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NUESTRA VOZ, NUESTRA SALUD, NUESTRO TEXAS:

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

CENTER FOR REPRODUCTIVE RIGHTS

National Latina Institute for Reproductive Health

NUESTRO TEXAS
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Loteria and chicharones during a community meeting of the Texas Latina Advocacy Network/Red de Abogacía de Tejas in a *colonia* near Edinburg.

TABLE OF CONTENTS

FOREWORD

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We envision a world where every woman participates with full dignity as an equal member of society. To do this, she must have affordable access to health care—a fundamental human right—and be assured that her reproductive rights are guaranteed and protected. In Texas, we are sadly far from that vision.

From a health care perspective, the landscape in Texas is abysmal: it has the highest uninsured population in the country, and the majority of the uninsured are Latinos. Wide disparities exist in health insurance coverage and access to health care within the state. Foreign-born Latinos are more than twice as likely to be uninsured as U.S.-born Latinos, and immigrant women of reproductive age are particularly vulnerable. The uninsured rate for women of reproductive age in Texas—35 percent—dwarfs the national average of 22 percent, and it is much greater than in other states with large immigrant populations, such as New Mexico and California.

Not surprisingly, this translates to poor reproductive health outcomes for Latinas—including high rates of gonorrhea and chlamydia, unintended pregnancies, and teen pregnancy. At a time when prevention and successful treatment of cervical cancer is gaining ground nationally, its prevalence in Texas has surged, particularly among Latina immigrants.

These statistics should be devastating enough for public officials to focus on improving access to health care. Instead, major policy changes to the state's family planning program that were enacted in 2011 have shredded the reproductive health safety net, and disproportionately affected Latinas living in the Lower Rio Grande Valley.

In 2012, the Center for Reproductive Rights and the National Latina Institute for Reproductive Health came together to investigate the impact of these new policies on women's reproductive health care in the region. We focused specifically on four counties in the Lower Rio Grande Valley because of their Latino and immigrant population; mix of rural, suburban, and urban communities; high number of medically underserved residents; and disproportionate number of family planning clinic closures. The area is also home to a number of *colonias*, isolated border communities that often lack basic services such as potable water, electricity, sewer systems, paved roads, and safe and sanitary housing.

This report gives a more complete view of the landscape of reproductive health within the region and makes clear recommendations for its improvement. Our human rights investigation prioritized the narratives of women most affected by the policy changes and worked with them as partners to identify problems and solutions.

Collectively, the women's narratives tell a bleak story. In addition to closing many health centers, state budget cuts have left those remaining strained beyond capacity while also exacerbating the additional barriers like lack of transportation, high cost of services, and impact of immigration status on women's accessibility to insurance and care.

Our findings reveal widespread violations of women's rights to life and health, non-discrimination and equality, autonomy and privacy in reproductive decision making, and freedom from ill treatment.

Even in the face of this harrowing health care climate, Latinas in Texas are galvanized and continue to organize. But sharing the stories and voices of these women is critical to shifting the landscape for reproductive health access in Texas.

While this report focuses solely on Texas—where geography and state policies intersect to hurt women—the issues it uncovers could easily arise in other states where immigrant populations continue to shift demographics. As states chip away at human rights by choking off access to reproductive health care through legislation, we are nationally at risk of dangerous violations against basic human rights.

To prevent this, the U.S. Congress, state legislatures, and civil society must acknowledge and work to remove—not construct—barriers that limit women's access to reproductive health care services.

We hope this report will pave the way for that work to begin.

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EXECUTIVE SUMMARY

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

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

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

BARRIERS TO REPRODUCTIVE HEALTH CARE

Lack of Accessible Clinics: The closure of nine out of 32 family planning clinics in the Valley funded by the Texas Department of State Health Services (DSHS) has had a disproportionate impact on rural communities who depended on these facilities. Women now no longer know where to go to get contraceptive supplies or obtain a range of services—from annual Pap tests to mammograms. Moreover, they have lost care from providers they had long trusted to serve the needs of a largely immigrant, Spanish-speaking community. The demand for services is now concentrated on fewer clinics, leading to delays of many months for an appointment at one of the few clinics that continue to offer reduced-rate services.

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

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

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

IMPACTS ON WOMEN

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

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

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

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

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

RIGHTS VIOLATIONS

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

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

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

INTRODUCTION

Brenda found several lumps in her breast in 2012. Every time she tried to get an appointment at a family planning clinic, she was told there were no available slots. The $50 fee was beyond her budget even if she could get one. She is now waiting to see if the lumps go away on their own.

Fatima is on a very limited income and, until recently, relied on free contraception from her local family planning clinic. Once the funding ran out, she could not afford both contraception and food for her two children. Without alternatives, she's now expecting a third child.

Ana was able to afford $35 for a Pap test two years ago. The results troubled her doctor enough that he asked her back for an ultrasound—at a price of $400. She still has not received the services she needs.

