. Among them, a sub-branch called medical anthropology stands out. This branch "is the subdiscipline that understands health in the field of culture and understands the trinomial of health-disease-care as universal, in the face of which, each human community has had to develop a specific response" (Díaz Bernal, Aguilar Guerra and Linares Martín, 2015), that is, it studies the need that has arisen in different societies to understand health from the cultural sphere, as well as to understand these three factors in order to provide an answer to a problem. This sub area studies the biological, psychological, cultural and social dimensions, which determine the way in which people understand and live health, as well as seeking to understand the various systems, beliefs and practices that derive from these dimensions and their role within society. (Díaz Bernal, Aguilar Guerra and Linares Martín, 2015).

Medical anthropology takes into consideration the cultural relationship of all the aspects that make up the human body (such as the physical, emotions, mind, etc.) and the different cultural conceptions of the universality of the health-disease-care process. Likewise, he was transforming his study of "shared conceptions" into applicable practices within the public health system. Its approaches were complemented by the dimension of applicability in response to sociocultural problems, specifically developing after World War II, creating development programs in public health. (Díaz Bernal, Aguilar Guerra and Linares Martín, 2015).

It is important to note that medical anthropology is not a mere theory, but an area of anthropology that was born from the attempt of different authors and scholars to explain, from different perspectives, the relationship that exists between the person (his body) and the sociocultural and political elements, which directly or indirectly affect the process under which this is subjected in order to obtain health or eradicate disease. Critical medical anthropology considers issues such as the health and medical systems of ethnic minorities and their relationship with official health systems, focusing on a human rights perspective and democratic participation. This branch allows us to combine aspects of medical anthropology such as the problems of public health, traditional medicines, and interculturality, questioning elements such as the political and ethical aspects of medical systems and practices (Junge, 2001).

It is important to emphasize that critical medical anthropology is centered on the importance of community participation, with the purpose of defining their needs (in terms of health) at the individual and community levels, as well as alternatives that may be useful in specific cases, and more importantly, that these are within their reach (Junge, 2001). This branch emphasizes the democratization of health, especially in view of the need to overcome established power relations and traditional (alternative) systems and practices.

For critical medical anthropology, the participation of patients, as citizens and as subjects of health, in defining their health needs is very important, since it opens up and pluralizes medical systems, so that services can promptly meet the needs of those who require them. It should be noted that openness and diversification within health systems not only means an opportunity to make health intercultural, but also gives importance to the right of citizens and subjects to health in general. (Junge, 2001)

It is important to recognize that when studying the experiences of migrant women when accessing health services in a country that is foreign to them, the cultural factors learned and ingrained in their way of life, although important and often could be the determinants of whether or not the woman decides to receive medical care, are not the only ones that take relevance in this issue, the social dynamics they face in a country different from their country of origin is important to evaluate when analyzing this issue. It is necessary to understand the weight that factors such as social class, lifestyle, the relationship that the person has with the health system, the person's behavior, among others, affect not only the person's health, but also the way in which he or she seeks and receives care in relation to his or her social circumstances.

Obtaining health care and services is not only dependent on the sociocultural relations that the person has with the health systems, whether public or private, but also depends on the person's perception of him/herself and the elements that make up the person him/herself. Understanding motherhood as a social practice allows us to understand the subjectivity of the subject of femininity and the role of women within society (Sánchez Benítez, 2016). Motherhood continues to be a subject conditioned by the patriarchal system "that divides productive-reproductive work, by sexuality and reproduction policies that conceive motherhood as a natural and biological matter" (Sánchez Benítez, 2016), but that also poses this stage as something that women should desire, that even can and should become something utopian to live.

Haraway (1995 in Sánchez Benítez, 2016) tells us that experience is an important element within the women's movement, since it is from this that feminist discourses and theories that explain the image of women as a subject constructed from a patriarchal perspective are built. Now, feminism as a movement, theory and even paradigm of knowledge (Pujal, 2002 in Sánchez Benítez, 2016) has theorized motherhood from different perspectives.

