

EQUAL ACCESS, KNOWLEDGE AND EMPOWERMENT: PROMOTING INCLUSION IN  
SEX EDUCATION AND REPRODUCTIVE HEALTH PROGRAMS FOR HUMBOLDT  
COUNTY'S SPANISH SPEAKING POPULATION

By

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## ABSTRACT

### EQUAL ACCESS, KNOWLEDGE AND EMPOWERMENT: PROMOTING INCLUSION IN SEX EDUCATION AND REPRODUCTIVE HEALTH PROGRAMS FOR HUMBOLDT COUNTY'S SPANISH SPEAKING POPULATION

Corinna Irwin

Improving access to sexual and reproductive health care for Spanish speakers in Humboldt County is dependent on the implementation of education, outreach and culturally specific information in Spanish. The economic, geopolitical and social dimensions of immigration to a rural county impacts access to health care, and in the current political climate, may further effect access to sexual and reproductive health care for women and youth. This ethnography examines both the experiences of women born in Latin American countries and Spanish speaking youth in Humboldt County, and their experiences with sexual/reproductive health services and sex education. Methods include participant observation in healthcare, educational and community settings, qualitative interviews, and a survey administered with middle school youth. The narratives and observations have been collected in order to better understand the existing structural barriers and how they affect these individuals. This research concludes that fear of deportation, cultural and religious values, language barriers, and institutionalized gender inequality have created systemic barriers to access in this population. In order to mitigate these barriers, it is recommended that programs take time to understand these structural barriers, through education for providers on structural competency and that reproductive health services

increase and maintain an intersectional feminist approach. In addition, the development of outreach and advocacy programs for Spanish speaking populations, and mandatory healthy relationships education for youth, assist in lessening these disparities by meeting Spanish speakers where they are at and educating them about services.

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## INTRODUCTION

### Personal Statement

As I conducted this study advocating improvements Latino health, many people have been surprised to learn that I, myself, am not Latina. They have a lot of questions about why I have chosen to do ethnographic research with a population that I am not a part of. Because of this, I feel called to begin this research with a personal account background of how I ended up in this research.

I grew up in Humboldt County, during a much different time. One could count the number of youth of color in the elementary school I attended. Since then, due to the international consequences of economic boom, trade deals, and the change in labor force, populations have begun to change. Growing up in a rural area with almost all white people, can give you a skewed perception of the complexity of this world. After finishing college, I ended up working a few different jobs in public schools with at-risk youth. Due to having learned conversational Spanish while traveling around Central America in college, I ended up working with many youth and their families who were immigrants. Through their personal narratives and struggles, I became acutely aware of the injustice, and the barriers, that these youths and their families struggled with, that their white counterparts would never know. This inspired me to take a job teaching English in Mexico, where I ended up spending nearly three years of my life.

Upon moving to Oaxaca City, I found incredible kindness and love from people who soon became my best friends and second family. Learning first hand of the traumas and struggles that my friends had faced when trying to go to my country, and when dealing with Immigration Customs Enforcement (ICE) made me realize that this was a fight that demanded much solidarity from people not affected by border enforcement. When I finally returned to the States for graduate school, my friends made me promise not to forget their struggles, and asked that I go home and teach my white community and institutions the grave injustices that their family members face away from their home.

At the beginning of this research, as I was working in a clinic and speaking with a Latino Health Educator of whom I shared many patients with. I told her I was frustrated with the passive discrimination our patient was facing at the hands of his medical provider, who did not seem to see his health issue in a larger context.

“This is what we face, Corinna,” she said. “A lot of people don’t see it, but you do. And you are going to graduate school, so you will have the power to change things. Please keep fighting for us.”

It is a great gift to be shown the struggles of an individual or community who have experienced this world differently than we have. For this, I am accountable forever to stand up for those who deal with circumstances I do not.

I hope that this research can serve as a token of my appreciation for all the people in Oaxaca who took me in and taught me their language and culture, to my friends who

continue to struggle with trauma from the institutional racism in my country, the Latino health educators and organizers working so hard to make Humboldt County a safe place for Spanish speakers, and to the many amazing women who shared with me their stories for this research. I can only hope that I do right by you, and that in solidarity we can work to make this community and this society as a whole more safe and equitable.

## Research Description and Relevance

The kind of research that has been conducted on health disparities in Humboldt County has mostly been done from an epidemiological perspective- looking at quantitative data regarding the rates of disease and population change. However, utilizing an ethnographic and qualitative approach allows the research to address the individual stories of people who have migrated to this county, and their experiences with healthcare systems. This study seeks to explore the cultural and social dimensions of immigration and influx in ethnic diversity in a rural area with a low socioeconomic index, and how it could affect public health interventions and outcomes, specifically regarding sexual and reproductive health (SRH).

Sexual and reproductive health (SRH hereafter) is, like immigration, a contentious issue in today's political climate. Targeted changes are clearly a priority for the Republican administration in 2017. On Donald Trump's first day as President in January 2017, he repealed the global gag rule, suspending funds to foreign countries for receiving SRH counseling which included information on abortion. Since then he has made changes to, or promised to make changes to, Planned Parenthood's funding and other programs providing pregnancy prevention for youth. In addition, he has promised to appoint a Supreme Court justice who is interested in appealing *Roe Vs. Wade*. [Grossman 2017 43] These political position pose direct challenges the community. Sexual and reproductive health refers to access to birth control, sex education and prevention services, access to safe abortion, support for domestic and sexualized

violence, lack of stigma regarding sexuality, prevention and treatment of sexually transmitted diseases including HIV, and prevention screenings and vaccines for cervical cancer which are key concerns for the population in this study. In addition, this study will explore the experiences that youth from Spanish speaking families have had in adjusting to their new lives in the United States, specifically Humboldt County, and if prevention programs are effective in reaching these populations.

These dimensions of healthcare and access will be explored by asking the research question, *how well have reproductive health services and sex education programs in Humboldt County served Spanish speaking youth and women? What features work to improved access?*

In order to holistically grasp these subjects, this research is conducted as an ethnography. In order to conduct an ethnography, one must integrate themselves into the lives of the population being studied- always taking into account the impact that the researcher's presence has on their subjects. Participant observation is thus key in the discussion of this research.

Through observing interactions in healthcare settings, events which organize and support the Latino community, sex education classes in schools, and outreach and administration of a Latino Health Assessment, a context has been built to augment rest of the research at hand.

Included in the ethnographic research are fifteen interviews with self-identified women born in Latin American, about their experiences accessing SRH services, their

perceptions of access in their communities, and for those who work in health care services, their experiences serving the Spanish speaking population with SRH services. In addition, a survey for middle school students of the public-school Fortuna Middle School was conducted in order to gauge receptivity of sex education classes in a school that is primarily Latino, and how Latino youth compared to their white student cohort.

Immigration and U.S./Mexico border issues have been topics of controversy for some time, and much research has been conducted on the disparities in health and human rights that exist for Latinos on both sides of the border. This includes ethnographic research on sex work in major cities along the border, the North American Free Trade Agreement's impact on small farmers and the relationship between food deserts and diabetes in migrant villages. There is also ample research on immigrant youth and teen pregnancy, but these are mostly concentrated in urban areas. Despite Humboldt County's unique rural location, access from a major highway, and being a major drug trafficking route, little research has been done on sexual and reproductive health access in these small communities.

This research intersects two major sociopolitical topics - access to sexual and reproductive health, and Latin American migration to a rural California county. This is done in order to expand the larger discussion on immigration and health to a microscale, by using Humboldt's rural Eel River Valley.

## II. PROJECT BACKGROUND

To understand access to sexual and reproductive healthcare here in Humboldt County, it is first important to know the national and global context for issues of sexuality, health care, and Latin American migration. To cover ample ground on this subject, this literature review is a combination of similar studies conducted in urban and/or border regions, and local studies on Latin America studies and healthcare. It also includes research done on sex education and teen sexual health disparities. This serves as a backbone for understanding the ways in which issues of access, systemic oppression, and policy can intercept the delivery of knowledge to disparate populations, specifically, Spanish speakers.

### Peer Reviewed Literature on Latin American Immigration and Sexual Health Access

These issues create a multitude of intersections regarding oppression, in regard to language barriers, social class, gender and gender presentation, ethnicity and skin tone, and country of origin. However, to look at these issues on a micro level in rural Northern California, Humboldt County specifically, little research has been done to specifically address sexual and reproductive health access in this population. It is well known that the economic routes of migration are often from rural to urban areas, in order to be in closer proximity to ample work opportunities. Health disparities based on ethnic background in urban centers along the border have been studied from a geopolitical perspective, and

studies have proven that issues like food insecurity and HIV infection among migrant workers are much higher than that of their affluent, Anglo counterparts. [Strathdee, Rodriguez 4] Within the research it will be important to take note of if and how structural changes are implementing for this changing global dynamic, and the immigration it has created.

To contrast these clear and obvious inequalities happening in urban, border areas, local theses conducted in the last ten years by former HSU graduate students are explored. In *Latino Grassroots Organizing in Humboldt County*, Daisy Barrios looks at the organizing efforts of True North, whose volunteers identified lack of bilingual social services and barriers caused by immigration laws, as the main causes for concern in the Latino community. In regard to health care, Breanne Sorrells-Olmstead's research study, *Resources as Resistance*, she uses Humboldt's Breast and GYN Health Project as a case study to explain effective patient navigation model. She explains how intersectional feminism plays a part in identifying dimensions of power and privilege in healthcare systems, and how important it is for patients to advocate for their rights within these systems. Anita Anguiano's research study *Opportunities and Challenges for Latino Victims of Domestic Violence in Humboldt County*, she interviews service providers about how they assist Spanish speaking people seeking services, and discovers that nearly half of providers have no specific protocol for dealing with these individuals.

These papers point to local systems intact to include the voices of marginalized populations, thus demonstrating the ways in which Latina migrants face multiple levels



of historical and structural oppression that could create barriers in accessing services in this rural area.

For Spanish speaking youth, cultural scripts, including family and social norms, could influence their sexual decision making and access to prevention resources. As many teen pregnancy and sexual health programs derive their funding from policies and programs, many of them religious, which ignore social inequality and focuses on individual responsibility instead of structural inequality, thus causing higher rates of unplanned pregnancy than their white counterparts. [Erickson 18] Many states follow abstinence only education laws due to parent's fear that comprehensive sex education will cause youth to experiment sexually, yet, states with less sex education, or only abstinence education, have higher rates of teen pregnancy than those with comprehensive. [Fields 23] Looking at the delivery of sex education, it may be clear whether or not lack of information, or culturally exclusive information, could perpetuate the disparities in the Spanish Speaking community in regard to sexual and reproductive health.

### Theoretical Frameworks

Theoretically speaking, this study uses grounded theory, post structuralist theory, and critical medical anthropology as reference points and frameworks for the data presented. Critical medical anthropology arose in the 1970s, as a social science critique of biomedicine and its practices. Critical anthropologists wanted to see real people speak

about the politicized nature of their experiences in medical and healthcare systems.

[Witeska-Mlynarczyk, A. 2015] Looking at poverty and inequality and how it relates to health is important work for medical anthropologists, moreover, looking at how disadvantaged parts of the world are affected by exclusion from medical developments, such as when pharmaceutical companies are exploitative of indigenous knowledge.

One example is the work of medical anthropologist Paul Farmer, whose extensive research on the HIV/AIDS epidemic revealed that poverty has played a role globally in the spread of the epidemic. In his article “On Suffering and Structural Violence” he examines a case study of HIV in Haiti, in which political corruption and war intersected with the HIV outbreak and mental health concerns to affect communities. [Farmer 2009] He explained that the various “axes of oppression” such as gender and race/ethnicity, must be examined inside of ethnography. A failure to do so, he explains, can result in an abuse of culture specificity, in which the researcher makes generalizations about the population they are studying.

Paul Farmer has been an important figure in the call to introduce qualitative research and narratives regarding inequality into the discourse on medicine. Biomedical studies are often completely quantitative in nature, only focusing on the human body as if it were a cyborg. [Seeberg 1998] For example, epidemiology is one tier of public health, and looks solely at statistics when considering how and why a disease spreads. Epidemiological research can provide data for speculation, but when looking at health disparities, social determinants of health cannot be elaborated on or explained when

solely looking at statistics.

Biomedical studies often run the risk of ignoring the interactions between doctor and patient, community dynamics, and other factors. Medical providers who treat every individual with the same expectations and bedside manner may be overlooking structural and socioeconomic dimensions which contribute to ill health. Ethnographic data is useful in healthcare research as it explores specific contexts, and acknowledges that some results cannot be applied to certain populations, due to the variety of contexts which exist. Because biomedicine does not usually take social context into consideration, using it as the only tool for improving community health can actually increase rates of illness and disease. By failing to hear the voices of specific populations, and social and cultural dimensions of how illness affect them, our society at large will not see an improvement in overall population health.

Considering all of these factors, the emergence of critical medical anthropology can be said to be a type of post-structuralist critique of biomedical studies. This is because like post-structuralism, critical medical anthropology narratives call for context on both macro and micro level analyses of health and wellness. The post-structuralist standpoint seeks to throw out all past assumptions about how systems function, and to see people and cultures as organic beings which need to be looked at on a case by case basis. The basis of post structuralism is that structures of economic, political and social power follow relational norms, and that the structure is subjective. Theorists like Foucault and Derrida founded this framework as a response to structuralism, which looks for an

underlying scientific explanation for all. [McGranahan 2010]. In our current society, ruled by globalization, economic development and technology increases, post structuralism could be applied as a way to look at how these power structures and changing times have created divides, oppression, and barriers for populations more disparate. For this, looking at Medical Anthropology, as well as structural competency, will be necessary for moving forward in healthcare development, and use applied anthropological research to view individual and community based themes.

Furthering this analysis is the concept of structural competency, which is a driving theoretical backbone for this project. Structural competency calls for an end to cultural competency, which often limits medical practitioners understanding of health issues as a “cultural problem” instead of as a result of structural violence and institutional oppression. [Hansen Metzl 2015] For example, instead of looking at personal characteristics like race as to why individuals in a certain community have high rates of diabetes, look at the overlying histories of that community. Metzl points to a case study in which providers in a clinic found that their community was suffering high rates of preventable, chronic illness. Instead of blaming the individuals and their habits, the clinic funded local grocery stores to ensure they had enough fresh, healthy food. This would be an example of looking at improving structures on a local level instead of attributing ill health to an individual, which is effectively blaming them for their own oppression.

Therefore, it seems that the theories mentioned will complement each other well in regard to studying sexual and reproductive healthcare access and sex education for

Spanish speakers residing in Humboldt County.

### III. RESEARCH DESIGN

As previously noted, this is an ethnographic study comprised of both qualitative and quantitative data. It also has elements of auto-ethnography as the researcher has incorporated her own experiences and herself into the research, showing up to community organizing meetings, participating in the facilitation of sex education classes, and working in healthcare with disparate populations.

This process is not without its challenges. Ethnography necessitates an ability to interpret and be descriptive about one's surroundings, while at the same time recognizing that the existence of the researcher herself challenges the authenticity of the interactions. True ethnography takes years to facilitate, and this study is limited in its resources and participants, as the research is unfunded, intermittent, and spans across just over a year.

However, the usefulness of using ethnographic methods appears when the researcher is able to see the issue studied in a wider context, integrating individual narratives and current happenings in real time. Ethnography has the benefit of functioning as a live document, especially as open coding allows it to. Participant observation has taken place in activist and community organizer circles, in sex education classes, and in healthcare situations, which allows for a data to appear in a variety of contexts. The rationale behind using ethnographic methods is to view the population outside of the words they share in qualitative interviews and survey data. The researcher integrating herself into the community helps to recruit participants, and gain rapport, which is especially needed in a population facing systemic racism and fear of deportation.

Participant observation allows for a more authentic interaction between researcher and participant.

While ethnographic fieldwork is the primary focus for this research study, qualitative interviews are conducted with a number of individuals, and a survey is distributed to middle school students.

For 7th grade students at Fortuna Middle School, students took a short survey which is attached below. [Appendix 1] When it was completed, the answers were analyzed quantitatively and compared between students who live in households where Spanish is spoken, to students who speak only English. Participant observation also was conducted in classrooms, both at Fortuna Middle School and Redwood Preparatory School, during sex education, HIV prevention, and consent workshops, and was coded by noting reoccurring themes. The method used will be grounded theory, so I cannot at this moment say how it will be analyzed. An IRB revision was conducted to include a short interview with the health educator about her experiences and observations working with Spanish speaking youth during the sex education classes.

The study on adult women relied heavily on data from participant observation, unstructured interviews, and participant narratives on experiences with services in regards to sexual and reproductive health. Participants were all female-identified, Spanish speaking, and born in a Latin American country. Communicating theoretical frameworks to my participants was not necessary, but participants who agreed to interviews signed a form of consent.

## Population and Sample Sites

The goal of this research was to give a larger context for understanding SRH and sex education access in Spanish speaking women and their children in Humboldt County. In order to gain a wide and diverse enough sample, this research has taken place in several different sites and specifically looking at two different populations.

The population of which participants are pulled from are Latinas who have migrated from other countries or other parts of the United States. Participant observation and qualitative research focuses on women's experiences. Specifically, qualitative interviews have been conducted with fifteen women who were born in Latin American countries. These women have shared their narratives regarding their own experiences with sexual and reproductive healthcare access, as well as their perceptions of the barriers to sexual health and education that exist within their communities. I met many of these participants during participant observation, and are actively involved in their communities in some way, whether that be as concerned community members, activists, or being healthcare providers themselves.

In addition, the research expands quantitatively to examine middle school aged youth in the Eel River Valley, specifically surveying 7th grade students at Fortuna Middle School, which has a more than half population of Latino youth. The sex education classes I observed for participant observation, were at both Fortuna Middle School and Redwood Preparatory Academy. These observations were mostly to explore exactly what is being taught, and the environment in which 7th graders receive sex education, and to



observe what seems to be absorbed by the youth in the classrooms. The researcher gauges the amount of information absorbed through participant observations of the students.

The goal of this survey<sup>1</sup> was to demonstrate the differences between youth who come from Spanish speaking families, and those from white and/or English-speaking families, in regard to the understanding of sexual health and disease prevention education. This survey aimed to augment the qualitative data in a way which includes the youth perspective. The relevance in including this qualitative data is to better understand the links between adult migrant experiences, and how their children are able to receive information. Studying both adults and children in a heterogeneous population allows one to see how cycles can perpetuate generationally when larger structures do not allow for growth. It also gives the opportunity to see a window into the minds of the youth, and to thus contrast that with the perceptions that the adult women participants may have of the youth in their family in regard to issues of relationships and sexuality.