These are just three of the stories collected from consultations with nearly 200 women in the Lower Rio Grande Valley (the Valley). These women are all too aware of the health issues that go untreated. Every day, they make decisions that put their family's health and well-being above their own. And they live with the anxiety and stress of not knowing what the future brings.

In the past, satisfying basic living needs was already a formidable challenge for the many immigrants in the Valley. Family planning clinics offered the foundation of health care for many women—essential services they could turn to for affordable preventive care, contraception, information, counseling, and more.

In 2011, Texas legislators delivered a blow that will reverberate for years when they slashed family planning funds, effectively shuttering nearly 30 percent of the area's family planning clinics. Those that remained had to reduce services and raise fees, and they still struggle to meet people's needs. While the Texas government restored funding in 2013, it bypassed family planning clinics. It is yet unclear whether this funding scheme will be sufficient to repair the damage done to the Texas reproductive health safety net and ensure the delivery of reproductive health care to hard-to-reach populations such as in the Valley.

In November 2012, the Center for Reproductive Rights (the Center) and National Latina Institute for Reproductive Health (NLIRH) came together to conduct a human rights investigation in order to capture the stories of some of the women most affected by funding cuts and other policy changes to reproductive health. This investigation exposes the profound barriers women in the Lower Rio Grande Valley have faced for years in trying to access basic reproductive health care and shows, through women's own voices, how recent policies have eliminated what little access they once had.

Left: Perla (right) with her son and mother at a community meeting near San Benito.

Right: Lucila Ceballos works as a volunteer Promotora to educate women about reproductive health access.

This report makes clear that Latinas in the Valley are resilient in the face of these violations to their human rights, which are very much at stake here. Without funding to support *promotora* programs, women now open the doors of their homes, churches, and community centers to hold workshops on reproductive health. As local clinics close, women organize transportation to facilities further away and pool their money for gas. And they speak up, sharing their stories and taking the findings of this investigation to policy-makers in Austin and Washington, D.C. to demand policies that respect, protect, and fulfill their human rights.

For six years, NLIRH has mobilized women in the Valley, educating them to be their own best advocates in the fight for the right to health. The Center for Reproductive Rights brings its advocacy experience—at the state, federal, and international level—to positioning this as a human rights crisis. Together, we are elevating these women's experiences as a counterpoint to the dominant narratives about women, immigrants, and reproductive health care.

This report will serve as a tool to educate decision makers about short and long-term barriers to reproductive health access and its far-reaching impact on Latinas and border communities. It makes a clear argument for the fair allocation of health resources—in the rural, migrant, and poor communities that need it most. The government must recognize this need and break down the barriers it has erected that are inflicting so much damage on the health and human rights of so many women and their families.

METHODOLOGY

NLIRH has been organizing, educating, and mobilizing Latinas in the Lower Rio Grande Valley of Texas (the Valley) since 2007 through its Texas Latina Advocacy Network/ Red de Abogacía de Latinas de Tejas.

This region was chosen as the focus of this investigation because of NLIRH's strong ties to these communities and because the Valley has an overwhelmingly large Latino/a and immigrant population, a mix of urban and rural populations including a large population residing in *colonias*, a population with generally poor access to health care and corresponding poor health outcomes, and a disproportionate number of family planning clinic closures compared to Texas as a whole.

A team comprised of Center and NLIRH staff conducted interviews and focus groups with Latina women living in Cameron, Hidalgo, Starr, and Willacy Counties in the Valley between December 2012 and January 2013. Interview and focus questions were designed to solicit information concerning women's access to affordable reproductive health care prior to and following the state policy changes enacted in 2011. Sites for the interviews and focus groups included community centers, churches, private homes, and community health centers, in locations selected by NLIRH, which included larger cities such as Brownsville and McAllen as well as rural and isolated communities known as *colonias*. Participants were recruited to participate in the project from a roster maintained by NLIRH after years of community mobilization activities in the Valley, and through informal publicity via their network of *promotoras* and community leaders.

In total, we spoke to 188 adult women in both private interviews and focus groups. The women, all of whom self-identified as Latina, were from cities as well as *colonias*. Out of a total of 49 women who agreed to be interviewed, approximately 10 were *promotoras*. Women were only asked their immigration status in private, individual interviews (and given an opportunity to refuse to respond). A majority (55 percent) said they were citizens or residents, and 39 percent volunteered that they were undocumented, and all who had emigrated to the U.S. identified Mexico as their country of origin. The age of interviewees varied from 18-60, but the majority of women were in their 20s, 30s, and 40s. No minors under the age of 18 were interviewed for this report. We did not conduct a random sampling of women in the Valley nor do we contend that our findings should be generalized to a wider population.

Prior to participation in a focus group or interview, all women provided their informed consent orally and in writing. Women were given written information about the project and guided orally through the consent provisions. All participants were instructed that sensitive information, particularly regarding their immigration status, would be kept strictly confidential. They were also told their participation was entirely voluntary, and no interviewee received compensation or material benefit of any kind as a result of her participation. After agreeing to participate, women were asked to sign a media release, at which point they could decide whether to allow use of their interview recording and transcript, photograph and video images, and/or their real name. In order to protect confidentiality, the report uses pseudonyms for all participants—even for those who permitted their real names to be used—and identifies their place of residence as the closest major town to which they live.