For example, for Simone de Beauvoir motherhood is natural because patriarchal culture has instilled in us that it is something natural, since patriarchy has established motherhood in women as one of the pillars of their subjectivity, a place of subordination and exclusion from the category "social subject", that is, we have learned that motherhood is a feeling, duty or "a calling" natural for women,

since, from the patriarchal system, women have been taught that this must be so, however, this idealization has been implemented to normalize women out of social participation. (Sánchez Benítez, 2016)

It is important to mention that not all branches of feminism perceive motherhood in the same way. For example; ecofeminism (branch that emerges in the eighties) identifies motherhood as a source of power, transformation and peace; feminism within lesbian critical theory explains motherhood from three institutions, heterosexuality, marriage and motherhood, linking these three elements as means of control and access by men towards women; psychologist Ana Maria Fernandez makes the distinction between reproduction (from the biological-species) and motherhood (as a cultural order) as:

> Social function where the myth of the woman-mother, which operates as a device that constitutes collective beliefs and longings that order the social valuation of motherhood at a certain historical moment. The mother arises in modernity as part of the process of transformation of the family, affections and as a form of control of bodies to potentiate productivity. (Sánchez Benítez, 2016, p.257).

According to what is conceptualized in Sánchez Benítez (2016) there is also the Chicana and postcolonial current, which contribute different elements to the concept of motherhood:

- Motherhood is shaped by modernization/coloniality through specific interests, in order to dominate and establish the perception of women in a given economic and social system.
- The resistance to this modern-colonial perception from the recognition of the rights of women-mothers has political implications.
- Talking about motherhood implies including other categories that affect the construction of the perception of the woman-mother, such as class, sexuality, spirituality, political position. This leads to the need to analyze the issue from the perspective of intersectionality, which allows us to identify the different elements that influence the construction of the woman-mother image.

Feminist theory cannot be generalized from a single point of view, since, as mentioned, the different experiences of women have built the discourse and the turn that the theory takes to explain the different dynamics (positive or negative) to which women are subjected. It is necessary to take into account the social, political and economic elements under which women are contextualized in order to analyze their experience. It is important to mention that feminist theory also allows us to put into perspective different elements that make up the problem analyzed in this work, such as the role of the state, which is questioned and even challenged for its lack of perspective and understanding.

Feminist theory goes even beyond the role of the state, it has also allowed us to understand the structures under which systems are built, in this case the health system, which (according to feminist theory) has been built from a patriarchal environment, where "medical training is hierarchical, and

teaching methods do not look beyond the biological" (Bedoya Ruiz, Agudelo Suárez and Retrepo Ochoa, 2020). It also allows us to understand concepts such as gender and gender violence, under which different problems arise, which are also subject to the socioeconomic and political conditions of women.

Health-Disease-Attention

Health in itself, seen from medical anthropology, is the state of integral well being understood from the cultural elements of the person, and which is conditioned by the social, political, economic, and gender contexts of the person. Public health, seen from the crisis model, can be understood as the social perception of health (Calvario Parra, 2006). Health services can be interpreted as a dimension and/or element of a state's health system. Therefore, the trinomial of health-illness-care, as proposed by Bernal Díaz, Aguilar Guerra and Linares Martín, is a universal process experienced by the individual in the search for the satisfaction of his or her needs, which is also conditioned not only by the social and cultural notions or precepts of the community where he or she develops, but also by the political, economic, ethnic and gender dimensions of the individual.

Disease

Illness and the way illness is understood belongs to culture, since it depends on the construction of human reality that each group makes (Baer 1994 in Junge, 2001). The understanding of illness is made by both the patient and the physician or healer through a series of shared interpretative activities (Junge, 2001). Thus, the way the physician understands and explains the illness is the way the patient will understand the illness.

Health Services

Health services, studied from critical medical anthropology, are referred to as "modern medicine" or "scientific medicine", where the globalization of Western medical systems is discussed and the focus of this modern medicine on the pathophysiological aspects of the disease and on the power relations it establishes with other types of medicine, such as indigenous or traditional medicine, is questioned. Health services based on modern medicine focus only on the aspect of diagnosing and treating the disease, making a definitive separation between body and soul (Baer 1994 in Junge, 2001).

Motherhood

Maternity, from feminist theory, is understood as a social practice, which defines femininity and the role of women within society, and which is conditioned by the patriarchal system "that divides productive-reproductive work, by sexuality and reproduction policies that conceive maternity as a natural and biological matter" (Sánchez Benítez, 2016). Furthermore, seen from the postcolonial branch of feminism, motherhood is shaped by modernization and establishes specific dynamics that seek to dominate and establish the perception of women within economic and social systems.