As mentioned previously, most of the participants who shared their narratives were recruited through participant observation. Attending regular meetings geared towards the Latino community, coalitions of health care organizations and social service

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<sup>1</sup> “Migrants” refers to people who have traveled from one place to another in any context. Although finding temporary work is a common goal for many migrants, this research uses larger scale of culture and migration, motivated by a multitude of reasons, and focused upon longer term locational shifts. For example in “New Keywords: Migration and Borders” a distinction is made between “asylum seeker” and “economic migrant” [De Genova Mezzadra Pickles 61]. The individuals in this study are not migrants in the sense that they come temporarily only for work reasons, but rather that they have settled and made themselves a life. All participants are migrants in the general sense of the word, but none have sought temporary labor from place to place. Thank you to Connie Stewart for pointing out this need for clarification.

providers and health fairs provided contact to the population studied. Gatekeepers and stakeholders had been identified in the community, such as service providers, parent educators, community organizers and ESL teachers. Getting to know these individuals has been an imperative process for better understanding the population at hand, and being granted access to the participants at hand.

I sent out emails asking for participants to Humboldt State faculty to refer to their students, and through a listserv called Promotores, which focuses on Latino community building and networking for events. Participants are a variety of ages, and come from several different Latin American countries. The Call for Participants announcement is included at the end of this paper in the appendix.

Sites for ethnographic research include community meetings, such as those of Centro del Pueblo, an organizing group to support immigrant's rights, health care settings and workshops for Spanish speaking folks, as well as sex education classes in the schools. These participant observations are important in that they integrate the researcher into the lives of the population, as well as helping to recruit more participants.

The survey was conducted at Fortuna Middle School in order to gauge the level of understanding of sexual health issues which are age appropriate for 7th graders. The survey focused on some material that would shed light on disease prevention comprehension, and other material that focused on exploring sociocultural understandings of relationships and sexuality. This study was facilitated due to my work with a health educator, who wishes to remain anonymous for this study, but who was

invaluable in gaining access to the classroom environment, and setting up communication with staff at Fortuna Middle School. The principal supported the research, and sent the parental permission slips home, and those children whose parents signed were able to participate in the in-class survey.

Parental permission slips were sent home in both English and Spanish. Copies of the parental permission slips are included at the end of this paper in the appendix. Also included in the appendix is The Participants Bill of Rights, which was included along with the survey. Students were asked to rip the page off of the survey if they consented to take the survey.

### Data Analytics

After all the data was collected, it was typed up and stored on a secure folder in google drive, and the programs Excel and Evernote will be used to analyze the data further. Emerging themes were coded, and the most common themes were expanded upon using data from all methods. Many themes ended up coming up in different contexts between the participant interviews and participant observations, all falling under the umbrellas of three major areas which will be explained further in the research findings sections of the paper.

These methods of research allow for ample space for interpretation and analysis, and the perspectives of a variety of individuals. For the survey at Fortuna middle school, it can be seen as a cross-sectional study, as it looks at a population at one point in time.

[Seale 121] The research done on Spanish speakers and SRH access is more ethnographic, because I have met most of the participants in other settings, and participant observation is included. This allowed for rapport to be built, as my face became recognizable from community involvement. However, with a cross-sectional study such as a survey for middle school students, developing rapport is much less possible.

The analysis of data is a multifaceted process. For participant observation, grounded theory was used. Grounded theory, much like the post-modern mid-range theory, looks at data as it arises from the research, using an inductive approach to draw conclusions, instead of guiding data back to specifically instituted theories. Grounded theory examines emergent social themes and processes as they come about, moving directly from collected data to theory, in an inductive approach [Foley 1197] Inductive approach specifically aims to draw conclusions from data, instead of the deductive approach, which starts with a list of themes and eliminates those which do not appear in the data. Using grounded theory allows the data to work as a live document of sorts, up until the time when it is ready for publishing. We are living in a time which is drastically changeable, and especially for the population being researched. The development of technology, and changing government policies leaves us with an unpredictable feeling for all working class people, and migrants, who may frequently change location, or have language and cultural barriers, may remain invisible or unaccounted for. Issues like safety and security have changed drastically in the past year with the changing political climate,

and has caused data to emerge differently.

Qualitative data is coded using open coding, which is closely related to grounded theory. Open coding is seen as a cycle: collect data, analyze data, notice things, and back again. This cycle allows for, as stated above, the data to remain a live being, open and ready for new interpretations as new themes arise. For example, during the research, there was an election of a new president, who has spoken racist, anti-immigrant rhetoric during his campaign. He promised to deport all undocumented immigrants, even those with no criminal histories, and to build a wall between the United States and Mexico. While themes of fear of deportation, social isolation, and language barriers have existed before this election, the threat of deportation and abuse from Immigration Customs Enforcement (ICE) has caused a drastic change in the Latino community. The amount of demonstrations and activism has greatly increased. Likewise, there have been anecdotal reports that some community members have ceased to go to work, and pulled their children from schools. Utilizing open coding allows these changes to be part of the analysis of studying barriers to SRH and sex education. In addition, utilizing open coding facilitated several IRB updates, one to collect narratives from Latina migrants who work in the healthcare system, in order for them to talk about what they have seen in their work, instead of their own personal experiences. The IRB was augmented to include a short interview with the health educator, and her observations regarding Latino youth in the Eel River Valley, specifically since the election and during days of protest.

Quantitative data collected from the survey has been analyzed separately. The survey asks general questions to gauge the level of understanding of issues like consent, sexually transmitted diseases, pregnancy prevention and healthy relationships amongst seventh grade youth. The survey also included a question about what country the student was born in and what language the student speaks at home. The survey was administered at the end of the school year, several months after the students' first sex education class. As long as enough surveys are collected from students, and parental consent has been given, surveys could be analyzed and divided based on which students were from Spanish speaking families and which were not. This will show if there is a disparity in understanding sex education and disease prevention. A copy of the survey administered is in the appendix.

#### Limitations, Barriers and Potential Bias

The nature of conducting research on vulnerable populations is having to navigate a multitude of barriers. One of the most pressing was developing rapport and trust with the women and youth who I studied in order to gain the most authentic and honest information. Having a great amount of respect for the agency of the participants, being compassionate to their experiences, being willing to follow up with them, and show up as an advocate in their communities was a part of that. In order to connect with participants, it was crucial to connect with gatekeepers, or folks who have already developed rapport with the population. Trying to show in public spaces that work to serve and fight for the

rights of Spanish speakers was important for building trust and showing positive intention. I believe it is my own integration into this community, and my continued support, that has allowed me to connect with participants.

However, much of Humboldt County's Spanish speaking population remains isolated and disconnected from resources. Those who do not involve themselves with community events are harder to connect with. All of my participants were willing to speak to someone outside of their immediate community, about vulnerable issues such as sexual and reproductive health, social barriers to services, and even trauma. Even though many participants reported having had negative experiences, all of my recruitment was done through community resources, so all participants are at least somewhat connected to services available. This in some ways creates a selection bias in which the women most isolated are not sharing their experience.

The selection bias could also consider parenthood and economic accessibility. Many of my participants came to the interviews with their children, or I went to their houses because of lack of childcare. While childcare did appear as a barrier in the research, it wasn't mentioned frequently enough to require a full section. However, I spoke with many women who were willing to speak with me about their experiences, but due to their work schedules and time caring for their children, we were unable to find a time to talk. So lack of childcare did factor in as a barrier for participant recruitment, even if it did not stand out as a barrier in access to SRH care. The participants who did agree to share their story were often dedicated enough to take time out of their busy

schedules to find a time that worked for both of us.

In regard to gaining access to middle schools, I was lucky in that both the health educator, and the school administrators, were very receptive to my study and allowed me to survey their students. However, one of my greatest barriers was gaining parental consent forms. This problem arose because when working with a vulnerable population such as youth, it is necessary to have parents complete parental consent forms. This could have also have created selection bias based on youth whose families were not willing to have their children attend sex education class. And failure for parental follow through could mean that I would not have enough data would create a less complete idea of how youth feel about sex education and healthy relationships in their schools. This could especially run a risk in my particular study, as it pertains to families who speak Spanish in the home. If Spanish speaking parents don't have the ability to read in English, or they are not literate in Spanish, then parental consent forms will be a barrier specifically to this population.

This foreshadowed problem was mitigated by having the teacher assign extra credit to students who returned permission slips, and the administration making calls home to encourage students to sign it. However, out of the sixty students in the 7th grade class at Fortuna Middle School, only eighteen students returned their permission slips. While 42 students completed the survey, it is not ethical to include the data from those whose guardians did not submit permission slips. While eighteen surveys did provide a considerable amount information to reflect on, it is hard to gain statistical significance



with this number.

Despite having predicted these problems with my research, and doing my best to mitigate them, less than half of the students in the class had parental permission slips turned in. This will be discussed in more detail further into the paper.

One issue that I hadn't fully explored before conducting research was the way that the school system trains young minds to behave well and have the "right" answer. Youth in middle school are at a pivotal time in their development, which is why I chose to study them. They have not yet reached high school age, when many start to defy and resist what they have been told by adults. However, they are no longer children who base all perceptions of reality on what adults have told them. This dichotomy makes it interesting to understand their comprehension of sexuality and relationships, since it may not be on their own lived experiences. However, when taking a survey in a classroom setting, they may feel internally pressured to answer questions correctly in order to please an adult. They may also ask questions of their peers or the teacher. This came to light during the administration of the survey. Many students asked for help on questions that they didn't know, asked each other or the teacher. I stated to them more than once that only their thoughts were what was important, and that there were no right or wrong answers. However, when they have spent seven years in a system that may not encourage critical thinking, this is a hard idea to convey.

There also is a possibility that some of the questions were misunderstood and their answers were not consistent with their actual beliefs, especially considering that the

research suggests that many students from Spanish speaking families may be behind in their English language development. This process could, on many levels, hurt the student. But this speaks to a larger structural issue of the ways in which public education exists. If students are answering questions in a way that they think adults will approve of, they may present as being more educated in the issues of sex education and healthy relationships than they actually are, signally to staff that they do not need further education on these issues. In a country in which lack of sex education is directly linked with higher rates of teen pregnancy, and 1 in 3 women are sexually assaulted during their time in university, being honest about knowledge and understanding is important. However, honesty is not something easily assessed by a quantitative survey. Since this is a structural issue, part of this has been impossible to avoid. Some of the questions ask the youth about their own perception, which has surely been influenced in every aspect of their lives. For example, one question to gauge the students' understanding of intimate partner violence is as follows:

5) If I have a relationship, it would be normal if my significant other: (Circle multiple)

- told me how to look and dress
  
- told me what I need to change about my looks
  
- cares about my hobbies and interests

- became friends with my friends
- expected me to have sex

Of course, as a researcher of SRH, I look at this and see the third and fourth answer as indicative of a healthy relationship, and the other three as not. However, this is my perception. Studying something like healthy relationships is incredibly subjective when considering many factors, such as environment, culture, preference and social upbringing. Analyzing this data has been done in a way to be cognizant of this. Regardless, the goal of this question is to explore youth's understanding of healthy relationships in a way that is subjective and isn't leading.

## RESEARCH FINDINGS

Because this study looks at two different populations, using two different research methods, the research findings chapter are divided into two separate sections. The first will explore the narratives and quantitative data regarding the 7<sup>th</sup> grade students at Fortuna Middle School, what they are learning in terms of sex education, and their own responses to cultural norms on sexuality and relationships.

The second section looks at qualitative research of adult Latina migrants and their experiences with SRH care access, through personal narratives and observations in community spaces.

### Cultural understandings of Sex and Relationships in Eel River Valley Youth: The Classroom Environment

Health Educator Kelly begins each of her lessons on sexually transmitted diseases with the same opening question, “If you want to have sex with another person, you need to get She puts her hand to her ear, and some of the students collectively call out “Consent!”

Kelly works for a local sexual and reproductive health organization which is responsible for teaching sex education in 54% of Humboldt County schools. In Fortuna, she teaches at Fortuna High School, Fortuna Middle School, Eel River Community School and Redwood Preparatory Academy. For many of these seventh-grade students, Kelly’s class will be their first on sexuality and sexual health. The environment is very

open and supportive, with the students given permission to write in anonymous questions, and the language in the classroom is non-gender specific to make all students feel included.

The title of the class on this particular day is “How to properly use condoms and protect yourself against STIs”. Kelly demonstrates with a model penis how to put on a condom, going over the ways to check if the condom is still functional and safe to use. She also talks about using dental dams for oral sex. The class is quiet, with only a few students giggling, and many watching with wide eyes of interest.

“Any questions about the process?” she asks. The students are silent. Finally, she asks the class, “So what do you do if the condom breaks?”

After a short pause, one student says that you should tell the other person. Kelly then explains that if the partner is female, and not on birth control, she could become pregnant. She asks the class what she should do.

A female student chimes in “The day after pill.”

After discussing these birth control options, the topic goes to sexually transmitted disease. Kelly asks the students to list out names of infections they have heard of. *Herpes! Chlamydia! AIDS!* The students shout out. Kelly begins to explain the difference between HIV and AIDS, what it does to the immune system and how it spreads.

“Someone can make out with, hug or play basketball with a person who is HIV positive, without any risk of the disease being transmitted.”

Kelly lists on the board the STIs that the students didn’t guess: gonorrhea,

syphilis, hepatitis and HPV. The creativity, insight and engagement that the sex education classes provide isn't just due to Kelly's skill and passion she brings to her job, it is also part of the California Education code, which mandates comprehensive, medically accurate sex education, including education on consent and HIV.

[<http://www.cde.ca.gov/ls/he/se>]

### Spanish Speakers in the Classroom

Just over half of Fortuna Middle School 7th graders speak Spanish in the home, with more than 35% being classified as English Language Learners [ELL] \* in 2017 [EdData 2017] This is almost double from the 2011-12 school year, when the percentage of English Language Learners was just under 20%. According to the data collected from the California Department of Education, only one of the 56 students who finished the school year spoke a language other than English or Spanish at home, so it can be deducted that children of Spanish speakers families account for the increased need for ELL support. In addition, Fortuna Middle School is classified as a Title 1 school, with nearly 80 percent (77.7) qualifying for free and reduced-price meals.

With the influx of Spanish speaking migrants coming to the Eel River Valley, FMS has made an effort to adjust to the needs of the population. State funded programs like Talent Search are able to provide support for youth who are from low income families in which neither parent finished college. The majority of the students in this program are from Spanish-speaking families.

Jorge Ambry began working at FMS conducting study skills and college prep

groups with the students signed up for the program. In his 7th grade class, he works with nine students. The small size allows him to get to know the students individually, and learn about their individual interests. The students are engaged and have lots of ideas during a class about higher education and what is best to study for the job you would like.

“How did you get your job?” a few students ask during his presentation. He explains that he has a bachelor degree, and wanted to get a Masters so he could teach, but needed a few years to work and pay off some school debt. He explained that he came from Southern California, and like all of the students in the program was a first-generation college student. Like many of his students, he came from a Spanish speaking family. Jorge later mentions that was one of the reason the school hired him- because he was someone who had a similar experience to the students in Talent Search, and he had a comprehensive understanding of the barriers that they were facing. For this, he is able to empathize with where his students are coming from, and connect with them based on their shared experiences.

In contrast, Kelly is neither bicultural nor bilingual. She says that during her time working as a health educator, it has only been in the last year that she has been aware of groups of students whose English was so limited that they needed a translator. Having some knowledge of Spanish herself, and with the help of bilingual staff, she has been able to translate some basic activities when needed, but lacks the ability to give a class in Spanish.

“I had another experience in a very rural school with a Spanish-only speaking

student who arrived at school the day before my sex ed classes started. There wasn't a professional translator, so the teacher asked another Spanish speaking student to translate for the new student. However, the other student didn't seem to be comfortable doing this, because he promptly sat on the other side of the room."

"I think the teachers' request, though made out of a lack on the part of the school and the last-minute nature of the situation, singled out this student in a way that was uncomfortable and potentially felt discriminatory. Like, why do I have to do this job?" Kelly ended up bringing Spanish language pamphlets about the material she was presenting the next day, but she knew this wasn't nearly enough.

Humboldt County's sex education program includes a peer based theatre group in which students from a variety of schools throughout the county audition to be part of it, and get to write their own skits about teen health and relationship issues that they feel are important within their specific schools and communities.

The topic for another class was bullying. The peer health educators along with Kelly begin to define bullying and discuss different scenarios with the class. After the demonstrations are done, the students get into four groups, each with a different scenario. Their task is to come up with a solution, or an intervention, in a situation where someone is being bullied. The class erupts in discussion in their small groups, and the peer educators begin circling the room for questions or help.

One group of five boys begins talking in Spanish, repeating the scenario to each other. A couple of the boys don't seem to understand the lesson. The scenario is that two girls are holding hands, and someone is calling them names. One of the boys is clearly



not a Spanish speaker, and he looks around at the other groups as if uncomfortable. The Spanish speaking boys seem confused and grow more silent, until one of the youth educators walks over to talk to him. Most of the boys seem to have no problem communicating in English, but a couple of them go silent. In a school where 35% of students are still classified as developing their English language skills, students who may appear as perfectly fluent may actually be misunderstanding parts of their lessons on a regular basis.

After observing sex education classes and Talent Search groups, I designed a survey to gauge the level of understanding the youth had of healthy relationships and sexuality. [Appendix 1] The survey was not given to assess the efficacy of the sex education class, but rather to gauge the retention of information between two subgroups. The survey was based off of many questions and themes that the sex educators gave to the students for pre and posttests.

As anticipated in foreshadowed problems, in the two classes of 42 students where the surveys were handed out, many students raised their hands to clarify the right answers. The students were told that they were only supposed to put what they thought. Some students talked and completed the surveys together. In the end, only 18 surveys were usable due to lack of parental consent forms. These 18 surveys were categorized by youth who grew up in English speaking homes, and youth who grew up in homes where Spanish was spoken. Many of the Spanish-speaking youth indicated that they also spoke English in the house. Due to the rampant fear of deportation in Fortuna that will be discussed further in this paper it was preferable to ask what language the youth spoke at

home to where their parents were born.

Luckily, of the 18 parental forms returned, an equal number of nine of each were available to be analyzed. While 18 out of the 56 students who took the sex ed class is too small a population sample to reach statistical significance, several questions stood out as particularly illuminating, and researchers who have spent time with the data believe that had there been more usable surveys, statistical significance would have easily been reached.