NLIRH staff led twelve focus groups in Spanish in the following cities or in *colonias* located close to these locations: Rio Grande City, San Juan, Mission, Edinburg, Alamo, Donna, Lasara, and Brownsville. Focus groups varied in size from 8-30 women. The precise locations of the interviews and focus groups are withheld from this report in order to protect confidentiality. Semi-structured individual interviews were conducted by female Center staff in English or Spanish, depending on the woman's preference. Interviews were conducted in private, wherever possible in a separate room but in a few instances in the same room as the focus group or another interview, but out of earshot. Three additional interviews and one follow-up interview were conducted by phone.

In July 2013 we shared our preliminary findings with a select group of 30 advocates, reproductive health care providers, and researchers at a private meeting in Austin, Texas to solicit their views on the findings and to inform our recommendations, and we later shared draft recommendations with a subset of this group.

BACKGROUND

LOWER RIO GRANDE VALLEY OF TEXAS

The Lower Rio Grande Valley of Texas (the Valley) comprises four counties—Cameron, Willacy, Hidalgo and Starr—and is home to 1.3 million people.[1] The population is overwhelmingly Latino, and over one quarter of the population is foreign-born, mostly from Mexico. [2]

The Valley is traditionally known for its rich agricultural production, but its metropolitan cities of McAllen, Harlingen, and Brownsville are growing rapidly. The area has the highest population of farmworkers of any area in the U.S., with an estimated one-third of its population employed in the agricultural sector.[3] Many of these are seasonal migrant workers who follow the harvest to other locations in the U.S. or return to their home countries frequently. Employment outside of the agricultural field, especially for uneducated and unskilled workers, is scarce in the Valley. Nearly half of the population has less than a ninth-grade education.[4] Hence, unemployment is high compared to the rest of the state.[5] Over one-third of the Valley's population lives in poverty.[6]

The Valley has the highest concentration of unincorporated communities called *colonias* in the United States, scattered along the state's 1,200 mile border with Mexico. Beginning in the 1950s, developers schemed to sell undesirable land in the U.S. border regions at very low prices to immigrants looking for affordable land. Those who bought parcels built homes gradually as they could afford materials. *Colonias* then and now lack infrastructure such as clean water and plumbing, electricity, sewage and drainage systems, and paved roads.[7]

REPRODUCTIVE HEALTH STATUS OF TEXAS LATINAS

Women's health is generally worse in Texas than in other states, but Latinas fare even worse in many key health indicators. They are the most likely of Texas women in any racial or ethnic group to report being in fair or poor health.[8] Texan Latinas report a higher rate of health problems, including diabetes, cardiovascular disease, obesity, and cancer mortality, than Latinas nationally.[9] In Texas, where Latinos are three times as likely to live in poverty as whites,[10] racial health disparities in poor regions like the Valley are even more acute. For example, both the prevalence rate of diabetes[11] and the age-adjusted mortality rate from diabetes[12] are significantly higher in the predominantly Latino counties of the Valley than the statewide average.

Numerous barriers to health care exist for residents of the Valley and of *colonias* in particular. Most of the Valley is designated as a medically underserved area by the federal government, meaning the population has a shortage of health services and providers while facing elevated health risks and numerous socioeconomic barriers to health access, such as poverty and lack of health insurance.[13] The Valley's women—rural, Latina, immigrant, uninsured, and poor—are largely unable to afford private health care. Consequently, they tend to forgo preventive care and seek medical attention only in emergencies.[14] Until recent policy changes, a notable exception was family planning services; this population did access women's preventive care such as Pap tests, breast exams, contraceptive services and counseling, and testing for sexually transmitted infections from clinics providing such care at low or no cost.

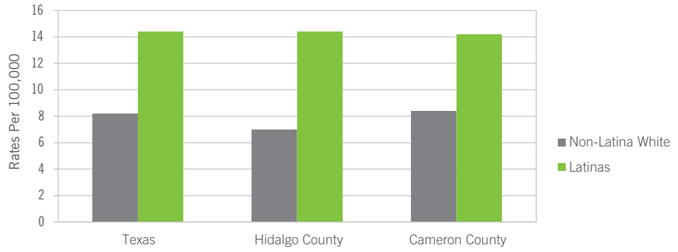
Lack of health insurance coverage is strongly correlated to lack of adequate health care. The state of Texas has the highest percentage of uninsured adults in the country at 27 percent of the state's population, or 6.1 million people.[15] And wide disparities exist in health insurance coverage and access to health care within the state. Latinos are more than twice as likely as whites to be uninsured in Texas,[16] and foreign-born Latinos in Texas are more than twice as likely to be uninsured as U.S.-born Latinos.[17] The uninsured rate in all four counties in the Valley is well above the state average.[18] In fact, Hidalgo County has the highest rate of uninsured people among urban counties in the entire nation.[19]