Methodological Framework

Migratory processes as well as pregnancy and motherhood should be understood from a key element, experience. Experience can be interpreted as the fact of having lived, known or witnessed something; this experience allows us to acquire knowledge of life through life circumstances or situations (RAE, 2022). Throughout the work, the importance of understanding the individual's experience within a specific social topic has been emphasized, whether the topic is migration, the process towards obtaining and accessing health, or the experience of motherhood, the key point that will allow the development of the research will be the experience of the person who lives the reality of that topic.

As previously mentioned, the topic of migration is a multifactorial one, no experience is composed in the same way, and just as ethnicity and country of origin are some of the factors that affect and influence the experience of the migrant person within their journey, personal traits such as gender, the perception of gender and its roles, and the socioeconomic conditions that derive from this perception are factors that also significantly influence within the migratory process. (González Arellano, 2017).

Even so, the experiences of migrant women are not lived in the same way since, from the beginning, not all migrate for the same reasons. Some migrate to improve their own socioeconomic situation, others migrate for security issues (personal or political), others migrate together with their families, others leave their families in their countries of origin and seek to be the provider figure for the family from a distance (Garrot, 2016).

The reality of the problem we are trying to investigate here is that there is no single reality, there is no single point of view, nor is there a single explanation, the reality is that the problem is multiple, diverse and subjective, since we cannot make a general assessment of the problem. Within this topic, the diversity of perspectives and thoughts or experiences that migrant women, specifically those of Central American origin and who have or have been able (or not) to access health services in Mexico, may share will be evaluated.

This research is an effort to explain that a woman is not similar to another woman, even if they live in the same world, work the same job, travel at the same time, and even if they are both mothers, they are not the same, since one will never experience these moments or stages in the same way. The way of thinking and feeling of the person is an element that builds the way in which the woman could experience these moments, even so, the cultural or social education that the woman has previously received is an element that significantly influences the experience and motherhood of the woman. The

research is also an effort to understand that migration, health and pregnancy are multifactorial, even though these three are elements that influence each other.

Due to the subjectivity and multifactorial nature of the topic, the research must follow a qualitative methodology. It is necessary for the research to understand the meaning that Central American migrant women who have or are pregnant give to the activity of accessing health services in Mexico and in the United States, specifically in Nuevo Leon and Florida, respectively. This, in order to be able to construct patterns, categories and themes that allow us to have a broad perspective about how the normative, institutional, and systematic health system in both countries benefits or limits Central American migrant women in their quest to obtain medical care. All this in order to make an interpretation about the situation that this population group lives, before, during and after exercising their human right to health when crossing Mexico and settling in Nuevo León, or continuing their journey to the United States and settling in Florida (Batthyány and Cabrera, 2011).

Regarding the methods to be used, as we seek to know, categorize and make an interpretation of the elements and factors that influence the process (before, during and after) of seeking access to health services for Central American migrant women who are or have been pregnant and, considering that there is little information focused on migration in Nuevo León and, considering that migration information in the state of Florida has not been updated during this year and, taking into account that there is even more scarce information focusing specifically on Central American migrant women, the ideal method to gather information is through semi-structured interviews.

Such interviews will allow me to mold and tailor the questions around the woman being interviewed, always prioritizing her comfort and the sensitive and empathetic handling of the information. The semi-structured interviews will allow me to identify the means and mechanisms by which these women have accessed health services in Nuevo León and Florida.

Another important aspect is to recognize and determine the limitations and problems that these women face or identify when accessing health services, for which it is necessary to conduct a documentary review, compile information from theories and other case studies, and reinforce those elements identified in the documentary review through semi-structured interviews, or identify and document new limitations or problems that the women have experienced.

Hypothesis

The way in which Central American migrant women, specifically those who are pregnant, access health services in Nuevo León and Florida is influenced by economic constraints, such as lack

of monetary resources; by cultural constraints, such as the perception of women and gender, and the concept that migrant women have of health; and by systemic or structural constraints. Access is also limited by mobility restrictions imposed on women by the collection centers, or by the people hired to help them move from their country of origin to another country. Women who perceive these obstacles and are unable to obtain medical care or services through public agencies seek care through alternative means, such as private medical services. Even so, they continue to identify various limitations along the way, such as access to follow-up medical services, access to medications or specialized medical care.

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