### Healthy Relationships

When looking at attitudes about relationships, answers and perspectives are more subjective than when discussing sexual health and disease transmission. Because of this, it is possible to see more of a reflection of sociocultural understandings and values,

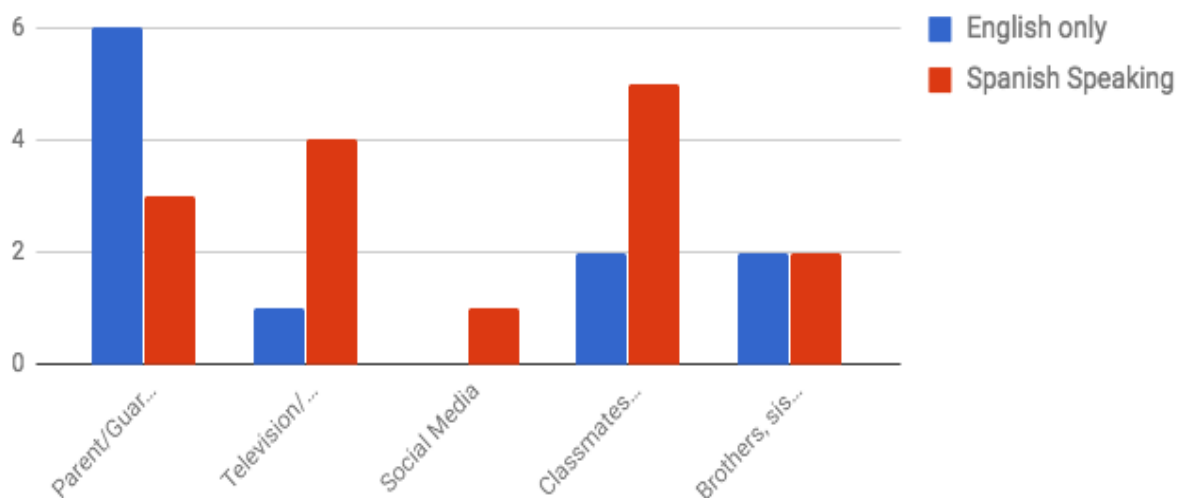


Figure 1: Where have you learned about sex and relationships outside of the class?(m=18)

whereas in questions about sexual health, the answers speak more to learning style and

understanding.

In Figure 1, students were asked where they had learned about sex and relationships outside of the classroom. The question was labeled as “mark all that apply” and all students listed at least one option, so the maximum possible for each option would be nine. Of English only students, 67% indicated that they had talked to a parent or guardian about sex and relationships, while half the amount (33%) of Spanish speaking youth indicated the same.

However, 44% of Spanish speaking youth reported learning about sex and relationships from television and movies, while only one English only student (11%)

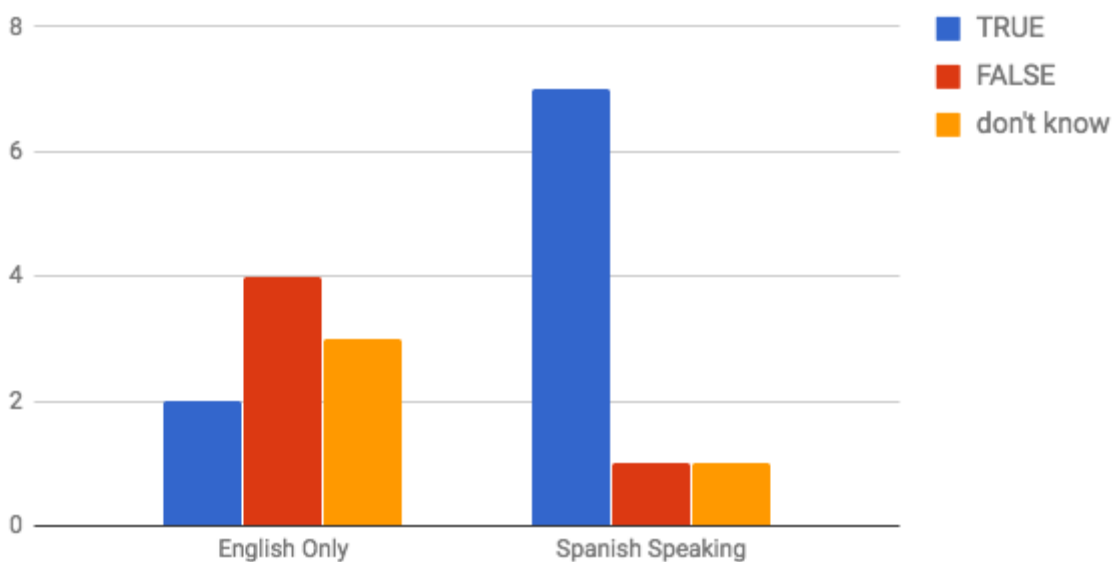


Figure 2: If my girlfriend/boyfriend was jealous when I spent time with other people, it means that they love me (n=18)

indicated the same. Spanish speaking youth also were more than twice as likely to learn from classmates and friends (56%) than English speaking youth were (22%).

In much of the mainstream media, the image of a jealous partner is often correlated with passion, love and desire. This can be a confusing message to young people who are at the beginning of their dating experiences. Considering Spanish speaking youth were more likely to learn about sex and relationships from television or social media, this could have a correlation.

Defining a healthy relationship is not as black and white as the prevention of sexually transmitted infections. In reality, a healthy relationship often means two (or more) people negotiating and figuring out their own needs and boundaries, and what they need for themselves. However, the appearance of jealousy in relationships can often lead to controlling behaviors, emotional manipulation and even intimate partner violence. [Park 2016] It is not surprising that for young people, this is a confusing issue.

Students in both cohorts had challenges answering this question. But the difference between the Spanish speaking youth and the English only youth is quite notable. Of the Spanish speaking youth, 78% have identified jealousy as a sign of love, and only one student believes that it is not. For English only speaking students, only 22% believed that jealousy was a sign of love. However, a third of English only students were not sure one way or another (33%).

In Figure 1, we saw that English only youth were much more likely to learn about sex and relationships from their parents or guardians, while Spanish speaking youth were more likely to learn from television or movies. The unknown variable is that we don't know what messages they are receiving. It is possible that the youth watching television could be watching educational programs promoting healthy communication, and the

youth who have an adult to talk to could be learning unhealthy relationship skills.

However, when considering the images of sex and relationships in current media, it's likely that those without trusted adult insight, only learning from television, would have a more negative view of sex.

However, a later question asks the participants if they have a trusted adult in their life who they can ask about sex, relationships, pregnancy prevention and STIs. The majority (83%) of the total 18 students indicated that they did. Only one student (Spanish speaking) said that they did not, while no English only stated they did not, but two indicated that they weren't sure. It isn't clear what adults the Spanish speaking youth can trust with these questions, since so few of them indicated that they had talked to a parent about these issues. One of the most positive outcomes on the survey was the acceptance

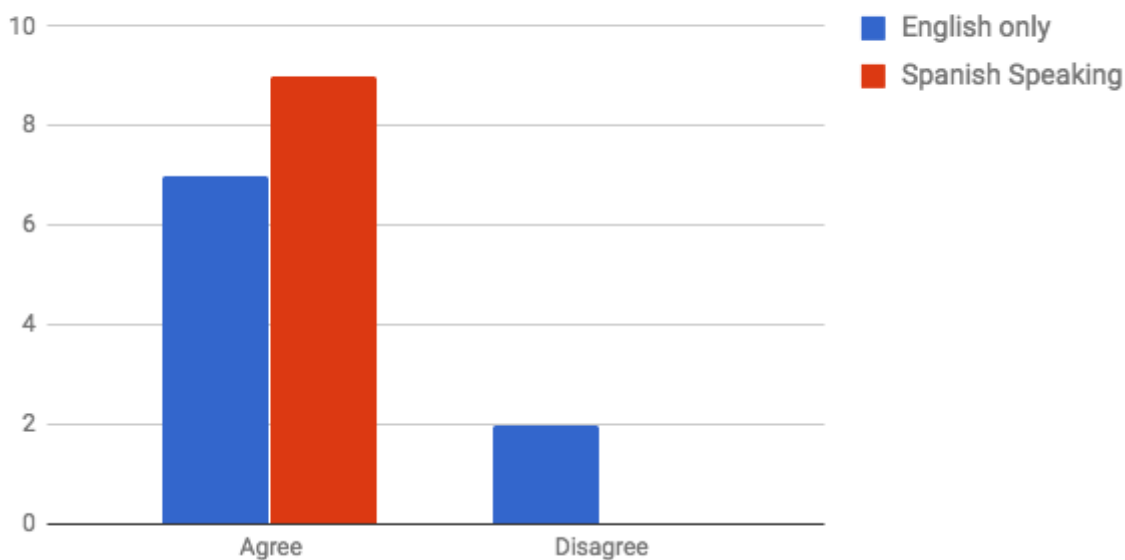


Figure 3: If my friend told me they had feelings for someone of the same gender, it would not change my friendship with them. (n=18)

of LGBT/queer youth.

In Figure 3, we see that the vast majority of students don't hold negative or homophobic towards LGBT students (89%) or at least they feel that they would be accepting if a friend came out to them. This is a powerfully positive statistic that is relatively universal, could change health outcomes for adolescents, as nearly one third of LGBT identified teens have reported attempting suicide, and more than a third say that they have been bullied at school [CDC 2017] [<https://www.cdc.gov/lgbthealth/youth.htm>]

In addition, 100% Spanish speaking youth said that they would not alter a friendship with a friend after they came out, while all but two English only students (75%) indicated that they would also support their friend. The reason for which more Spanish speaking students expressed support for LGBT students could have many variables. It could be interesting to further study the television shows and movies that youth are watching. Since more Spanish speaking youth are getting their messages about sex and relationships from television, this could have some correlation.

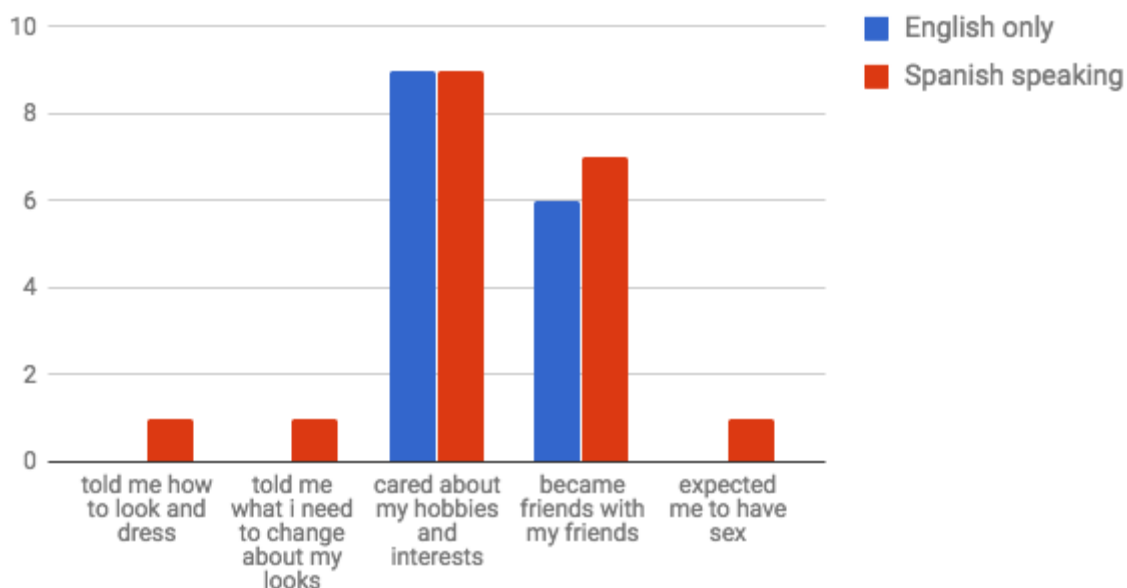


Figure 4: If I have a relationship, it would be normal if my girlfriend/boyfriend... (n=34)

In Figure 4, participants were able to mark all that applied. All 18 students marked at least one answer. Beginning with the positive, all students indicated that in a healthy relationship their partner would care about their hobbies and interests. In regard to thinking that their partner becoming friends with their friends is healthy, 78% of Spanish speaking youth and 67% of English only youth agreed.

However, for the other options, which were considered traits of unhealthy and/or potentially abusive relationships, three separate students stated that they thought they were healthy. When broken down differently as it is in Figure 4.1, we can see that Spanish speaking youth are far more likely (33%) to see controlling or abusive behaviors as part of a healthy relationship. When considering that 78% of Spanish speaking youth

see jealousy as an indicator of love, this shouldn't be surprising, but is very illuminating in the way that it shows a disparity in understanding healthy manifestations of loving

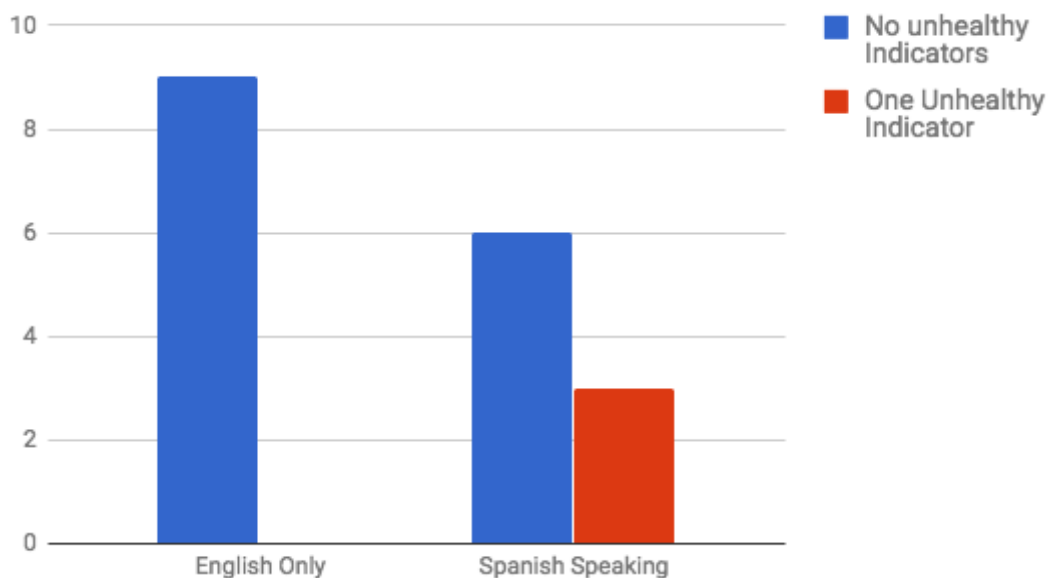


Figure 5: Healthy and Unhealthy Relationship Indicators (n=18)

relationships.

### Sexual Health and Disease Prevention

California is well prepared to have comprehensive sex education because the school system is required to provide information that is medically accurate. Only 24 states are mandated to teach both sex education and HIV prevention, and 20 of those specify medical accuracy. [NCSL 2016] However, only one person for the whole state of California is responsible for the regulation of these mandates, and in Humboldt County, a number of schools have no known curriculum on file for sex education Kelly's classes include five class sessions, each one focused on a different, age appropriate topic. One of



these days includes a class on STI (including HIV) prevention education. During this 45-minute period, the educator explains transmission routes of 6 or 7 different diseases, while maintaining gender neutral language and emphasizing consent. While the youth overall showed a good understanding of the importance of condoms and a basic understanding of sexually transmitted diseases, there were some gaps in understanding.

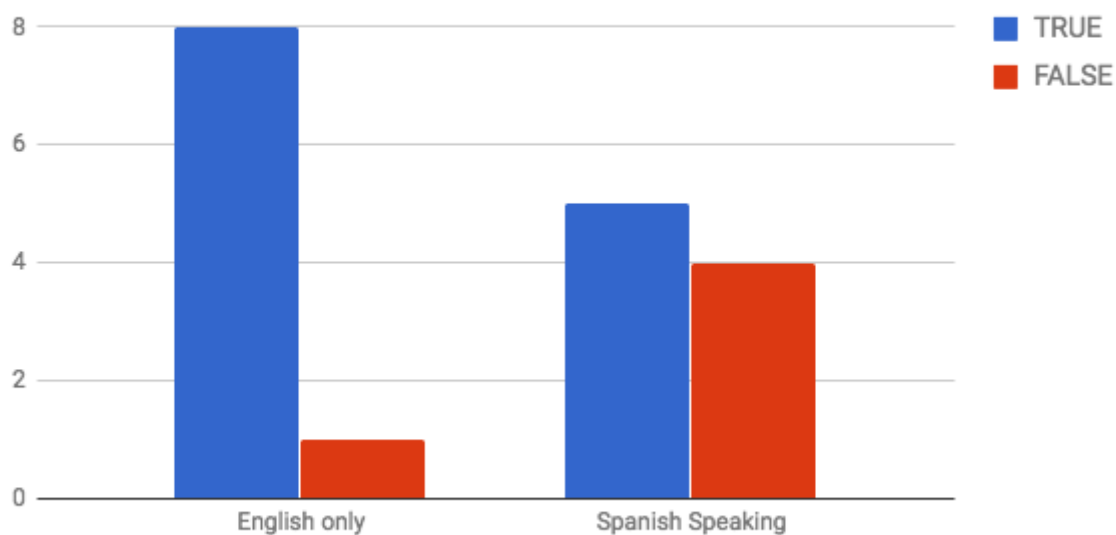


Figure 6: STIs can be transmitted through vaginal, oral and anal sex (n=18)

For the question presented in Figure 5, students were asked to identify the types of sex acts that could cause an STI to be transmitted. All but one English only student answered, “all of the above”. However, nearly half of all Spanish speaking students (44%) did not recognize that STIs can be transmitted through anal, oral and vaginal sex. In Figure 6, students were asked to mark all activities that could transmit HIV, including:

- a. *Having unprotected anal or oral sex*
- b. *Kissing*
- c. *Erotic Dancing*
- d. *Sharing needles*
- e. *Drinking from the same glass*

The answers indicate much less of a disparity between the level of understanding. All nine English-only participants marked at least one option (20 were marked in total) while one Spanish-speaking participant neglected to mark any. The eight Spanish-speaking participants marked 17 options in total. This means that almost the same amount of answers (30% of English- only students, and 29% of Spanish-speaking students) were incorrect, making a disparity non- existent, but indicated that in general, almost a third of students lacked a solid awareness of HIV prevention.