Nationally, 22 percent of women of reproductive age are uninsured, but this rate is much higher in states with large immigrant populations such as Texas (35%), New Mexico (31%), and California (25%).[20] While approximately one-quarter of Texan women of reproductive age are uninsured, nearly half of Latinas in this age group are uninsured.[21]

Compared to Texan women from other racial and ethnic groups, Latinas experience some of the highest barriers in accessing sexual and reproductive health care. They are by far the most likely group of women to lack a personal doctor,[22] and the most likely to have not seen a doctor in the past year due to cost.[23] As of 2008, Texan Latinas between the ages of 40-64 were less likely than white or black women to have received a mammogram in the past two years and less likely to have received a Pap test within the last three years.[24] In Texas from 2000-2010, the unmet need for publicly subsidized contraception increased by 30 percent to 1,690,150 women, with half of the women in need being Latinas.[25] This tracks a national trend showing Latinas to have the largest increase in the need for contraceptive services of any group in the last 10 years.[26]

Because of their lack of coverage and access, reproductive health outcomes for Latinas in Texas are also poor. As of 2010, Texas had the highest number of reported gonorrhea cases in women of any state in the country and was second only to California in the number of reported chlamydia cases.[27] Texas has a higher rate of unintended pregnancy than the national average (in 2008, 52 percent of pregnancies compared to 49

Wide Disparities in Invasive Cervical Cancer Incidence in Texas, Lower Rio Grande Valley Counties



Invasive Cervical Cancer Incidence 2000–2009

Data from the Texas Cancer Registry. Rates are age-adjusted to the 2000 U.S. Standard Population. Veterans Health Administration and military hospital reporting is incomplete for 2008–2009 Texas Cancer Registry

percent nationally),[28] and one of the highest teen pregnancy rates.[29] Although reported sexual activity of Latina teens is not significantly different than that of their white counterparts, Latina teens have significantly lower rates of contraceptive use and higher pregnancy rates than white teens.[30] This is largely due to the barriers that young Latinas face in accessing comprehensive sexuality education and obtaining a regular form of contraception.

The incidence of cervical cancer in Texas is 19 percent higher than the national average, but Texan Latinas also have a higher incidence of cervical cancer than the state's white or black women (12.4% compared to 9.3% and 10.4% respectively).[31] While cervical cancer has been on the decline for U.S.-born women, research shows that the disease—which can be prevented through routine gynecological care and is highly treatable when caught early—is becoming more prevalent among immigrant women, especially Latinas.[32] Racial and ethnic disparities in cervical cancer are especially wide in the counties on the border of Mexico. In Hidalgo County, the incidence of invasive cervical cancer for Latinas is more than double the rate for non-Latina white women (14.3 versus 7.0 per 100,000) and in Cameron County the rate of cervical cancer deaths for Latinas is twice the rate for non-Hispanic white women (4.8 versus 2.4 per 100,000).[33] Women living in counties bordering the Texas-Mexico border are 31% more likely to die of cervical cancer compared to women living in non-border counties.[34]

POLICY FRAMEWORK

Federal Policies

Immigrant women face profound legal barriers to affordable health care as a result of long-standing federal policies that restrict access to means-tested public benefits for certain groups of immigrants. These barriers were greatly exacerbated by further restrictions imposed by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)[35] on immigrants' eligibility for Medicaid and the Children's Health Insurance Program (CHIP).[36] Undocumented immigrants are ineligible for all public insurance programs regardless of their income. In most states, those lawfully present in the United States become eligible for Medicaid after a five-year waiting period. Texas is one of a handful of states that refuses to extend coverage to those lawfully present in the U.S. who arrived after 1996 even after they complete the five-year waiting period.[37]

Two limited exceptions to these federal exclusions on coverage—Emergency Medicaid[38] and the "unborn child" exception under CHIP[39]—allow some low-income immigrant women to qualify for services related to pregnancy and childbirth regardless of their immigration status. Nevertheless, the eligibility restrictions have greatly impacted low-income immigrant women's ability to access preventive reproductive health care including contraceptive access, cancer screenings, and testing for sexually transmitted infections.[40]

The 2010 Patient Protection and Affordable Care Act (ACA) largely incorporated the existing federal restrictions on coverage for immigrants. Lawfully present immigrants are permitted to purchase health insurance plans on the state exchanges and to apply for tax credits to offset the cost of such plans. Undocumented immigrants are both denied tax credits and barred from purchasing insurance on the exchanges with their own funds. Some of this population will benefit from the ACA's provision for $11 billion for operation, expansion, and construction of community health centers (CHCs) to reach underserved populations. Yet, despite evidence that the number of people in underserved areas needing care was five times the amount served in those areas by CHCs, Congress reduced the appropriation for health centers in 2011 by $600 million, or more than a quarter.[41] As a result, funding was diverted to support existing health centers rather than to construct new ones in underserved areas. As of July 2013, Congress had allocated only $3 billion of the funding for CHCs provided for under health care reform.[42]