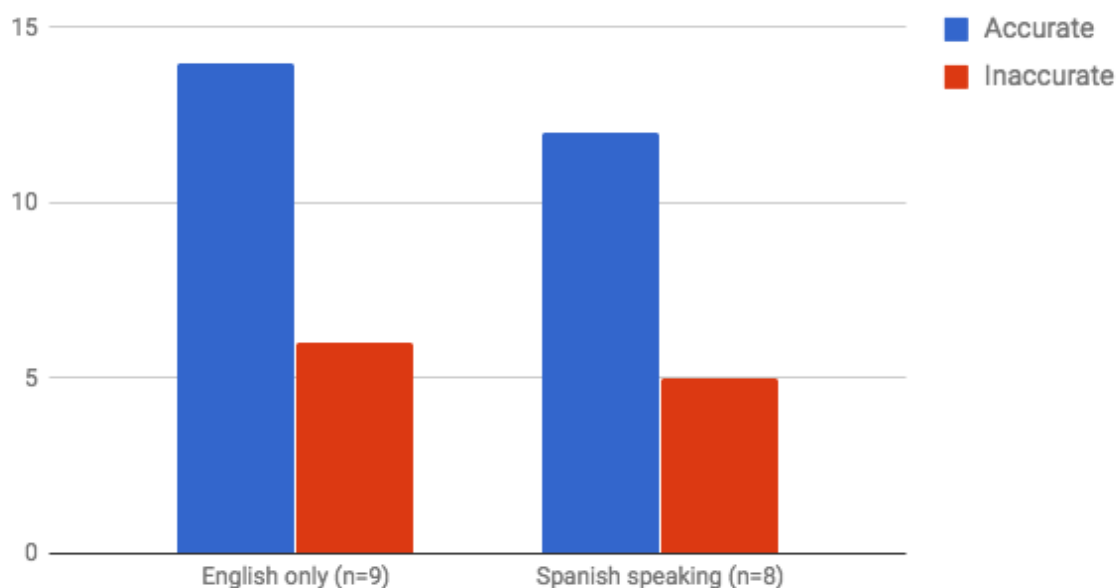


Figure 7: Routes of Transmission for HIV (n=37)

### Bullying

When Kelly brought the peer educators to help facilitate a class at Fortuna Middle School on bullying, it was because the principal had asked her to do so. There were reports of rampant bullying around campus, specifically associated with sexting.

They began the class with an activity lead by the peer mentors called “stand up.” The peer educators explained that if anyone had related to the statement, they could stand up.

Some of the examples included:

*Stand up if you’ve ever used social media*

*... if you’ve ever been pressured to do something you really didn’t want to do*

*... if you’ve ever supported someone who has been hurt*

*.... if you’ve ever felt like no one really understands you.*

This was a silent activity, and most students were a bit reluctant, hands in pockets and heads down, but for each statement listed, at least a couple students rose. After the activity was finished, the class brainstormed the ways in which bullying occurred. The students named hitting, cyberbullying, name calling, and verbal abuse. The peer educators added threats and exclusion.

After an activity about bullying in general, around the topics of homophobia, body size and disability, Kelly moves the topic to sexting. She defines sexting as sexually explicit messages, videos or photos. The peer educators have a couple of statements, and students are to move to one side of the room or the other based on whether they believe the statements are true or false.

Everything posted online is temporary

All students move to “true”.

“Even snapchat?” asks one female student.

“While snapchats disappear,” Kelly explains. “Someone could still take a screenshot.”

If you don’t use your real name on a website or email, your message will be anonymous The students discuss amongst themselves for a minute, and 10 students move to false, 1 to true, and 3 to not sure.

“You don’t need to be a professional hacker to find someone’s identity,” Kelly says. “Yeah,” a student adds. “Even if you use a fake name, they can track you!”

If a minor sends a nude photo to another minor, it is not the same thing as child porn.

Most students go to False, one goes to True Kelly clarifies, "It is still child porn."

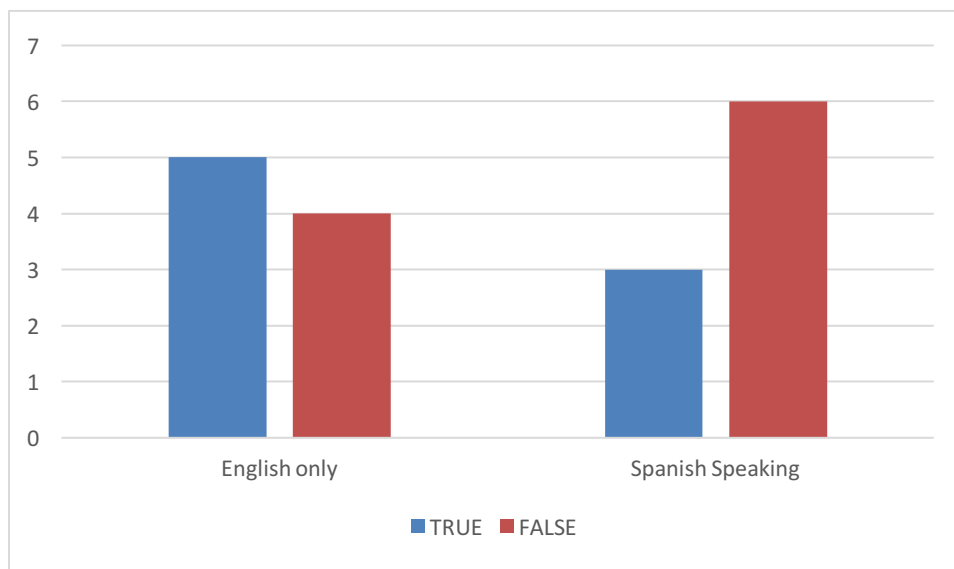


Figure 8: I have been asked to send naked or "sexy" pictures (n=18)

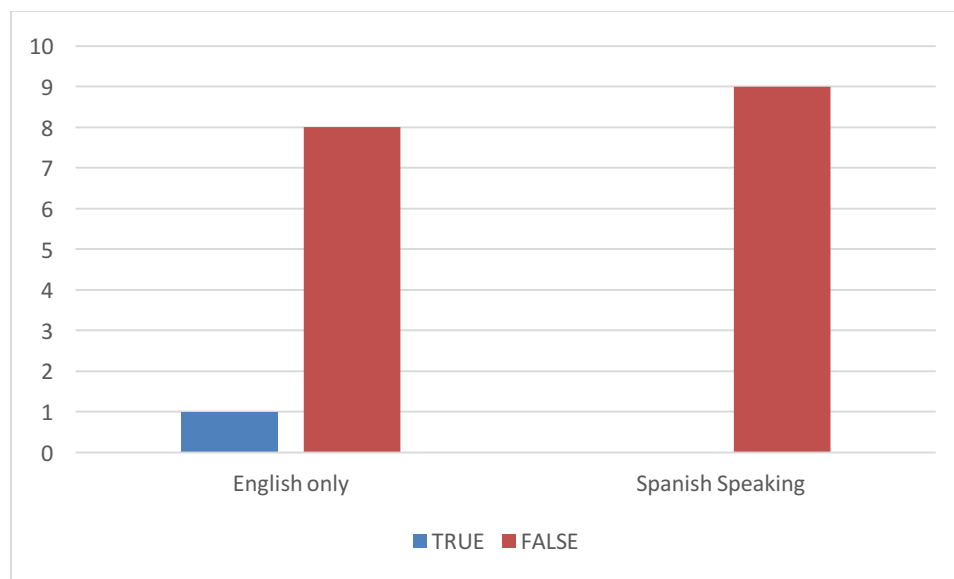


Figure 9: I have asked someone to send me naked or "sexy" pictures

Figure 7 shows the responses to a question geared at understanding how sexting is effecting the lives of 7<sup>th</sup> grade youth. Nearly half of students (eight out of eighteen students) indicated that they had been asked to send a naked or sexy picture. It is not indicated who asked to send the pictures, if the people requesting are other youth in the middle school, or older adults. But as indicated in Figure 8, only one student admitted to asking someone to send them a naked or sexy picture. This student is an English only speaking, 13 year old boy. One 12-year-old English-only student answered that while she had been asked, she would never do it.

In this case, more than half of English only students stated that they had been asked for pictures (56%) while a third (33%) of Spanish speaking students stated that they had. For whatever reason, this makes being Latino, or being from a Spanish

speaking household, a protective factor for underage sexting.

### Discussion

Due to the small sample size, it is hard to say whether or not these statistics are comparable to what would be the entire Fortuna Middle School 7th grade class, the whole school, or the whole Eel River Valley. Issues with 7th grade students being conditioned to giving the “right” answers, or misunderstanding the wording of questions could add some uncertainty in terms of confidence. In these cases, it would have been ideal to combine the surveys with narratives and focus groups with students in the two cohorts.

However, even with limited time, resources and money to support this research, some of the questions did shed light on areas where students who speak Spanish at home could have different levels of understanding than those who don't. Considering that 35% of Fortuna Middle School students are classified as ELD (English Language Development) this could have an impact on students' ability to fully comprehend the information on STI/HIV transmission, especially when it is given in only a 45-minute period. Ideally, educators would have more time to explain these concepts, but if that is not a possibility, incorporating more visual aids or other strategies to assist ELD students could be helpful. The California Healthy Kids act mandates that ten hours of sex education be taught to students at both a middle school and a high school level. This means that seventh graders would ideally receive five hours, and with five classes of 45 minutes, they receive less than four. Considering that many students are English language learners, having this limited amount of time may not allow for proper comprehension,

especially in the case that lessons are heavily focused on complex themes like anatomy and disease transmission.

### Ethnographic Examination of Latina Migrants Experience Navigating Healthcare in Humboldt County

My ethnographic research began in January of 2016. At the time I was working at a clinic, and as a Spanish-speaking liaison for a local non-profit, kept me busy, but also in contact with the population being studied. Accompanying Spanish-speaking patients with chronic health issues to their doctors' appointments was part of my job at the clinic, and while the issues were not reproductive health related, it was easy to see the disconnect between well-meaning practitioners, and Spanish-speaking immigrants, frustrated with their lack of understanding over their health issues, and the process of taking care of themselves and their insurance. Once, a man who had issues with depression and addiction, got up the courage to ask his doctor for anti-depressants. The doctor dismissed him, said he first needed to get his chronic health issue under control before she would consider treating his depression. In this situation, I couldn't help wondering if this same exchange would have taken place with a white person who could communicate in perfect English.

Between January and May of 2016, I collected my first six narratives and was able to observe participants when working in the clinic setting and in community meetings. In May, when the event I had spent four months promoting was unattended by the Spanish-speaking population, I thought back on the data I had collected. At that point, social isolation had appeared as a major issue for Spanish speakers in accessing services.



Despite having promoted the event, which focused on presenting women's health data, to many gatekeepers in the service provider community, and my own growing relationship with the migrant community, we failed to get any attendees. This experience, while it could not officially be a participant observation, spoke directly towards the emerging themes in the research- that even with ample promotion, it was difficult to research the Latino migrant, Spanish-speaking population in a short period of time. For the fifteen women who I had the privilege of speaking with for this study, one thing they all had in common was their connection to community, as all of them were recruited through community groups. While the event had been promoted extensively to community groups which focused on reaching the Latino population, the low turnout spoke to the findings that fear of deportation had created an isolation in the community.

This section begins with a subsection regarding intergenerational communication about sex and relationships. When I found a correlation in the data that half the number of Spanish-speaking youth had talked to their parents or guardians about sex, as compared to their English-only speaking counterparts, it created a distinct correlation between the two populations. In many of the narratives, women brought up the concerns about talking to their kids about sex, or how their parents did not talk to them. It also came up in participant observations. Because of this, it was important to highlight that this issue was brought up by both populations studied.

#### Ellos Saben mas que Ustedes: Intergenerational Communication About Sex

“It's not appropriate to discuss anal sex with a thirteen year old,” the only parent

who contacted me about the survey said. I explained that the goal was not to discuss anal sex with students, but educate them on disease prevention. Still, this parent did not sign the consent form for his student to participate in the survey.

Of the 45 students who took the survey, only 18 were usable due to returned permission slips. As mentioned above, this created challenges in terms of being able to claim statistically significance even for questions with large disparities. There are many barriers that could be responsible for the unreturned permission slips. Parents who feel similarly about sex education as the parent aforementioned could have elected to not return them, but lack of communication between students and parents, or forgetfulness on the parts of youth or parents is also a possibility.

While in the end an equal number of Spanish speaking and English-only families returned permission slips, with only 3 out of 9 Spanish speaking students indicating that they are much less likely to talk with their parents or guardians about sex, it is a possibility that this could have been a barrier to receiving permission slips.

Of the 15 women who gave narratives regarding their own experiences and perceptions with access to sexual and reproductive health, more than half (60%) mentioned the communication issues between the generations as a barrier for Spanish speaking youth to learn about pregnancy and disease prevention and healthy relationships.

Some organizations locally exist to support and advocate for Spanish speaking and/or Latino families, such as Paso a Paso. For example, the health educators hold women's groups in Eureka and Fortuna, in which women can receive information about

services or programs, and share their feelings and experiences in a supportive, safe environment.

One women's group in May is held at a church in Fortuna, the room is full and there is a table with snacks and coffee. Two health educators, Jessica and Haylee, place the chairs in a circle and the 15 women in attendance sit, many of them holding babies or with very young children at their side. Childcare is always provided at these events. When asked, a few women comment that there are no affordable day care services, and their spouses work so taking care of the children is their priority. For this, finding spaces that allow children is imperative.

After a discussion of what it means to be a mother, the conversation turns to issues of access to sexual and reproductive health. The women at first are silent, but then some women begin to talk about the challenges in having multiple children that they need to care for.

"My husband doesn't want to use any type of birth control," states one woman in Spanish. A few other women nod in empathy. A short conversation ensues about abortions and miscarriage, and the strain it puts on their bodies. Haydee talks about the limitations in receiving birth control, due to St. Joseph's hospital's Catholic policies not allowing patients to access birth control or abortion services.

I begin explaining to the group about the situation with Fortuna Middle School and sexting, and how the school has been recording complaints of bullying through sexting. Haydee jumps in to go into more detail about sexting, what it is, and how it has been affecting youth.

“I want to talk to my children about sex. But I don’t know how,” one woman says. She is holding one baby and has another small child at her side. “My parents never talked to me about this.”

With a large amount of my participants mentioning the need for communicating with their children about sex and relationships, it’s no surprise that so few Spanish speaking youth indicated that they speak to their parents about sex. Of course, this study is going to have some bias, since the participants all agreed to share their thoughts with a researcher regarding issues of sexual and reproductive health, which implies that those who were not comfortable would not talk at all.

Many women, because of the lack of day care services for low income and/or Spanish speaking folks, bring their children with them to their appointments. One patient receiving treatment for HIV agreed to speak to me, and brought her young daughter into the appointment room with her. When I asked her what her experience with sexual and reproductive health services had been, she said she didn’t have any. She needed to work, and take care of her daughter, and didn’t have the time to see the doctor. She said it just wasn’t her first priority.

This woman would not talk to me about her experiences accessing HIV treatment services. As her daughter sat next to her, she talked about how young girls needed to learn from the experiences of their mothers. “They need to take care of themselves in their sexual relationships. They need to protect themselves so that they don’t repeat the same mistakes made by other women.”

It was unclear if she had not mentioned her health issues because her daughter

was present in the room. The daughter, young enough to not have started puberty, but old enough to understand a conversation about health, sat listening to her mother. Was her short conversation with me a way to connect with her daughter, were they having these conversations about disease prevention and pregnancy at home already?

Andrea, a young mother of two daughters, said that her generation is more educated than her parents. “We try to talk to children when they are young, to give them an open mind, and we don’t want them to be afraid to ask us questions.”

She said if she didn’t have the answers to their questions, there were resources that could help her explain what they needed to know, or give them those resources. She stated that she had gone to Planned Parenthood and felt comfortable asking them questions about things that she didn’t know. She was also involved with Paso a Paso, and said they had helped her with information about condoms, preventing infection and pregnancy.

“Kids (teenagers) are stressed because lots of them work and go to school. And then there are a lot of parents who are afraid to give their consent for them to take sex education classes. I wouldn’t want my daughters to have children early because it is a lot of responsibility, and that would be too much on top of work and school.”

I spoke with Andrea after her English class. Her two daughters played in the hallway outside the classroom when we spoke. Women like Andrea had taken time out of their lives to speak with me; away from their jobs, their children, and what little time they had for extracurricular activities like going to women’s groups, ESL classes, or dancing.

In regard to consent forms, several participants mentioned that the fact that parents had to give permission for their children to be in class would create a big barrier for kids to learn about sex and healthy relationships. For programs like the one that Kelly taught at Fortuna Middle school, they use an “opt out” form. That way, only parents who actively object to their children being in the classrooms will have their children removed.

One of the women who talked passionately about the need for sex education, and beyond that, parent education so that parents would understand the importance of educating their children, was Raquel. Raquel is a working mother of four and a community activist of Latino and immigrant rights. Despite her obligations, Raquel had made time to show up in her community, at meetings for local organizations, rallies, and community groups. I first met her during a healthy cooking class offered by another Latino health education group through one of the clinics. A handful of people showed up because either they or someone in their families had recently been diagnosed with a chronic health condition and they were looking to learn new recipes to improve their health. This day they were cooking a vegetarian chorizo (a spicy pork dish) with spices like oregano substituting high salt hot sauces.

Raquel has a big personality and likes to joke and laugh with her whole body. As the chorizo was cooking, she turned the topic away from food and to politics.

“Let’s go, it’s time to get organized,” she started to say, directing her comments at the other adults in the room, looking deeply at them one by one. “There are a lot of Americans out there who don’t know our strength. For now, let’s just let them think we are weak. Eventually they will see.”

When Raquel said “they” she meant Americans, and when she said Americans she meant white people. It had been said many times by people who spoke Spanish that people who were white were Americans, as if any other word could be rude or offensive. In reality, many immigrant and human rights advocates would say that Raquel was an American too, but she didn’t refer to herself this way. It would have been interesting to know how many of the others in that group thought of themselves as not being American either.

The other adults listened to her, sometimes engaging with comments. Everyone seemed amused by her speech, but with warm smiles that conveyed agreement and solidarity. The space seemed to foster a sense of community where attendees could ask questions of the health educators about their wellness, and about community resources.

After the class I approached Raquel and asked to interview her. The next week when she got off of work, she took the bus to the clinic to meet with me.

“The problem with Latinos is that we don’t want to talk about sexuality. It’s a taboo for us. We are in this generation where parents are still afraid to open up and talk about sex. And when I was young, my parents would say “how can I let my children sit through a class about sexuality?” But they didn’t want to talk to us about it. They can’t talk about infections or anything else. Since they didn’t have the words to explain these things to us, they should have allowed someone else to.”

Raquel had her first baby when she was thirteen. She said that no one had ever talked to her about sex, or getting checked.

“I think they should make these classes mandatory so that parents can’t refuse for

their children to participate. We have to look at our current reality. It's hard because a lot of parents don't understand that their children often already know more than them, yet they still think of them as babies. Girls have told me that their parents won't listen and they would like for me to talk to them. They are afraid their parents will find out that they went [to get checked] and their parents will be critical. It is a custom- if you live in your mother's house, you need to get your mother's permission."

Xochil is a woman who moved to Humboldt from Southern California, and is passionate about advocating for the rights of Spanish-speaking migrant women. She described her perception of most Latino families similarly to what was said by Raquel. She did mention, however, that she knew a woman who took her pre-teen daughter to class at Planned Parenthood about puberty and sexuality.

"You need the parents buy in because you need to have them sign the consent forms," she stated. "So, it has to start with the parents, and the parents have to be open to it."

She said that when she was a teenager, her parents wouldn't talk to her about sex. Her father would only tell her not to come home pregnant. "I knew I had to take care of my birth control completely on my own."

Xochil was not the only participant who mentioned having experiences with their families refusing to talk to them about sex. Two other participants, Graciela and Erica, had similar experiences.

Graciela works in healthcare, and she has lived all her life in Humboldt County,



since emigrating from Mexico with her family as a baby.

“As a teenager, I never had access to [SRH services]. Not from my parents; I didn’t have any education. At school I had one class, but that was pretty much it. My parents didn’t even know. They never talked to me about [sex].”

Erica is a student at Humboldt State, and lived part of her youth just south of the border from San Diego in Baja California. She says that the Catholic religion creates a climate in which sex is frowned upon.

“When I was in high school, or even now, if my mom found out I had pills or something, she would freak out,” Erica says. “My parents are like, no. They don’t even want to think about it. But I have two older brothers and they have lots of girlfriends and my parents are ok with it. They even joke about it. But when it comes to me, it’s different.”

Three other participants briefly mentioned their experiences and/or observations regarding intergenerational communication about sex. One other, Cecilia, who is from Argentina and moved here with her American husband, mentioned that she had a positive experience with sex education, and none of her friends got pregnant until they wanted to, because they were educated about options. She attributes that to the fact that her school was not Catholic.

The issue of intergenerational communication barriers had both come up in the qualitative study with Latina migrants, and with 7th grade youth at Fortuna Middle School. Considering this, two issues with have already arisen remain highly important; to create bicultural, bilingual and culturally competent spaces for Latino youth to ask

questions and speak openly about issues of sexuality and relationships, and to engage Spanish speaking parents to make them feel more comfortable talking to their children about sex and relationships.

The following sections will further explore the three most commonly discussed barriers that Latina migrants face when accessing SRH services and involving themselves in the mainstream social discourse that encourages access.

### Land of the Free, Home of the Scared: Fear of Deportation

“When Mexico sends its people, they’re not sending their best. They are bringing drugs, they are bringing crime, they are rapists.”

Donald Trump’s famous attack on Mexican immigrants came long before he was elected as President of the United States. This, along with promises of mass deportations, the end of DACA (Deferred Action for Childhood Arrivals), and the building of a multi-billion-dollar border wall. These statements are only a part of the culture of fear that President Trump has created for people of color.

During the Obama administration, deportations rose to the highest number in history. [Street, Zepeda Millan, Jones-Correa 2015] This has caused tension and fear within Latino families, affecting their feelings of stability in the country. Now under Trump, this rhetoric about crime, border walls, and deportations has scared many families into hiding, isolating themselves from the broader culture. In February of 2017, fears heightened in Humboldt County and more specifically, the Eel River Valley, when ICE (Immigration and Customs Enforcement) were reported to be present in Fortuna. Local

Latino activist organization, Centro del Pueblo, responded swiftly, holding meetings to discuss organizing to gain support for local politicians to support a sanctuary county movement.

During the second meeting in February, about 60 people were in attendance. The meeting was conducted entirely in Spanish, with the few English only speakers wearing head sets with a translator on the other end. They had previously broken out into committees- a committee to petition legislators to make Arcata a sanctuary city, a committee to intervene and help children in the school, a committee to contact churches in each town to make them sanctuaries for immigrants, and so on.

The members of Centro del Pueblo facilitated a discussion on concerns in the undocumented community, which included presence of ICE in the bus stations, ability for ICE to take children from schools, military style deportations, and that Central Americans would be deported to Mexico.

These scenarios were not far from true dangers- in fact, it's very likely some of these things have happened. But the true likelihood of many of these scenarios were farfetched and rare. However, they spoke to the deep fears in the community that were keeping some folks isolated, and affecting their mental health. The solutions Centro Del Pueblo participants suggested were to hold trainings in the community about ICE, to hold local government accountable to inform citizens if ICE is present, and creation of a phone tree, in order to create a network of support for individuals who are afraid migrations officers are in their neighborhoods.

Some of the organizers orchestrated role plays to demonstrate how to talk to

migration officers if they were approached. They explained that these people can be very friendly, and many of them are Latinos who speak perfect Spanish.

The third meeting in March had only one person who didn't speak English- the room was divided into two parts, one for those who speak Spanish and the other for those who speak English. Because of the English-only presence, the meeting is held primarily in English, with parts interpreted for Spanish speaking attendees. CDP is discussing holding a meeting- a safe space - for Latinos in Fortuna and the Eel River Valley to discuss racism in their communities. There was some debate over whether or not white, non-Spanish speaking folks should be allowed at the event.

“I wouldn't want them [white people] to be at the meeting,” says one young man, hesitantly. “Because just their presence could trigger past experiences of racism that brown and immigrant people have faced at the hands of white people.”

An older white man starts to raise his hand, reaching it towards the sky, and without being given permission to speak, interjects, “White people should be included in the discussion on immigrant rights, because we can help advocate and potentially change policy.”

One of the head organizers of CDP tries to bring the two opposing sides together. “In order for change to happen, we mustn't exclude anyone who wants to show support or solidarity.”

She empathizes with the young man's feelings, and agrees that this meeting will be focused on Latino immigrant voices, and to create this environment it would be held in Spanish, without an English translator.

Of the 15 women interviewed for this research, seven mentioned fear of deportation or violence as a barrier to accessing reproductive health services. Leti, a Spanish speaking service provider and native of Mexico, has spoken with many women who had recently come to the county, did not have papers, and expressed fear in going to a clinic, or obtaining medical coverage at all. They often approached her with questions about medical concerns when applying to enter the country, and how they may be barred from entering if they had certain health issues.

“Many women have approached me with a fear that if they have a sexually transmitted disease, they would be rejected from entering the country,” she stated. “I don’t know how to answer this question because I’m not homeland security. But I would like to know what the process would be for women who have HIV. I know a lot of women are constantly in fear when they deal with this. They are afraid to seek medical services.”

Until 2010, those migrating across the US/Mexican border were mandated to take an HIV test. If they received a positive test, they would not be permitted to enter the country unless they were granted a waiver from homeland security. [CDC 2011] Since January of 2010, migrants are not required to take an HIV test. But it is unsurprising that this is a concern for some migrants, who may not know the laws, or rely on stories from family members who crossed long before 2010.

The issue of stigma has arisen again and again in the data, in regard to Latina migrants accessing sexual and reproductive health. But it is not only the stigma that prevents women from seeking health care, it is also the lack of information. Leti says that

many undocumented women do not see a difference between immigration enforcement and social service programs. This causes them to be afraid of even seeking medical care at all.

“The important thing is to let them know that no one can be denied health care, whether they have citizenship or not,” Leti explains. “But many women do not know this.”

Paola came to the US fourteen years ago, and after a challenging pregnancy in which her son needed special medical attention, paid thousands of dollars because she was not educated on how to navigate the healthcare system. Now she is an active member of her community, hoping to educate other women who have recently migrated in accessing social service programs.

“Many migrants are afraid of being deported and having any contact with immigration officials,” she said. “This keeps them away from a lot of events where they can learn about services.”

According to the Latino Community Needs Assessment (LCNA), 49% of participants were not able to vote in the 2016 presidential election. This means that it is likely that nearly half of all participants are undocumented. Moreover, since participants were located at community groups and events, it is likely that a large part of the Latino population is further removed from services, isolating them from potential community support.

“A big part of it is feeling safe,” said Erica, the HSU student. “[A migrant woman] could probably go to the student health center, or to Planned Parenthood, but it’s

just a matter of feeling safe. Because they constantly feel vulnerable.”

Xochil’s thoughts reflected much of Paola’s experiences- that a lack of understanding of the health care system could cause some undocumented folks, or people in general who have migrated, to spend large amounts of money on health care.

“The president who has been elected has expressed so much racism and hatred towards us,” she says. “Which causes people to draw away from services such as Medical, Cal fresh and other basic need services. They are fearful that [if they have] undocumented status, they will be linked to deportation.”

Racism is also an issue in Humboldt County, and more specifically in the Eel River Valley, as mentioned before at the Centro Del Pueblo meetings. Of course, racism can play out in many ways- from outwardly hateful treatment, to passive housing and job discrimination, and even well-meaning but culturally ignorant questions.

Maribel has been in Humboldt County since 2011, but lived in a different county before that. She states that she arrived knowing some English and had her paperwork in order. Her story of leaving Mexico involved a lot of trauma, and upon arriving in the states she actively sought out birth control, knowing that she wasn’t ready to have children.

“Growing up in Mexico, I was tired of seeing so much corruption and garbage and shit, not only from the government but from the people around us,” she stated. “A lot of people [in this country] say that Mexicans come here and take our jobs and use our social services, but I’m just trying to do the best I can.”

While Maribel doesn't feel like she has experienced any outward racism directed at her, she does feel that there should be a stronger Latin community.

"Sometimes people say to me "Do you want to go out Salsa dancing?" And I know it comes from a good place, but sometimes I feel like, why? They think that because you are from a different culture you are exotic or something."

Students also have reported feeling racism against them on campus. The Latinx Center for Excellence held an event in which 50 students were in attendance. When the students broke out into groups, they listed the five barriers to student success. Most of the themes that arose were related to racism. These included lack of ethnic diversity, micro aggressions, tokenism, mental health support and cost of living.

One student even said that going out into nature, while something she was excited to do when she moved here, now scared her after going to a party at a friend of a friend's house in Southern Humboldt.

"He was talking about Mexicans in a derogatory way," she stated. "I'm light skinned so he didn't know that I'm Mexican, and he was shooting a gun. He was saying that he was joking, but he was really being derogatory. I was afraid to speak up."

The fear of being deported has permeated the realities of many Latin Americans in The United States, affecting their friends, families and neighbors, as demonstrated through both the narratives and the quantitative data discussed in this chapter. Racism and the fear of deportation has appeared as the ground work for many of the other barriers discussed in this paper, a foundation built of social isolation and distrust that pushes migrants away from important available services, and may work to keep them



ignorant of their rights.

No hay nada mas parecido a un machista de derecho que uno de izquierda: The Burden of Gender Inequality and Sexualized Violence

The famous Spanish saying, “No hay nada mas parecido a un machista de derecho que uno de izquierda”, or, there is nothing more similar to a right-wing chauvinist than a left-wing chauvinist, is seen spray painted on walls all over Latin America. The message is powerful, simple and true- it doesn’t matter what your political beliefs are- if you are a man who doesn’t respect women, then you are a male chauvinist.

While machismo translates directly to ‘male chauvinist’, I have chosen to keep the word machismo for this section. This is because the frequency which ‘machismo’ is used, and the conviction of which it is spoken about, seems to give it a multi-layered meaning, tied to histories of pain and colonization that the phrase ‘male chauvinism’ doesn’t have. Specifically, it is rare that the word ‘chauvinism’ is used- in United States media the words sexism and misogyny are more common than the word chauvinism, giving the Spanish word machismo a certain dimension that is culturally specific. The way machismo has been used by participants, and in various forms of Latin American media, encompasses the epidemic of femicide, believes that women should remain in the home, male dominance, and all contexts between. Its like an important word, thus, to categorize the many experiences of my participants.

Of the fifteen participants interviewed, eleven mentioned machismo or gender based violence as barriers to reproductive health access, or simply for health care access in general. Moreover, mental health issues were mentioned alongside of this, including

trauma from witnessing or experiencing violence. For this, machismo is in many ways, just as impactful a barrier for Latina migrants as fear of deportation. It creates a shaky foundation in which other issues can easily grow; it can permeate all things.

In Eureka's Jefferson Center, an old abandoned elementary school turned community center, a popular ESL class is flourishing, perhaps due to its kind and passionate instructor Mary Ann, who regularly works to connect her students with community resources. Because of funding, the class is free, and well attended by many families. Each week presenters come to the class, to talk about issues and resources in the community.

"Every Woman Counts" is an organization working to spread awareness about breast and gynecological cancers affecting women. This particular night, a workshop is given by a facilitator to a packed room of mostly women, and some men. Children come in and out, many of them being cared for in the next room by young volunteers. Since it is an ESL class, the presentation is in English, while an educator from Paso a Paso translates.

When the facilitator explains the process for women to get breast exams, discussing the need for women over 40 to be checked, a couple of the women speak up about their concerns with their doctor, one who says that she has pain in one breast that her doctor has repeatedly told her not to worry about.

Approaching the woman later, she agrees to meet another time to talk about her experiences. She is eager to share her thoughts and feelings about the doctors in Humboldt County who she feels do not listen to her.

“I have gone to doctors, but they tell me I’m ok. I have headaches that cause me so much pain that it worries me it might be a tumor. They say that it is stress and that it will pass. “

Adela has lived in the United States for 14 years. When she arrived with her young son in 2004, she was escaping interpersonal violence. The pains in her body, especially in her head and her breast, were places in which her ex-husband had caused her physical trauma- kicking her, breaking bottles over her head, even hitting her with a hammer. The violence started at age 17 when she married him. He beat her because she had a child at age 14, taking her out to the woods or locking her in a house so others would not hear her cries. She didn’t go to the police out of fear, and the abuse her husband inflicted upon her was often in isolated places where others would not know. The details that Adela explained of years of physical, emotional and sexual abuse were severe and traumatizing.

Coming to the United States in 2004 was her way of escaping the abuse that her and her son faced. He experiences mental health issues and trauma, she says, but hasn’t ever received psychological help. Her ex-husband came to the United States in 2009, first promising to change and treating her well. When his behavior became abusive again, she felt empowered this time to leave him

“I felt comfortable in saying “If you treat me badly, I will tell my family”,” she said. “I felt supported, connected and brave. But I never made a police report. I didn’t feel comfortable reporting him because of the kids, I didn’t want them to blame me.”

Adela had sought psychological help, but didn’t feel it was helpful because it only

stirred up her feelings about the past. She said that still she suffered pain from where her ex-husband had kicked her and hit her with bottles, even having lost sleep the night before.

Although Adela was still affected by the trauma of her past, she was now connected with resources- she attended the ESL classes at Jefferson School and was receiving services from Paso a Paso and Changing Tides. This helped her gain a sense of community, as she explained above. The abuse she explained having to endure in Mexico happened because she was isolated, and here she felt comfortable reaching out and attending community events.

Other participants discussed more subtle ways that machismo had affected their lives, and the lives of women in their families and communities. Andrea had a lot to say about the machismo, both in Humboldt County and her home country of Mexico.

“A machista is a person who thinks he is absolutely right in every way, who is very aggressive with his partner and his children. A machista thinks his male children are better than his female children. He thinks that his female family members (daughters, wife, mothers etc.) should be working for him, and that they need to work in order to gain his respect.”

She added. “The male has this mentality over women that he is allowed to subordinate and hurt us. They think we aren’t worth anything, but they are wrong. We are very strong.

Maybe not physically but we have a desire to fight for ourselves. We take care of the

children, the house, we work.”

Xochil spoke with conviction about her belief in the strength of women, despite many beliefs that they have that they need to stay with their man. “We are talking about the systemic sexism that happens in our culture, being afraid to call the police in our political climate, not knowing how to access services. Also going to court is a huge challenge; there is a lot of isolation and depression in our community.”

“We are resilient. Latin people are resilient. There are barriers and they are part of our experience, but a lot of women are capable of being strong and leaving these situations. The acceptance of violence as the norm is part of machismo; it is part of the patriarchy.”

Much like Adela’s story, Xochil reflected on a woman she knew who didn’t know she was in a domestic violence situation because she thought of it as the norm, and had never realized that this wasn’t the way that men should treat women. Eventually, she was able to step out of the relationship as she came to terms with the violence.

Adela, Kelly and Maritza all mentioned that they perceived Humboldt County, and the United States in general, as a place in which speaking out and asking for help in regard to interpersonal violence is more accepted and more of a possibility than it is in their home countries.

Maritza is a woman who migrated from Central America when she married an American man. She said even as a child she knew she was different from how it was culturally expected that she be; she never wanted children, and when coming to the United States, felt passionate in finding work in women’s health and rights. She is now

studying to be a nurse, so she can educate women on their health.

“They are afraid, they don’t want their husbands to know [they’ve asked for help] and become more violent,” she said. “I think it happens to migrant women more than women who were born in this country. I come from Honduras and it’s different. I didn’t know I had rights. Here it is more open, I can say more about how I feel.”

Raquel also talked about how parents’ unwillingness to talk to their children about sex and relationships was rooted in machismo- how more conservative parents’ attitudes about their daughters’ sexuality was radically different from that of their sons. She stated that when young girls became pregnant, this often meant losing support of their families, both emotionally and financially, and the girls would end up going to live with their boyfriends, who they would then depend on.

“Girls in Junior High are even at risk,” she explained. “There’s a lot of pressure from boys who say things like ‘if you don’t sleep with me that means that you don’t love me’. And because the girls don’t have information they end up pregnant very young. This affects their futures with work and school because they don’t receive the same support or opportunities when they are taking care of babies.”

Machismo, since it functions as a foundation for many barriers that women experience, was also applied to women having reproductive control of their bodies, and to border crossings and immigration. Leti, who before working in healthcare in Humboldt County, had worked as a nurse in Mexico, talked about how machismo acted as a barrier to reproductive health.

“Machismo is very integrated into our culture,” she stated. “Many women come

here already pregnant, or they become pregnant while they are here, and the men want them to continue having babies because he is the head of the household. If they say they want five or ten kids, the women may disagree but she doesn't feel she has the right to make decisions about her body. [Some] men don't let their women get their tubes tied because they want to be in control of their bodies. This is a form of domestic violence.”

Leti also talked about how women had come to her, afraid that they had an infection because they suspected her partner was cheating. If she asked him to wear a condom, he would become angry and accuse her of being with other men.

“They completely change the story and blame the woman,” she said. “I constantly hear these stories.”