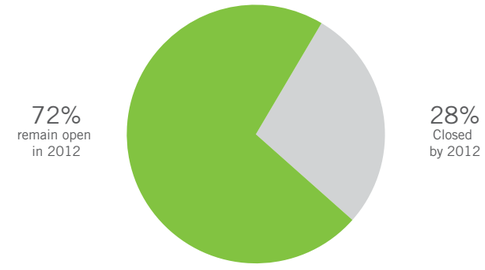
Finally, regulations proposed in August 2012 exclude millions of young immigrants from the benefits of health reform. The Deferred Action for Childhood Arrivals (DACA)[43] program offers young immigrants who lack legal status but arrived in the U.S. as children the opportunity to apply for temporary relief from deportation. However, a regulation that went into effect in August 2012 excludes those granted relief through DACA from eligibility for expanded coverage options under the ACA or public insurance options under Medicaid and CHIP.[44] Consequently, the 840,000 women of reproductive age expected to gain temporary relief from deportation through this program[45]—the vast majority of whom is Latina[46]—will not be able to access affordable health insurance that is available to immigrants who qualify for deferred action under other programs.

State Policies

Slashing Family Planning Funding and Limiting Providers

Two state-based programs serve the reproductive health needs of low-income Texan women. First, DSHS administers a family planning program, supported primarily with federal funds

Percentage of family planning clinics in the Valley funded by DSHS in 2010 that had closed by 2012



Source: TXPEP Family Planning Data Finder

through Title X of the Public Health Service Act and Titles V and XX of the Social Security Act, to support 288 family planning clinics across the state. These clinics are a critical source of family planning services for low-income women who lack health insurance coverage. Second, like more than half of all states, Texas participates in a family planning expansion program under Medicaid to allow low-income women who do not meet the strict income eligibility requirements for regular Medicaid to receive coverage for family planning.[47] (To qualify for regular Medicaid in Texas, working parents of dependent children must have an annual income below 25 percent of the federal poverty level, or $6,892 for a family of five.) Combined, these programs provide a critical safety net of women's preventive services including basic wellness, preconception care, and contraceptive counseling and supplies.

In 2011, Texas made significant policy changes that endangered this reproductive health safety net. First, the legislature slashed the state budget for family planning by two-thirds, from $111 million to $37.9 million, for the 2011-2013 biennium.[48] It then devised a three-tier system for distribution of the remaining funds that gave priority first to public entities that provide family planning services in addition to other basic health services (Tier 1), second to nonpublic entities that provide comprehensive primary and preventive care including family planning (Tier 2), and third to clinics that provide family planning services only (Tier 3).

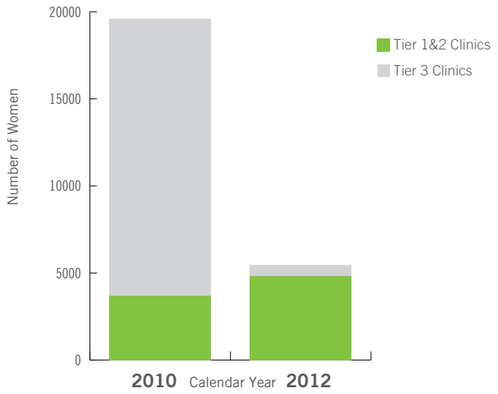
In addition, the state restricted any funds from reaching Planned Parenthood—the state's largest provider of family planning services. Upon direction from the legislature in 2011,[49] the Texas Health and Human Services Commission began enforcing a regulation known as the "affiliate rule,"[50] which bars Planned Parenthood health centers from receiving state family planning funds because of their brand affiliation with clinics that perform abortions.[51] Consequently, the state's Medicaid family planning expansion program—known as the Women's Health Program (WHP)[52]—was legally prevented from distributing any state family planning funds to the facilities that had served half of all women who received care through WHP in 2010.[53] Federal law prohibits distributing federal Medicaid funds to states that bar qualified providers because they provide certain services. Consequently, the federal government withheld $32.2 million in federal matching funds from the WHP.[54] In response, on January 1, 2013, Texas dissolved the WHP and created in its place the entirely state-funded Texas Women's Health Program (TWHP) with its own state provider qualification standards that are free to exclude Planned Parenthood.