She mentioned that during women's groups, women would share these stories, sharing a common fear of getting an STI and being blamed by their partners, even being beaten or kicked out of the house.

“This is one of the reasons that myself and other female health educators are fighting for these programs, so we can educate women about their rights. How can we avoid all these problems and fight machismo and the misunderstandings that men have about women?”

Graciela also works in health care, has had many experiences working with Spanish speakers who don't speak English well, as being fluent in Spanish and being born in Mexico allows her to forge trust and build rapport.

“I had a patient come in just last week, and she was filling out an assessment form that asked about STDs. She lived in Mexico, her husband used to come home after work

dirty and force sex on her.”

The patient had expressed worry that her cervix and vagina had been damaged. “A lot of it comes down to them not being educated, and not knowing where to go to ask for help.”

Xochil mentioned that often times women are responsible for taking care of the children while men are at work. Since many families only have one vehicle, the men are usually using it, and since the women may be at home with young children, leaving the house to go to a medical appointment could be a challenge.

She also brought up the issue of violence on the US Mexican border. There are many statistics which discuss the prevalence of sexualized violence against women on the border, and nearly all state that over half of women have some type of experience with assault. In a report by Amnesty international, 60% of female migrants experience sexualized violence while making their journeys across the border. [Pickering and Cochrane, 2012]

“A lot of families who come to the United States are brought up here from Mexico on buses in our fields,” she said. “[There are] experiences during migration in which a lot of women are getting sexually assaulted [and ending up with] an unwanted pregnancy. Many of the women chose to keep the baby whether that be cultural or religious.”

The strength of the participants willing to share their thoughts and experiences with violence is immeasurable, and perhaps more importantly, reveals that while their



transits across the border may have been traumatic, their journeys have in the end, led them to a better place in which they feel empowered to uphold their, and often their children's safety. While violence against women, sexual assault and institutional sexism remains a serious issue in the United States, the majority of participants expressed a feeling of openness here, which has fostered a recognition of unhealthy and destructive gender norms, and the confidence to challenge them and protect themselves and each other. In addition, the conviction these women have in supporting their community and helping each other is an important dimension to these conversations.

### Al Tiempo Malo, Buena Cara: Language and Cultural barriers

According to The Migration Policy Institute, 61.6 million families speak a language other than English in their homes [ US Census 2013] Of those classified as having Limited English Proficiency [LEP], 81% were foreign born. Spanish speakers make up the majority of LEP individuals, at 62%.

When I first moved to Oaxaca, Mexico, in 2012, I was lucky to have a conversational level of Spanish. Despite my ability to communicate at this level, moving through life was often absolutely exhausting, causing me to some days not want to leave the house, feeling anxious about speaking incorrectly or using the wrong words, feeling like every time someone gave me a confused look, or even laughed at me, I had failed to learn. This led to feelings of shame.

However, I was lucky- I had the time and resources to learn to speak more clearly, and even more importantly, I quickly connected with a community who were open and eager to teach me their language, and see the challenges I had when expressing myself as only a small hindrance in having me as a friend. The people I grew close with were some of the most generous, kind, and compassionate people I have been privileged to know, and without them I would not be a Spanish speaker today.

However, for many Spanish speakers, their experiences have been quite different.

For example, in many public institutions like banks, schools or grocery stores, there may not be a Spanish speaking person on staff, or not more than one. Moreover, for me as a native English speaker, I have the privilege of knowing the most powerful language in the world, one in which many people in other countries strive to know. In the

United States, the teaching of foreign languages in most public schools and universities is not a requirement, unlike throughout much of the world, where learning English is considered a necessity.

This section will cover not only the mentions of language barriers, but of cultural barriers as well. Of my 15 participants, only three did not mention language or cultural beliefs as a barrier to accessing sexual and reproductive health (80%).

When working in the clinic, both the receptionists were native Spanish speakers, and normally, two Spanish speaking health educators were available to translate for the clients who only spoke Spanish, or who had limitations with their English. However, on days in which all of these people were busy, the nurses would often call me to come translate.

Without a bilingual person available to translate, important health information was often lost. One older couple, for example, regularly brought their adult daughter to translate the doctor's information. Myself or another Spanish speaker were asked to attend the appointments when the doctor began to believe that the daughter was not actually translating correctly. As one of the Spanish speaking health educators explained to me, this was a common situation, in which the adult children of older parents often told them what they wanted to hear. That the elders often cared more about being and polite to the doctors than actually hearing about their health issues. And often when they did want to know, their children didn't always understand the medical terminology to make a proper translation.

Carla is a Fortuna resident who has lived in the United States since 2006. Her

English is limited, but she took part in the free ESL classes offered in a Fortuna community center. Mostly she talked about the pregnancies of both her children, and having had good experiences in the hospital. The issues she complained of- long wait times, pharmacy mistakes, lack of medical coverage for certain services, are common problems related to being in an isolated, rural area with few medical services. But she did talk about how people just arriving, who don't know anyone in the community and don't know English, would have a very hard time finding resources.

“Sometimes they don't have employees who understand Spanish. I've been [to the doctor] with my mother in law. There was someone who spoke both English and Spanish that came with us. But other times I've had to bring one of my children to translate because there wasn't anyone else there to help.”

Victoria was another participant who is involved in the Paso a Paso women's group. She talked about how her main barrier to accessing services and building trust with health care staff was their inability to speak to her in Spanish, or worse, their lack of patience with the language barrier.

She talked about having an infection during labor, and being asked to sign documents in English without proper translation. “I had to sign so many things, and thank god I didn't have to pay anything. But I didn't know that then. We are in pain, we are not reading anything and we don't know what is happening.”

Maritza has had experience in women's health during her time studying to be a nurse. Being the only Spanish speaking staff limited her abilities to help the women who came in. “I was working but I could only do one at a time. Some would have to wait on a

phone line. That's so detached. I wouldn't even want to be there if I had to talk on the phone with someone.”

On the plus side, two participants, Leti and Cecilia, stated that having Spanish speaking health care workers available had drastically improved the situation with access in SRH.

Cecilia had gone to the Latino Health Fair (Festajando Nuestra Salud) in October of 2015.

“There was an American who spoke really good Spanish,” she said, regarding the Planned Parenthood table. “I wanted to find out about the IUD and he explained everything well. His Spanish was great and he was young and professional and attentive.”

She remained hesitant to get the IUD due to her fear and anxiety, but a year later finally decided to go in. While her experience physically with the IUD was difficult, her experience navigating the system with Planned Parenthood was positive. While she knows some English and can get by, she prefers to speak in Spanish when it comes to matters of health. When she asked to speak in Spanish, there were three or four people there who could help her.

“If I hadn't had that experience with that man, then I probably never would have gotten to know Planned Parenthood. I never expected that an American, a white person, would approach me speaking perfect Spanish. It surprised me so much. It was so much dedication that they put into reaching me.”

Leti also talked about how much things had changed since her arrival in the

United States. “Now we have more help, but before the help didn’t exist. Now we have more health care staff that are bilingual. I say this from my experience; when I came here I spoke very little English. When I was trying to raise my kids, and get my family planning services, it was very hard speaking no English.”

“Language, for me, is the biggest barrier, because they need information about their health. They need to feel like they are well-received in a new place. It’s really frustrating when they are looking for help and there isn’t anyone who speaks their language and can help them. There are questions which aren’t very understandable. For us it’s easy but for them it’s difficult. Some of the questions are complicated. There are a lot of words that women might have learned in Mexico that aren’t used or translatable here.”

Leti expressed what many participants expressed- that language alone is not enough connect services to Latina migrants- it takes knowledge of the culture as well. “Not only is it important to speak Spanish, but to understand the culture as well. I understand these women and their experiences because I have had similar ones.”

“Women come here with their old ideas and practices from their countries which includes false ideas about pregnancies and dangerous abortion methods,” she explains. “There isn’t anything like Planned Parenthood and women just have kids without thinking about how many they can support, because of the lack of information. So in an area like Humboldt they come here and think that it’s culturally the same.”

In Mexico, abortion is illegal, and in some states, a criminalized offense. This excludes Mexico City, where abortion in the first 12 weeks became legal in 2007.

[Becker 2013]

“Many women traffic medicine,” Leti says. “For example, if they want to do an abortion or something, they will go ask someone who brought these pills or they will return to Mexico to buy the pills. It could work but realistically, there is a chance it won’t. They need a better option. They don’t realize they can go to a doctor and take a safer route for their wellbeing and the baby’s but a lot of them prefer to take a medicine that comes from Mexico, or a traditional abortive like herbal tea. This worries me because I have seen that happen, and it still does. They often ask their aunts or neighbors in Mexico if they have any abortive medicine.” Some participants also commented that religious beliefs are a barrier to birth control. Xochil talked about how many myths existed in Latino communities, especially regarding birth control. One was that women believed that if you were breast feeding you could not get pregnant.

Stigma is also an aspect that appeared frequently in this research- often stigma attaches itself to other factors, such as religion, gender or mental health issues. Graciela stated, “I think that in the Latino Community it’s really shamed upon, if you are seeking birth control or something preventative. People are really closed minded, they don’t like to talk about it. I think they believe and know of no pre-sex marriage, so they think ‘you can’t do anything so you can’t learn about it until you are married’. But that isn’t always the case.”

Andrea had a lot to say about mental health issues, such as post-partum depression. She also attributed self-stigma as a reason why some women don’t access services. “The barrier is more mental. They are very closed minded to the idea of sexual

health; it's a big taboo because of religion, so they don't learn about protecting themselves. Some women, they think that if they get pregnant many times that it is a gift from god, so birth control would be ungrateful."

"In Mexico, there isn't really a culture of talking to your children about sex," she added. "It took me a long time to learn about sex because there weren't modes of communication around it in my small town. So, when you come here, it opens your eyes a lot. There is a lot of information, the world is open."

Maribel, having arrived in California with her papers and marrying an American man, expressed feeling that she didn't feel very connected to Humboldt's Latino community. She said when she first arrived, she had to adjust to the openness around sexuality, having come from a small village.

"A lot of people just choose not to reach out. Asking for help is hard because they are afraid, one of the things about Latin communities, people worry about what friends and family think. There is always something bigger than you. "

Maritza also had to adjust when coming to California from Honduras. "We are more related to family. Having a kid is something to make you get up every day, instead of just being alone. In Honduras, it is not looked down upon for a girl to have a child. In the US, it is. Here it's more about education and finishing college and having a kid gets in the way. But in my country, it's part of life. It's easier for them to have a kid because they receive family support."

In regard to having trust built with a medical practitioner, Maritza talked about how in her home country, it was not uncommon for a community to have the same doctor for



their whole lifetime. Here, medical practitioners come and go, making it harder for them to build trust when discussing their health.

Cultural barriers and misunderstandings have also been tied to mental health issues. Rebeca was a woman attending the ESL class, who had a lot of questions about resources in the community. Her struggle was mostly related to fertility, and how many troubles she had finding doctors in Fortuna who would help her become fertile. She was able to have one son, but due to health issues, has not been able to have more babies. When she went to a clinic to talk to them about treatment, they told her to wait longer and to pray. She tried medicine following her difficult pregnancy, but it only caused her more pain.

“I had so much anxiety and depression that I hallucinated,” she explained. “The pills were supposed to make me feel calmer. I ended up in the hospital for almost three weeks. When I go home, I stayed in bed for a month. My spouse had to stop working to take care of me.”

In the women’s groups held by Paso a Paso, many women mentioned cultural barriers and issues with isolation and mental health. Jessica, one of the leaders of the group, talks about how May is mental health month, and they want to beat the stigma of talking about mental illness in Latino communities.

“Half of all adolescents suffer from depression or another mental health issues,” she states. The women seem concerned, one asks how to talk to their teenage children to see if they are ok.

Jessica adds, “One out of every seven mothers suffers from post-partum

depression. For us Latinas, it's one in five.”

Andrea also mentioned post-partum depression. “There is a taboo, a fear in this, because they don't want to have their children taken away from them. A friend had depression during her pregnancy. She yelled at her daughter and felt terrible. But she didn't ask for help, because she didn't want to have her children taken away from her.”

Being in a new place, with different customs, and a different language, can be an extremely isolating experience. For this, the forging of connection is important, cross-culturally. One evening during a healthy cooking class for Spanish speakers, run by the health educators at a local clinic, an older woman turned to one of the educators, and in reference to me, said “Why is she American, but her Spanish is so good?”

The educator nodded at me to answer the question, and I explained that I had lived in Mexico, and spent time working with immigrant families in the United States. But this interaction speaks volumes- the older woman hadn't felt comfortable asking me this question, so she turned to the native Spanish-speaking educator. These little things that can be done to make Spanish speaking folks feel welcome can bridge these gaps.

## VI. SUMMARY OF FINDINGS IN A LARGER CONTEXT

During the year and a half that I was collecting data for this research, a series of themes quickly arose, and remained, for the duration of the study. This includes the primary themes explained; fear of deportation, gender inequality and language and cultural barriers. These issues present as umbrellas for other overlapping issues such as mental health, racism and stigma. Each one of these issues is intricately interwoven and it is often difficult to see where one ends and the other begins.

Intersectional theory addresses the ways in which people are disproportionately marginalized by race, gender and other aspects of their identity. The phrase was coined by Kimberle Crenshaw in 1989 to speak about black women in practicing law, and has since been taken on my academics in fields of women's and ethnics studies to expand to sexuality, class, ability, etc. [Crenshaw 1989] In the case of women who come from Latin American countries, the intersections of their identities include their gender, race, country of origin, and many times, their documentation status. This causes access to SRH services to be more a more complex process than it is for women who are white, English speaking, and American born. When speaking with white, US-born folks about my research, their responses were often to tell me that obviously, language was a barrier. It is true that access to proper translations is an important factor in access to health care. However, even as health care providers begin to employ more Spanish speakers in clinics and through health education and outreach, the population remains isolated. This is because looking at only language as a barrier of access when it comes to Latina migrants

is not an intersectional approach to understanding the challenges this population deals with in terms of accessing services.

Feminists theorists of the 1970s talked of ways in which American society had created norms and standards based on a hierarchal gender binary that put men in power over women. However, later on feminists of color, and intersectional feminists, criticized this form of feminism as short sighted of how issues like race, class, sexuality and ability were not incorporated into this idea of liberation. By the same token, the degree to which women in the study mentioned gender inequality and violence indicates that these issues are still very pressing today. The study does not include the voices of white, US-born women, so it is impossible to know what the similarity would be. However, the issues with gender inequality and violence expressed by the participants are also linked with language barriers, and/or fears of deportation.

Based on the research, for SRH and sex education to be intersectional and specifically inclusive to Spanish speakers, Spanish language services would always be available when needed, as well as knowledge of the barriers that may exist for the women seeking services. To truly carry an intersectional approach into SRH care, finding the time and the avenues for discussing and explaining SRH issues to Latina migrants is necessary to close the gap. As demonstrated in this research, the participants have faced many challenges during their experience seeking services- from lack of trauma informed care, to impatient healthcare providers who don't have proper translation. Barriers can also come from living in a rural area, or having children to take care of. In order to strengthen SRH services, practitioners should know the intersections of identity which

exist for their clients.

Medical Anthropologist Seth Holmes wrote an in-depth account of migrant workers in his ethnography, *Fresh Fruit, Broken Bodies*. After Holmes completed more than a year of ethnographic research working with a group of migrant farm workers coming from Oaxaca Mexico to work in strawberry fields along the West Coast, he came to the conclusion that “cultural competency” should be thrown out. This might be of surprise to many social scientists and medical professionals alike, who have long linked cultural competency to the understanding of cultural norms in order to serve disparate populations. However, what Holmes saw in his research, was that over and over again, cultural competency turned into bias and stereotyping, when medical practitioners were unable to view their subjects as whole people, affected by a system which systematically disregarded them. Cultural competency used alone, without a solid and in depth understanding of histories of oppression, inequality and colonization, fails to give practitioners the tools to fully reach and assist their patients. [Holmes 128]

To replace cultural competency, Johnathan Metzl, professor of Sociology and Medicine, coined the term “structural competency” in 2013. In the introduction of his paper, *Structural Competency: Theorizing a New Medical Engagement*, he brings the paper describing the challenges in cultural competency:

...the politics of the present moment challenge cultural competency’s basic premise: that having a culturally sensitive clinician reduces patients’ overall experience of stigma or improves health outcomes. Increasingly, we hear that low-income African Americans are unable to comply with doctors’ orders to take their medications with food, not because they harbor cultural mistrust of the medical establishment, but because they

live in food deserts with no access to grocery stores....These and other encounters suggest how the clinical presentations of persons at both ends of the economic spectrum are shaped by “cultural” variables, and also by the economic and political conditions that produce and racialize inequalities in health in the first place.”

He describes the five core competencies to structural competency: 1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating “cultural” formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility.

In order to fully understand the struggles of the Spanish speaking population, we must look at the intersections of barriers and identities that exist within the population. As revealed in the research presented, Spanish speakers have struggled with language and cultural barriers, institutionalized sexism, stigma, mental health, racism and fear of deportation. In addition, being located in a rural area, isolated from urban life, and with fewer Spanish speaking people, must be considered as a barrier. The intersectional identities and thus experiences of Latina migrants in Humboldt County are complex. For example, to only look at a Latina migrant woman as from a Latino group, and apply cultural competency to her, leaves behind her gender, her language, her experiences, her socioeconomic class, and her life in a rural area.

Much like it is mentioned by Metzler, areas considered food deserts often exist in both working poor urban areas and rural areas. A practitioner who lacks the understanding of these intersections will likely fail to reach this population with important and necessary information that can improve their lives. But in rural food

deserts, other issues must always be at play. And for Latina migrants, practitioners need to understand the many levels in which their access is effected, from transportation in a rural community, to mental health outcomes from worries over the presence of homeland security.

However, as stated by Leti, there have been improvements in the last fifteen years. This includes a higher number of service providers who speak Spanish, and Latino focused advocacy programs, such as Paso a Paso, the clinics Latino health educators, and a free ESL class. Planned Parenthood has also made great strides in having Spanish speaking staff on hand. And activist organizations such as Centro Del Pueblo has mobilized to fight for the rights of their communities.

As stated by many of the participants, there is a need for Spanish speaking people to go out of their way to reach Latina migrants and educate them on services such as Cal fresh, Medi-cal and Planned Parenthood, so that they can feel comfortable accessing these services, and do so with confidence. Andrea, Cecilia and Maribel were some of the participants who stated that due to Spanish speaking staff at health care organizations, they were able to leave their appointments feeling informed about their reproductive health.

It is also important for members of the non-Latino, US born community to make a point to reach out to Latino, Spanish-only communities. Folks like Mary Ann, who opened her English class to Spanish speakers free of charge, have succeeded in building bridges between Spanish speaking migrant communities and social service programs who have long struggled to connect with this community. Those who are English speaking and

not of Latino decent certainly play a part in creating an equitable society.

Structural competency is a methodology that should be adopted by medical practitioners. Cultural competency runs the risk of asking the migrant why they didn't go to the doctor sooner when they were sick, so they could have prevented their chronic illness. This is an example of blame, which furthers isolation and stigma. Structural competency, on the other hand, asks what the barriers were for the migrant to getting into the clinic, and how these structural barriers could have been mitigated.

As we move into a time where the United States increases in racial and ethnic diversity, it will be important for all individuals to take a more holistic look at individual identities, and how they interplay with histories of oppression and colonization, and a current climate of fear. Each of these factors displays differently in each person, and being to see people as individuals and not as members of certain sociocultural groups is an important part of creating equity in access and to empower communities.



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APPENDIX A : FORTUNA MIDDLE SCHOOL STUDENTS' UNDERSTANDING OF  
CULTURAL ATTITUDES ON SEX AND RELATIONSHIPS

Your child has been invited to join a graduate research study to look at what messages they have received about sex and relationships before they have attended their first sex education class.

Please take whatever time you need to discuss the study with your family and friends, or anyone else you wish to. The decision to let your child join, or not to join, is up to you.

In this research study, we are investigating the messages 7th grade students attending Fortuna Middle School have received about issues of sex, such as HIV/STI transmission, healthy relationships, consent and teenage pregnancy, outside of the public education system.

Specifically, looking at how variables such as language spoken at home, and country of origin, effect the students exposure to information.

WHAT IS INVOLVED IN THE STUDY?

Your child will be asked to fill out a short, age appropriate survey about what they understand regarding preventing and understanding sexually transmitted diseases,

pregnancy, sexual assault and dating violence. We think this will take him/her 10 minutes.

The survey is anonymous, so the answers of the student cannot be tracked back to the student. Therefore, your child's participation in the survey is low-risk. After completing the study, the anonymous data will be used for consideration in improving Fortuna Middle School's sex education classes, so to better educate children on issues of dating violence, STI/HIV and pregnancy prevention.

#### YOUR RIGHTS AS A RESEARCH PARTICIPANT?

Participation in this study is voluntary. Your child has the right not to participate at all or to leave the study at any time. Deciding not to participate or choosing to leave the study will not result in any penalty or loss of benefits to which your child is entitled, and it will not harm his/her relationship with his teacher or school staff.

#### CONTACTS FOR QUESTIONS OR PROBLEMS?

Call Corinna Irwin at (707) 407-6400 or [email ci15@humboldt.edu](mailto:ci15@humboldt.edu) if you have questions or

doubts about the study.

If you have any concerns with this study or questions about your rights as a participant, contact the Institutional Review Board for the Protection of Human Subjects at [irb@humboldt.edu](mailto:irb@humboldt.edu) or (707) 826-5165

#### Permission for a Child to Participate in Research

As parent or legal guardian, I authorize \_\_\_\_\_ (child's name) to become a participant in the research study described in this form.

Child's Date of Birth \_

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Parent or Legal Guardian's Signature

Date

APPENDIX B: ENTENDIMIENTO DE LAS ACTITUDES CULTURALES SOBRE EL  
SEXO Y LAS RELACIONES DE LOS ESTUDIANTES EN FORTUNA MIDDLE  
SCHOOL

Su hijo ha sido invitado a unirse a un estudio de investigación de posgrado para ver qué mensajes han recibido sobre el sexo y las relaciones antes de que hayan asistido a su primera clase de educación sexual. Por favor tome el tiempo que necesite para discutir el estudio con su familia y amigos, o cualquier otra persona que desee. La decisión de dejar que su hijo se una, o no a unirse, depende de usted.

En este estudio de investigación, estamos investigando los mensajes que los estudiantes de 7° grado que asisten Fortuna Middle School han recibido sobre temas de sexo, como transmisión del VIH / ITS, relaciones saludables, consentimiento y embarazo adolescente fuera del sistema público de educación. Específicamente, observamos cómo las variables como el idioma hablado en el hogar y el país de origen, afectan a la exposición de los estudiantes a la información.

¿QUÉ ESTÁ INVOLUCRADO EN EL ESTUDIO?

A su hijo se le pedirá que llene una encuesta corta y apropiada para la edad sobre lo que entiende acerca de la prevención y comprensión de las enfermedades de transmisión

sexual, el embarazo, la agresión sexual y la violencia entre parejas. Creemos que esto le tomará 10 minutos.

La encuesta es anónima, por lo que las respuestas del estudiante no pueden ser asociada al estudiante. Por eso, la participación de su hijo en la encuesta es de bajo riesgo.

Después de completar el estudio, los datos anónimos serán usados para considerar en mejorar las clases de educación sexual de Fortuna Middle School, para así educar mejor a los niños en temas de violencia entre parejas, ITS / VIH y prevención del embarazo.

#### SUS DERECHOS COMO PARTICIPANTE DE INVESTIGACIÓN?

La participación en este estudio es voluntario. Su hijo tiene derecho a no participar en absoluto o dejar el estudio en cualquier momento. Decidir no participar o elegir dejar el estudio no resultará en ninguna penalización o pérdida de beneficios a los cuales su hijo tiene derecho, y no cambiará su relación con su maestro o el personal de la escuela.

#### CONTACTOS PARA PREGUNTAS O PROBLEMAS?

Llame a Corinna Irwin al (707) 407-6400 o envíe un correo electrónico a [ci15@humboldt.edu](mailto:ci15@humboldt.edu) si tiene alguna pregunta o duda sobre el estudio.



Si tiene usted algun duda con este estudio o preguntas sobre sus derechos como participante, ponerse en contacto con el “Institutional Review Board for the Protection of Human Subjects” por [irb@humboldt.edu](mailto:irb@humboldt.edu) o (707) 826-5165

Permiso para que un niño participe en la investigación

Como padre o tutor legal, autorizo \_\_\_\_\_ (nombre del niño) a participar en el estudio de investigación descrito en este formulario.

Fecha de nacimiento del niño \_\_\_\_\_

Firma del padre o tutor legal

Fecha

## APPENDIX C: CALL FOR PARTICIPANTS

Ethnographic Examination of Latina Migrants Experience Navigating Healthcare in  
Humboldt County

Are you a self-identified woman living in Humboldt County who was born in a Latin American Country? Do you have something to share about sexual/reproductive health care in this area?

I am an Anthropology graduate student looking for narratives and thoughts from you regarding issues of birth control/abortion access, sex education, STI/HIV testing, cervical cancers, and sexualized violence or assault.

All contributions will be 100% anonymous and used for research purposes.

For more information, please contact Corinna Irwin, [ci15@humboldt.edu](mailto:ci15@humboldt.edu)

(707) 407 6400

## APPENDIX D: PARTICIPANTS BILL OF RIGHTS

Thank you for your help with this study! It will help understand what things are like for Fortuna Middle School students so we can better help support and educate you. This survey includes questions about your relationships, knowledge, attitudes and behaviors.

Your answers will be kept private. Do not put your name on the survey.

We want you to be honest. There are no right or wrong answers!

Please know that your participation is voluntary

You can skip any questions that you do not want to answer

The answers you give will be completely private.

Choosing to not take this survey will not affect your grades.

If you want to take the survey, you can rip off this page and begin

## APPENDIX E: QUESTIONS FOR HEALTH EDUCATOR

- 1) What has your experience been with working with Latino and Spanish speaking youth during your time working as a health educator with [omitted]?
  
- 2) Have you noticed any changes in this population during your time working with [omitted]? If so, what?
  
- 3) According to your experiences and perceptions, what do you think some challenges that youth coming from Latino migrant families have in terms of sexual and reproductive health resources and education?

## APPENDIX F : CONSENT FORM FOR ADULT PARTICIPANTS

(ENGLISH/SPANISH)

## Consent Form (English)

I, \_\_\_\_\_ agree to share my story and experiences with Anthropology graduate student Corinna Irwin, for the purpose of her thesis, titled *Ethnographic Examination of Latina Migrants Experience Navigating Healthcare in Humboldt County*. My story and experiences may be used to inform others of the current state of sexual and reproductive health in Humboldt County for Latina immigrants. Direct quotes from what I share may be used. This will be for the purpose of improving healthcare services for Latinas in Humboldt County. What I share will be kept confidential. Narratives will be conducted in Humboldt County, in a space elected by participant where they feel comfortable. The time needed to conduct this narrative will be as little as ten minutes, and no more than one hour. If narrative is used, names will be changed, only age, profession and general region will be included. Written data will be destroyed after it is compiled, and digital data will be kept in a password protected file.

The Investigator will answer any questions you have about this study. Your participation is voluntary and you may stop at any time.

Corinna Irwin ci15@humboldt.edu (707) 407-6400

Academic Advisor: Rebecca Robertson

Rebecca.Robertson@humboldt.edu (707)599-5608

If you have any concerns with this study or questions about your rights as a participant, contact the Institutional Review Board for the Protection of Human Subjects at irb@humboldt.edu or (707) 826-5165

---

Signature

Date

***Consentimiento informado (Espanol)***

Yo,\_\_\_\_, estoy de acuerdo en compartir mi historia y experiencias con Antropología estudiante graduado Corinna Irwin, con el objeto de su tesis, titulada *Etnográfico Examen de Migrantes Latinas Experiencia en Navegación de Atención Primaria en el condado de Humboldt*. Mi historia y experiencias pueden ser utilizados para informar a otros de la situación actual de la salud sexual y reproductiva en el condado de Humboldt para los inmigrantes Latinas. Citas directas de lo que comparto pueden ser utilizados. Este será el



propósito de mejorar los servicios de salud para las latinas en el condado de Humboldt.

Lo que comparto será confidencial. Las narrativas será conducidas en Condado de Humboldt, en cualquier lugar cómodo que esta elegido por la participante. El tiempo que se necesitara para conducir esta narrativa será por lo menos diez minutos, y no mas que una hora. Si se utiliza, los nombres serán cambiados, sólo la edad, la profesión y la región en general se incluirán. Datos escritos serán destruidos después de que se compila, y los datos digitales se mantendrán en un archivo protegido con contraseña.

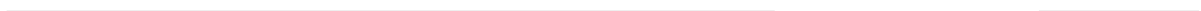
La investigadora contestara cualquier pregunta que tenga acerca de este estudio. Su participación es voluntaria y usted puede dejar de participar en cualquier momento.

Investigadora: Corinna Irwin [ci15@humboldt.edu](mailto:ci15@humboldt.edu) (707) 407-6400

Tutor académico: Rebecca Robertson

[Rebecca.Robertson@humboldt.edu](mailto:Rebecca.Robertson@humboldt.edu) (707)599-5608

Si usted tiene alguna preocupación o duda en lo que respeta a sus derechos con este estudio, contacte La Junta Institucional para la protección de los seres humanos por [irb@humboldt.edu](mailto:irb@humboldt.edu) o (707) 826 5165



Firma Fecha

APPENDIX G: ETHNOGRAPHIC EXAMINATION OF LATINA MIGRANTS  
EXPERIENCE NAVIGATING HEALTHCARE IN HUMBOLDT COUNTY

**Was this protocol registered as part of a grant submission?:**

No

**Proposed Start Date:**

Monday, February 15, 2016

**Principal Investigator:**

Student

**Responsible Faculty or Staff Name:**

Rebecca E. Robertson

**Responsible Faculty or Staff Department:**

Anthropology

**Responsible Faculty or Staff Email:**

[Rebecca.Robertson@humboldt.edu](mailto:Rebecca.Robertson@humboldt.edu)

**Responsible Faculty or Staff Phone Number:**

(707) 826-4342

**CITI Training Date of Completion:**

Sunday, January 31, 2016

**Student or External Name:**

Corinna Irwin

**Student or External Department:**

Applied Anthropology

**Student or External Email:**

ci15@humboldt.edu

**Student or External Phone Number:**

(707) 407-6400

**CITI Training Complete:**

Yes

**CITI Training Date of Completion:**

Wednesday, January 27, 2016

**Purpose of Project:**

Graduate Research

**Do you or anyone else plan on disseminating the information acquired from this project outside of the specified course classroom or the University? (Please check “yes” for dissemination if you are conducting research for a thesis that will be published on Digital Scholar.):**

Yes

**If Yes, please explain:**

This project will consist of data collection from February-May 2016, and I hope to use it to augment a thesis around Latin American migration, sexual and reproductive health and structural competency in Humboldt County health programs.

**Assurances:**

Ensuring the quality and accuracy of the written materials included in the Application for Review;

Ensuring Human Subjects in Research Training for all personnel who may interact with human subjects or have access to subjects' information or responses;

Supervising the conduct of research protocols submitted under their direction;

Ensuring compliance with all federal, state and local regulations, as well as Humboldt State University policies regarding the protection of human subjects in research;

Adhering to any stipulations imposed by the Humboldt State University IRB;

Ensuring that permission from outside institutions (e.g., tribes, hospitals, prisons, or schools) is obtained, if applicable;

Retaining all research data, including informed consent documentation of participants, in accordance with institutional, local, state and federal regulations;

Reporting to the Humboldt State University IRB immediately if there are any adverse events and/or unanticipated problems involving risks to subjects or others.

**Lay Abstract:**

Rural counties often struggle with issues of access and delivery when it comes to health services. Humboldt County has been a traditionally white, working class economy, dependent on lumber and fishing industries to support its population. In the last thirty years, a shift has been made away from these industries and towards an underground drug economy, which has caused both funding for social service programs, as well as the health and wellbeing of the citizens, to suffer. Humboldt County also sees a growing Latino migrant population, both from other parts of urban California, and from South of

the border. Many of these migrants are undocumented and do not know English, and women and children from this population may especially be effected by local policy and systems, due to gender and age disparities. This ethnographic study aims to examine Latina migrants in Humboldt County, and their experiences navigating the healthcare system especially in terms of sexual and reproductive health. The narratives and observations will be collected in order to better understand the existing structural barriers and how they effects these individuals.

**Type of Data:**

Interview

Observation

Secondary/Existing Data or Records

**Sources for data or records::**

Census, Department of Public Health, California Center for Rural Policy

**Type of Subjects:**

Latinas residing in Humboldt County

**Estimated Number of Subjects:**

10- 20

**Expected Age of Subjects:**

18-50

**Approximate total time commitment required from subjects:**

10 to 60 minutes

**Will subjects be Compensated?:**

No

**Description:**

Humboldt County is a rural county in Northern California with a population of 134 thousand. Historically white, in the last twenty years it has seen an influx of ethnically diverse populations, specifically Latin Americans, who now constitute at least 11% of the population. [Census 2012] Rural counties such as Humboldt often struggle with poverty related to geographic isolation and lack of access to adequate resources. Since migrants generally live in poverty, often with unreliable sources of income, they may suffer more stress and food insecurity, as well as facing unequal treatment and potential threats of violence or lack of safety. Studies have shown that these factors contribute to Latinos having higher rates of preventable, chronic diseases as well as young Latinas having higher rates of experiencing sexualized violence and unwanted pregnancy. [Vega, Rodriguez & Gruskin; 2009] Limited English language ability, and a lack of translators could be included as further barriers to accessing services. In rural Humboldt, lacking a strong cultural community, could also contribute to health disparities or social isolation. As studies of health disparities in urban Latino communities are ample, there is less research on rural communities. This ethnographic study will aim to examine the life of Latina migrants living in Humboldt county, through participant observation, narratives, pre-existing statistical data analysis and literature review. My research question is focused on better understanding the local barriers that exist for Latina migrant women in accessing sexual and reproductive healthcare. I will be conducting a literature review to put migration and health care in Humboldt County into a larger context, by studying

sexual health disparities on the US/Mexican border from an anthropological perspective. Through this analysis, I hope to conclude that health disparities in Latin American migrants exist in rural communities, but appear differently than they do in urban centers. I hypothesize that these same health disparities exist in rural Northern California, and that Latina migrants remain an isolated population from accessing services, although great efforts are being made in regards to networking social and health service organizations to include this population. I will also be using this study as a case study to further discuss the idea of structural competency, which is about looking at how systems have historically excluded and promoted violence towards certain populations.

**Recruitment and Selection:**

Research participants will all be adults of sound mind, 18 years and older, of Latino/Hispanic descent and residing in Humboldt County. Research participants will have been born in a Latin American country, may or may not speak English, may or may not be documented citizens of the US. I will be conducting participant observation at public health fairs and other public community events. I will also be asking participants to share narratives. Participants who consent to give narratives regarding experiences in sexual and reproductive health may do so in English or Spanish, and they must be women or female-identified. I will also conduct participant observations during meetings consisting of Latino health and service providers, in order to better understand the interventions being made towards this population. Since I am currently working in Open Door Community Health Center in Eureka as a Health Coach, and with the Breast and GYN Health Project in Arcata as a Spanish Speaking Community Liaison, I have access



to participants, but will not want to affiliate my research with my roles in these places. Therefore, I want to use these avenues to establish connections but present myself and my research in an outside forum. I also plan to conduct participant observation and look for participants to research in areas of the County where Latinos tend to live, work and congregate. To show respect, I would like to frequent these places first, participate in the activities that potential research subjects are doing, and hold casual conversations. I plan to do this to show my sincerity in working to improve avenues of inclusion in these communities, listen to linguistics of speech, which could perhaps improve word choice on future surveys. My introductory wording will be as follows: "Hi, I'm Corinna Irwin, a graduate student of Applied Anthropology at Humboldt State University. I'm also a native of Humboldt County. I'm working on a research project to help understand the barriers Latina migrants face when accessing healthcare. I'm especially interested in sexual and reproductive health care. I'm doing this in order to try to improve the healthcare programs that already exist in the County. If you have a specific experience you'd like to share with me that I may include, I would love to speak with you more. Also, if you know someone I should talk to, I would be happy to meet with them. All the information you share with me will be kept confidential, and if used for publication, all identifiers will be removed." I will also be able to explain this in Spanish, as I am bilingual. If the participant wishes to share their narrative, I will give them a copy of a consent form, stating that all identifiable information will be removed if used. The form will be available in English and Spanish, depending on the language of preference of the participant.

**Types of Vulnerable Subjects:**

Not applicable to this project

**Documentation Type:**

Informed Consent : is written in language that is understandable to the subject or the legally authorized representative.

**Consent Process:**

If someone is interested in speaking with me, and sharing their narrative, I will both explain and provide a written explanation of the project, the research objective and the justification. This document will be written in both English and Spanish, both in language that someone with an eighth grade education can easily understand.