In 2012, the federal government awarded a $32 million Title X grant to a consortium of family planning providers known as the Women's Health and Family Planning Association of Texas, rather than to the state of Texas as it had done since 1982. The Association is not limited by Texas' tiered funding system and can therefore provide funds directly to cost-effective family planning clinics, potentially serving up to twice as many women as the DSHS-administered funds.[55]

Impact on Family Planning Provision in Texas and the Valley

The budget cuts significantly reduced the number of family planning providers in Texas. Seventy-six medical facilities that offered family planning services have closed or stopped providing services due to the loss of funding.[56] The closures disproportionately affected Tier 3 facilities, resulting in 39 percent of specialized family planning clinics losing support

Women receiving family planning services at DSHS-funded clinics in the Valley



Source: TXPEP Family Planning Data Finder

entirely by 2012[57] and 56 such facilities closing.[58] Almost half of the entities that continued to receive state funding were forced to reduce staff, with more severe cuts at clinics providing only family planning services (63 percent) compared to facilities that offer family planning as well as other health services (39 percent).[59] Moreover, as DSHS facilities try to meet demand with fewer funds, they are no longer able to purchase contraception at a steep discount through Title X (unless they receive Title X funds through the Women's Health and Family Planning Association of Texas).[60] By 2012, 144,000 women statewide had lost family planning services as a result of the budget cuts—a nearly 40 percent decrease in women served compared to 2010[61]—which even then served only 13.8 percent of the 1.7 million low-income Texan women in need of publicly supported contraceptive services and supplies.[62]

The Valley was disproportionately affected by clinic closures. In the four counties of the Valley, nine out of 32 DSHS-funded family planning clinics closed in the two-year period from 2011-2012.[63] The remaining clinics in the Valley reduced their hours, with some only able to stay open one day per week.[64] Many no longer provide a range of contraception or the most highly effective methods such as IUDs and long-acting contraceptives that are 20 times as effective as birth control pills.[65] The clinics that remain open have to serve more people with less funding, and consequently are forced to decrease services or charge fees for services that were formerly free.[66] As a result, the number of women in the Valley receiving family planning services at DSHS-funded clinics plummeted from 19,595 in 2010 to 5,470 in 2012—a 72 percent drop.[67]

Legislative "Fix":
Directing Family Planning to Primary Care

Facing estimates that Texas taxpayers would be forced to pay $273 million for 24,000 additional Medicaid-covered births by 2014-2015,[68] the Texas legislature took actions to address the reproductive health crisis in its 2013-2015 biennial budget. The legislature granted an additional $100 million for women's health care to the state's Primary Health Care Services Program;[69] 60 percent of these funds were earmarked for family planning. The legislature also added $71.3 million to the Texas Women's Health Program to compensate for the federal funding withheld as a result of enforcement of the affiliate rule.[70] Finally, it dedicated $32.1 million in state funding to DSHS to replace the lost Title X funding.[71] Despite these gains, it is far from clear whether these legislative actions will be sufficient to repair the extensive damage to the reproductive health safety net in Texas.

One concern is whether provider capacity can meet the demand for family planning services, especially considering the provider shortage in Texas that predated the budget cuts.[72] In the Valley, the four WHP providers with the highest volume of patients in 2010 were all Planned Parenthood health centers.[73] Two of these facilities have since closed.[74] Community health centers are well positioned to receive the increase in women's preventive health care funding via primary care, but these centers have historically served less than 20 percent of the number of patients served by Planned Parenthood health centers.[75] Nationally, research shows that primary care providers in poor and rural areas face greater challenges in meeting demands for family planning due to the strain of addressing their patients' competing health needs.[76]

In addition, women may not be able to receive the same quality of family planning goods and services through primary care providers, who tend to lack specialized training and expertise in women's preventive services.[77] Moreover, DSHS-funded providers that no longer receive Title X funds may not be able to afford to provide a comprehensive range of contraception, such as the more effective long-acting reversible methods that are more expensive but highly preferred by low-income women.[78] Finally, there are questions about the state's ability to deliver women's preventive services effectively by circumventing family planning clinics. In 2012, for example, the state served 63 percent fewer women at an average cost per patient of 15 percent more than in 2011.[79]

Top Left and Right: Children play on a trampoline with holes in a *colonia* near Donna in Hidalgo County.

Left: A Planned Parenthood health center in Brownsville has reduced staff and hours since 2011. Now, one nurse practitioner sees clients a few days a week, and the center is open at other times only for dispensing of medicine.

Bottom: People sell clothes and various goods along the border fence running parallel to Highway 281, near Brownsville.

Sisters Sylvia (left) and Karina (right) from Mission have not been able to get contraception or annual exams since their local Planned Parenthood closed in 2011.

"We want to grow, give back to this country. But for that to happen we need to be in good health."

— Liria in Brownsville

FINDINGS

BARRIERS TO REPRODUCTIVE HEALTH CARE

Interviews and focus groups conducted in the Valley show that barriers to accessing reproductive health care for Latinas and immigrant women are profound and wide-ranging.

The daily challenges of their lives—marked by poverty, geographic isolation, and for some, fear and insecurity regarding their immigration status—constrain their ability to obtain reproductive health care. The clinic closures and the severe reduction of services in the Valley have greatly exacerbated these systemic barriers by requiring women to wait longer for appointments, travel further away from their communities, and pay more for reproductive health goods and services.

LACK OF ACCESSIBLE CLINICS

The closure of over one-quarter of the DSHS-funded family planning clinics in the Valley has left many of the low-income women interviewed for this report without an affordable source of reproductive health care in their communities. Because the family planning and community health clinics that continue to offer low-cost family planning services are clustered in the cities of Harlingen and Brownsville, women living in rural communities are the most affected by the closures. For example, Felicia lives in a *colonia* near Edinburg. She never had to travel for her Pap tests in the past, but since the birth of her twins four years ago she has not received one because the local clinic closed. "All of us here want to get a Pap test, complete checkups. We know that it's better to get ourselves checked in time, but we can't find a place… I need a check-up but I don't know where to go."[80]

A woman from Brownsville who has had difficulty finding care reported that the closure of some clinics places a great strain on the remaining ones. "[W]hen they take away that money from the agencies, for example Planned Parenthood. the local clinics become more burdened, so… I cannot go to Planned Parenthood for the service that they specialize in, so I go to the local clinic. I speak with them and [they say] 'Oh, yes, ma'am, but we do not have an appointment for six months.' Or, 'I don't have an appointment [until] next year.'"[81] Even the *promotoras* do not know where to refer women to obtain family planning and other reproductive health services. "Referrals are a big problem," said Sandra, a *promotora* from Brownsville. "In the past I'd just say go to Planned Parent-hood. But now I don't know what to say. I've come across several women who've asked about a place to have Pap tests and mammograms, and I don't know the answer."[82]

Women expressed disappointment that the clinics that closed were the ones that provided the best source of care to their communities. "The clinics that served us and provided us with care—Hope, Milagro—have all closed," said a woman from Edinburg.[83] A woman from Brownsville explained, "Planned Parenthood was a trusted and safe place where people knew they could go to get services or their checkup. Now that they cut their funds, it's like they closed the door in our faces."[84]

COST

Nearly every woman interviewed identified cost as the primary barrier to accessing reproductive health services and supplies. This was true for women in each of the four counties of the Valley, and irrespective of health insurance coverage or immigration status. Even if women could afford the cost of a preventive care visit, specialty tests such as ultrasounds and mammograms, as well as any kind of follow-up care for more complicated health conditions, were generally out of reach. For most, the cost of contraception and other forms of medication was also prohibitive. As a result, even if they managed to obtain a prescription from a clinic, it was often difficult for them to fill it.

The vast majority of women interviewed (78 percent) lack health insurance of any kind. Most U.S. lawful permanent residents and citizens interviewed are low-income but do not meet the extremely low threshold for Medicaid in Texas. Others do not qualify for Medicaid because they lack U.S. residency or citizenship.

Health insurance coverage does not ensure that women's reproductive health care needs are affordable, as more than half of the women who do have private insurance could not afford the cost of the co-payment. Gloria from Brownsville explained that due to her family history of cancer, she would like to be able to get an annual Pap test and mammogram: "I have health insurance from work… but sometimes I can't go because I can't afford the co-pay." It has been two years since she's had an annual exam because the fees and tests total $80, even with insurance covering part of the cost.[85] Before the funding cuts, many chose to pay out-of-pocket for an exam at a family planning clinic because it cost less than the co-payment for an exam elsewhere. Now, the increased cost at clinics and the steady rise in co-payments leaves even insured women with few options for affordable care.[86]

Annual Exams

Over half of the women surveyed identify the high cost of annual gynecological exams as a primary barrier to accessing services. Until the state funding cuts took effect, most women in the Valley were able to obtain free or very low-cost ($10-25) annual exams from family planning clinics. Now the majority of women report that a basic annual gynecological exam costs $60-200, depending on where they go, excluding lab work and tests such as ultrasounds and mammograms. Many reported that family planning clinics are no longer able to offer sliding scale fees based on income or pay in installments, as they did prior to the funding cuts. For example, the community health clinic Nuestra Clinica del Valle used to offer sliding scale fees, but now the flat cost is $100 for an annual exam, and waiting time for an appointment is at least one month.[87] Without a sliding scale fee or the option of payment arrangements, women are unable to pay upfront costs for a preventive care visit. As Noemi from Brownsville said, "Planned Parenthood now is more expensive than the private doctor."[88]

> I say that the people with the power to make changes should think that prevention, preventing cancer, preventing breast cancer, or cervical cancer, in the end works out for the best. It's better to fund these programs and let us get help, because if a mother is gone her kids are going to be orphaned, and they are going to end up depending on the government for help. So it's best to fund those clinics so women can find care and get their families ahead.[89]
> *—Esperanza, Mission*

Contraception

In the past, women were able to obtain contraception from local family planning clinics for a subsidized rate. "Before you could go and get contraception," reported a woman from Edinburg, "but now with the cuts, you have to pay for it, and there's no money for that."[90] At a Planned Parenthood health center in Brownsville, for example, a one-month prescription for birth control pills used to cost $12 per month, but now ranges $40-50. Long-acting reversible contraception can be $65 or more.[91] Consequently, contraception has become a luxury few can afford. A focus group participant in Mission wondered what would happen when her existing supply of pills ran out: "In a week I'll run out of my last package of pills, I don't know what I'm going to do next month. I don't want to get pregnant… Later, in two years, yes I do want to get pregnant. Right now is not the time and I don't know where I'm going to go to get my contraceptives because they are very, very expensive."[92]