**Methods:**

This study is an ethnographic examination, as it will rely heavily on data from participant observation, unstructured interviews, and participant narratives on experiences with services in regards to sexual and reproductive health. The qualitative data aforementioned will be augmented with pre-existing statistical data. I will also be conducting a literature review using local Humboldt County research from the last ten years that touch on social determinants of health, sexual and reproductive health and/or Latin American immigration, in order to include and consider the work done by researchers before me. I will also be including studies done in urban and border areas regarding these subjects in order to put my ethnographic study into a larger context. Because of this, I would say that a theoretical framework of my project will be post-structuralist, although I want to focus more on empirical data than theoretical frameworks. In addition, an intersectional theory

will be considered, due to the complex identities of my participants. Participants will all be female-identified, of color, migrant, and do not speak English as a first language, therefore it can't be denied that the challenges faced are multifaceted and intersectional. Communicating theoretical frameworks to my participants will not be necessary, as long as I communicate with them a sense of respect and a commitment to privacy and informed consent.

**Benefits:**

While I won't be providing participants monetary benefits, the purpose of this study is to gain information from the Latina migrant community that can be used to help improve sexual and reproductive healthcare services and interventions. I will be transparent with my participants that the information I collect from them could possibly be used to educate others on the importance of including migrant stories in healthcare policy.

**Potential Risks:**

I believe my project will be relatively low-risk. This is because it will be based heavily on participant observation, pre-existing statistical data, and literature review. The most potential risk lies in the narratives and/or unstructured interviews I will be collecting from participants. For example, part of sexual and reproductive health deals with sexualized violence and interpersonal relationships. There is a possibility that these issues could come up in an interaction with a participant. In this case, I will make sure to have bilingual community resources available that the participant may contact for support. Likewise, discussing health issues can bring up health concerns. Since I am not a medical practitioner and cannot legally give medical advice, I won't be able to help them with any

medical concerns, but again I can prepare for this potential challenge by having plenty of community resources available to provider participants with outside support. Finally, my affiliation with two local health organizations, Open Door Community Health and The Breast and GYN Health Project, could confuse my role as a graduate student researcher. Although the research I will be conducting is not affiliated with either of these organizations, it is a small possibility that participants living in this rural area may associate me with one of them. This could cause their narratives to contain some influence regarding services they have received or experiences they have had from one or both of these organizations. Although my involvement in the healthcare community could help me to easily build rapport with participants, it could potentially blur boundaries and understandings of the research. The best way to mitigate this is to be very transparent about the research objectives and lack of affiliation between myself and the other organizations in this project.

**Risk Management Procedures:**

I have previously mentioned that informed consent and confidentiality will be very important for this study. As a researcher who wants to complete this study in order to improve health systems and interventions to this historically excluded group, it is a top priority of mine to respect the rights of participants. For this, as previously mentioned, I will approach my research subjects equipped to refer them to necessary community resources who can further support them. Providing both verbal and written explanations of the project, and contact information so they can follow up with any questions, will be necessary for creating transparency. Above all, treating participants with respect and

gratitude for sharing their stories will be an important part of supporting the participant and building rapport. I believe that as I begin communicating with potential participants and collecting data, it will become more clear in which ways I can properly support them and identify potential risks that may arise early on so that they don't grow into bigger issues.

**Anonymity and Confidentiality:**

In order to keep the identities of my participants confidential and safe, I will need to omit certain details. First of all, I may refer to participants with pseudonyms or quickly refer to them by one characteristic, such as their work position or country of origin. However, even in these two examples, referring to someone by their profession or country of origin could violate privacy. For example, if in my sample I only have one woman from El Salvador, and I find in statistical data that there are very few people from El Salvador in Humboldt County, I may need to omit this detail. I want to identify the regions where my participants reside, which I think is safe if they are from Eureka, a town with a population of 30,000. However, much of my research will come from the Eel River Valley, a region of Humboldt consisting of many small towns of a population of 1,000 or less. In this case, revealing the specific locale could be too risky for complying to confidentiality, so I would say just that the participant lived in the Eel River Valley region. The same goes for occupation- I would like to specify the occupation held by the participant, but if the combination of occupation and locale is too specific, the final analysis will have to be changed.

**Data Storage, Security and Destruction:**

In regards to records of data collected, they will all be digitalized and kept in a password protected computer folder. Consent forms will need to be kept until after the work has been finalized. All documents, including names and contact information of participants, will be kept in a locked file cabinet in the researcher's home or an office in the department of Anthropology at HSU. When the project is complete, all files will be deleted and physical documents shredded. I plan to have this project completed by June of 2016, so by this time measurement, all will be destroyed within this timeframe.

**Informed Consent Storage:**

Written informed consent forms signed by participants will be kept in a locked file cabinet in the Department of Anthropology for 3 years after the completion of the research. Digitalized informed consent forms will be kept in a password protected file with all other data regarding the study and will be deleted upon study completion.

APPENDIX H: CULTURAL UNDERSTANDINGS OF SEX AND RELATIONSHIPS  
IN EEL RIVER VALLEY YOUTH

**Was this protocol registered as part of a grant submission?:**

No

**Proposed Start Date:**

Saturday, April 1, 2017

**Principal Investigator:**

Student

**Responsible Faculty or Staff Name:**

Mary L Scoggin

**Responsible Faculty or Staff Department:**

China Studies Prgrm

**Responsible Faculty or Staff Email:**

[mary.scoggin@humboldt.edu](mailto:mary.scoggin@humboldt.edu)

**Responsible Faculty or Staff Phone Number:**

(707) 826-5286

**CITI Training Date of Completion:**

Saturday, January 16, 2016

**Student or External Name:**

Corinna Irwin

**Student or External Department:**

Applied Anthropology

**Student or External Email:**

[corinna.irwin@humboldt.edu](mailto:corinna.irwin@humboldt.edu)

**Student or External Phone Number:**

707 407 6400

**Qualifications:**

I am an Applied Anthropology graduate student, working for the department of public health, and conducting qualitative and quantitative research on sexual and reproductive health access in Humboldt County.

**Responsibilities:**

My responsibilities will be to collect narratives from Latina migrants regarding their experiences accessing sexual and reproductive health services in Humboldt County, or perceptions of these services. Also conducting surveys in Fortuna Middle School to gauge attitudes and knowledge of sexual health and healthy relationships. It will also be my responsibility to conduct participant observations in sex education classes, Latino community organizing events and health outreach for the Latino community.

**CITI Training Complete:**

Yes

**CITI Training Date of Completion:**

Saturday, January 16, 2016

**Contact Name:**



Mary Scoggin

**Email:**

[mary.scoggin@humboldt.edu](mailto:mary.scoggin@humboldt.edu)

**Department:**

Applied Anthropology

**CITI Training Complete:**

Yes

**Purpose of Project:**

Graduate Research

**Do you or anyone else plan on disseminating the information acquired from this project outside of the specified course classroom or the University? (Please check “yes” for dissemination if you are conducting research for a thesis that will be published on Digital Scholar.):**

Yes

**If Yes, please explain:**

This research is part of an MA thesis.

**Name:**

Corinna Irwin

**Type of Personnel:**

Student

**Email:**

[ci15@humboldt.edu](mailto:ci15@humboldt.edu)

**Qualifications:**

I am an Applied Anthropology graduate student, working for the department of public health, and conducting qualitative and quantitative research on sexual and reproductive health access in Humboldt County.

**Responsibilities:**

My responsibilities will be to collect narratives from Latina migrants regarding their experiences accessing sexual and reproductive health services in Humboldt County, or perceptions of these services. Also conducting surveys in Fortuna Middle School to gauge attitudes and knowledge of sexual health and healthy relationships. It will also be my responsibility to conduct participant observations in sex education classes, Latino community organizing events and health outreach for the Latino community.

**CITI Training Complete:**

Yes

**CITI Training Date of Completion:**

Saturday, January 16, 2016

**Assurances:**

Ensuring the quality and accuracy of the written materials included in the Application for Review;

Ensuring Human Subjects in Research Training for all personnel who may interact with human subjects or have access to subjects' information or responses;

Supervising the conduct of research protocols submitted under their direction;

Ensuring compliance with all federal, state and local regulations, as well as Humboldt State University policies regarding the protection of human subjects in research;

Adhering to any stipulations imposed by the Humboldt State University IRB;

Ensuring that permission from outside institutions (e.g., tribes, hospitals, prisons, or schools) is obtained, if applicable;

Retaining all research data, including informed consent documentation of participants, in accordance with institutional, local, state and federal regulations;

Reporting to the Humboldt State University IRB immediately if there are any adverse events and/or unanticipated problems involving risks to subjects or others.

**Lay Abstract:**

Rural counties often struggle with issues of access and delivery when it comes to health services. Humboldt County has been a traditionally white, working class economy, dependent on lumber and fishing industries to support its population. In the last thirty years, a shift has been made away from these industries and towards an underground drug economy, which has caused both funding for social service programs, as well as the health and wellbeing of the citizens, to suffer. Humboldt County also sees a growing Latino migrant population, both from other parts of urban California, and from South of the border. Many of these migrants are undocumented and do not know English, and women and children from this population may especially be effected by local policy and systems, due to gender and age disparities. This ethnographic study aims to examine sex education in the Eel River Valley, and the pre-existing knowledge that youth from both US-born and Latin American born families around sexual health issues such as HIV, STI,

and pregnancy prevention, dating violence and sexual assault. Surveys and observations will be collected in order to better understand the existing structural barriers and how they effects these individuals.

**Type of Data:**

Interview

Survey/Questionnaire

Observation

Secondary/Existing Data or Records

**Sources for data or records::**

Humboldt County Office of Education

**Type of Subjects:**

Students in Fortuna Middle School and Redwood Preparatory School

**Estimated Number of Subjects:**

40-50

**Expected Age of Subjects:**

12-17, 30

**Approximate total time commitment required from subjects:**

10-20 minutes

**Will subjects be Compensated?:**

No

**Description:**

My project is an ethnographic exploration of sexual and reproductive health services in rural Humboldt County, and its accessibility to Latin American migrant populations. First, I am conducting ethnographic exploration of Latina migrants and Latino community health organizers, including personal narratives and participant observation. (IRB 15-143) I am also studying sex education in the Eel river valley, and the messages on relationships and sexual health that middle school aged youth are receiving from outside public education. This study considers any disparities between youth born in the US, and youth who were born in Latin American countries, or speak Spanish at home. My goal is to explore any disparities that exist, and give a narrative historical analysis on rural health care in Humboldt County. This research will be gathered from 7th graders in two schools in the Eel River Valley, Fortuna Middle School and Redwood Preparatory Academy, in the form of participant observation and in quantitative data from survey. The survey will be administered to the 7th graders at Fortuna Middle School a few months after their first sex education class by educators from Planned Parenthood, and used to gauge an idea of where youth get their attitudes and beliefs about sex, aside from in the classroom. Seventh grade sex education class by Health Educators from Planned Parenthood will be observed and documented. Participant observation will be utilized during workshops about consent and HIV in Eel River Community school. In addition, a short interview will be conducted with the health educator from Planned Parenthood to learn about her experiences and observations regarding Latino/Spanish speaking youth in her sex ed classes. Research question will be "How do youth from

Latin American migrant families, as opposed to US born families, absorb and respond to cultural norms and attitudes regarding teen sexual health?"

**Recruitment and Selection:**

Participants will be students at one of the schools involved in the study. Permission has been given by administrators at both schools. For Redwood Preparatory School, only participant observation will take place, and permission has been given by the teacher for the researcher to observe. Sex education classes will be part of regular classroom time, so parental permission slips are not necessary. For students at Fortuna Middle School, a parental permission slip will be sent home before the students take the survey. The permission slip will be in both English and Spanish, due to the large number of Spanish speaking families in the district. Students will also receive an assent form, or "Bill of Rights" to inform them that participation in the survey is not mandatory. Copies of the parental permission slips, assent forms, and survey are attached below.

**Types of Vulnerable Subjects:**

Children (see Federal Guidelines, [45CFR46 subpart D](#))

**If vulnerable subjects are involved, describe safeguards for each population::**

I will be surveying middle school students in a classroom setting, as well as teenage student participants who attend a workshop. Students in the middle school classroom will need to have parents sign parental consent forms in order to participate, and will receive an assent form titled "Participants bill of Rights", that helps them understand their rights in taking the survey. Students being observed during sex education will be kept anonymous in data collection, and if interactions or words from students are documented

and used as part of the researchers, identifiers will be excluded. The survey itself is low risk, because the data is anonymous. Students will participate and share only what they are comfortable with.

**Documentation Type:**

Parental Permission: agreement of parent(s) or guardian(s) to the participation of their child or ward in the project.

Assent: A child's affirmative agreement to participate in the project. Failure to object should not be construed as assent. Adequate provisions must be made for soliciting the assent of the children.

**Consent Process:**

The principal will have the parental permission slip sent home to parents who have 7th grade students at Fortuna Middle School two weeks before the survey is presented in class to the students. This gives parents ample time to contact the researcher with any questions or potential concerns. In addition, before taking the survey, the students will be read a short assent form by the researcher. This explains that by taking the survey, the students consent to give their anonymous answers. There will be a cover sheet on the front of the survey, which students will tear off to signify their willingness to participate in the survey.

**Methods:**

For 7th grade students at Fortuna Middle School, students will take a short survey which is attached below. When completed, the answers will be analyzed quantitatively and compared between students who live in households where Spanish is spoken, and/or who

were born in a Latin American county, with students who speak English at home and were born in the US. Participant observation will also happen in classrooms, both at Fortuna Middle School and Redwood Preparatory School School, during sex education, HIV prevention, and consent workshops, and will be coded by noting reoccurring themes. The method used will be grounded theory, so I cannot at this moment say how it will be analyzed. Grounded theory is the methodology for looking at emerging data and from there, coming to a theoretical framework. Using grounded theory requires keeping an open mind to what appears in the data, and to formulate conclusions from this. Applying grounded theory to data analysis facilitates open coding, which is used to keep the data as a live document. For example, IRB revisions may continue to happen as participant observation concludes that different questions need to be asked about the population and their experiences.

**Benefits:**

The benefits of this study are not concrete, since the participants will not be compensated. However, I believe that participating in this research gives students an opportunity to give second thoughts to their own beliefs regarding sexual health, pregnancy prevention, healthy relationships, and other topics, and this could help them in the future to make better decisions.

**Potential Risks:**

Risks are minimal since data is anonymous and students will not be sharing their own personal experiences. A risk that could come up is that a student could become triggered



by a question on the survey and not recognize why they are having this reaction. Some students might not feel comfortable being honest on the survey.

**Risk Management Procedures:**

In the case that something comes up for students, as a sexual health concern, or an abuse experience that needs to be dealt with, this researcher will have ample referrals and contacts to refer students or parents to. In addition, contacts are made at both schools who are aware of the study and able to assist in necessary referrals. Resource employees are aware of the research and will be available to students if needed.

**Anonymity and Confidentiality:**

The identifiers asked in the survey include age, ethnicity/race, and language spoken at home. The data is quantitative and mostly multiple choice. Considering Fortuna Middle School is more than half Latino, and all students will be in the same age range, the data shouldn't be reliable for identifying specific students. For students who speak other languages at home other than English or Spanish, should they appear in the data, when data is compiled it will be lumped into two categories - Spanish speakers, English or other language speakers. Ethnographic data collected from participant observation is primarily to observe the lessons taught by the Planned Parenthood health educator, more so than to collect statements from youth. You will be observed in their engagement and responses, but specific details that could be traced back to particular students will be omitted.

**Data Storage, Security and Destruction:**

In regards to records of data collected, they will all be digitalized and kept in a password protected computer folder. Parental consent forms will need to be kept until after the work has been finalized. All documents, including names and contact information of participants, will be kept in a locked file cabinet in the researcher's home or an office in the department of Anthropology at HSU. When the project is complete, all files will be deleted and physical documents shredded. I plan to have this project completed by December of 2017, so by this time measurement, all will be destroyed within this timeframe.

**Informed Consent Storage:**

Written informed consent forms signed by participants will be kept in a locked file cabinet in the Department of Anthropology for 3 years after the completion of the research. Digitalized informed consent forms will be kept in a password protected file with all other data regarding the study and will be deleted upon study completion.

APPENDIX I. 7<sup>TH</sup> GRADE SURVEY ON SEX AND RELATIONSHIPS

**Gender:** Boy  Girl  Other  **Age:** \_\_\_\_\_

**Language spoken at Home:** \_\_\_\_\_

**Place of Birth:** \_\_\_\_\_

1) Where have you learned about sex and relationships outside of school?

- a) Parents/family d) instagram
- b) Television/movies e) Classmates/friends
- c) Facebook f) SnapChat

2) To me, having a healthy relationship means

\_\_\_\_\_.

3) Consent means...

- a) Both people said "yes"
- b) No one feels threatened, manipulated or under pressure
- c) No one is impaired from drugs or alcohol
- d) All of the above

4) If two people have had consensual sex in the past, they do not need to get consent anymore.

(Circle one) True / False

5) If I have a relationship, it would be normal if my significant other: (Circle multiple)

- a) told me how to look and dress
- b) told me what I need to change about my looks
- c) cares about my hobbies and interests
- d) became friends with my friends
- e) expected me to have sex

6) If my significant other gets jealous when I talk to or spend time with other people, it means that they love me.

(Circle one) True / False

7) Besides abstinence (not having any kind of sex), what is the best way for me to prevent pregnancy and sexually transmitted infections?

- a) the birth control pill c) withdraw / pulling out
- b) condoms d) IUD

8) If I want to get condoms, I know where I can get them:

(Circle one) True / False

9) Sexually transmitted infections (STIs) can be transmitted through:

- a) oral sex
- b) vaginal sex

c) anal sex

d) all of the above

10) I can tell by looking at someone if they have an STI or HIV/AIDS:

(Circle one) True / False

11) HIV can be spread by:

a) Having unprotected vaginal or anal sex

b) Kissing

c) Erotic dancing

d) Sharing needles

e) Drinking from the same glass

12) If a girl is drinking at a party, wearing a revealing outfit, and flirting, she definitely wants to have

sex:

(Circle one) True / False

13) If my friend told me that they had feelings for someone of the same gender, it would not change

my friendship with them.

(Circle one) True / False

14) If I have questions about sex, relationships, pregnancy, STIs/HIV, or dating violence/assault, I

have an adult in my life I can talk to:

(Circle one) True / False

15) I feel that I have the power to say no if peer pressured in relationships or friendships

(Circle one) True / False