Ida

Ida from Donna described her situation as "desperate" because her supply of contraception was about to run out in one week's time. She was given a year's supply from a Planned Parenthood health center before it closed, but once her current supplies ran out she knew she would not be able to afford more. Ida supports her two children on her own. "Right now I'm not prepared for another child… my financial situation is rough, pretty rough.… I don't know how to get more pills because they charge for them now, they have no funds for that, no one does now." Ida also has human papillomavirus (HPV), a risk factor for cervical cancer, and has had surgery to remove cervical cysts in the past. Now, she cannot afford to get a Pap test that doctors told her she needed every six months to check on her condition. "It's $60 for a checkup. I thought, either I pay $60 or I buy food for my children.… Sometimes I don't have money for milk, food, other things.… Either I pay the rent and give my children a place to live, or I have a mammogram, a Pap test, or contraceptives. It's one or the other, but not both." She would like to go to Mexico for health care but is not legally permitted to cross the border on her temporary permit. "Being unable to see a doctor has me worried sick. I'm so afraid of the virus coming back. Last time it wasn't cancerous, but I'm afraid that if it does come back it will be worse, because I'm not having regular checkups."[177]

Isabel

Isabel from Brownsville has diabetes, a weak heart, and a history of reproductive health issues, including infertility and hormonal trouble. In the past she received Pap tests and sonograms from a low-cost clinic. Now she is able to get a Pap test for $20, but she cannot afford the full cost of all the tests and lab work. Recently, she started experiencing worrying symptoms: “Since last Friday, I have like a pelvic pain and I start[ed] spotting. To me that is not normal, but I told my husband maybe it is because of—you know you jump to conclusions.... Last week I had to cancel my appointments because I had to go [for] four different sonograms because my Pap came out abnormal and supposedly they are checking to see if I have uterine cancer. Well, I cancelled the appointments because I had to pay $80 for [another Pap test and the four sonograms] and lab work and all that and I’m like, ‘Well, reschedule it, because I don’t have the money right now.’”

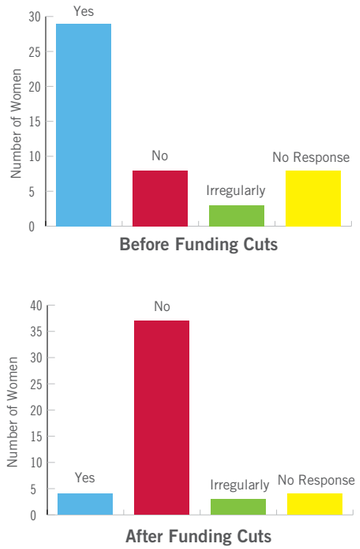
The cheapest place she found where she could get an ultrasound was a clinic in Weslaco that charged $180. Isabel is hesitant to go to a clinic knowing she cannot afford the fee because she already has $15,000 in medical debt, not including the $200 she pays per month in medications to manage her diabetes and heart problems. “To me, even $50 is expensive right now. Plus we have the gas [to get to Weslaco]. The gas is going up.” She was told that at her local clinic the cost of the Pap tests would soon rise from $20 to $35, and she worries the clinic may close entirely. “They cut back a lot of things, and sonograms and mammograms were one of them.... Then they were saying that they were going to close [the clinic] down, and we are like, ‘Oh my God, where am I going to go now?!’ There is another clinic that charges mostly the same, but there is a long waiting list, like months of waiting. But it is like [at] my clinic, if you need [a] specialty [service], you have to go out somewhere to see a specialist.... Where am I going to go?”[98]

Mayda

Mayda from Mission has been waiting years to be able to afford a mammogram after nurses discovered lumps in her breast while treating her for a miscarriage. “I searched all over for a place to have the mammogram.... I asked my sister [to come] along because she also has these lumps, so the two of us went all over the place looking for someone to do a mammogram because she too needed one. What we heard was $180, $280, $480. I didn’t have it because we just couldn’t afford it. My husband was out of work, we had nothing, we had no help, no money for a mammogram, so I just left it at that. It’s been four years since the last time, going on five since I was told.” She sought one at a hospital and offered to pay in installments, but the hospital refused to perform one unless she paid up front in cash, and they also refused to help Mayda find a place where she could get one at an affordable cost. Mayda has yet to receive a mammogram and every day she grows more concerned about developing cancer, especially now that she feels itching and discomfort near her cervix too. “That’s why I say, if it’s possible, we need a clinic here. [A visit] doesn’t have to be free, but if they charge, it should be affordable, or at least something you can pay in installments.... All this week and last we didn’t have an egg to eat in the house. We had no food, no nothing. I borrowed $20 here and $20 there to buy groceries because my husband is out of work.... Think about it, if we can’t afford to buy food, how on earth can we afford [fees at] a clinic?”[99]

Women also expressed concern about no longer being able to afford contraceptive methods that were better suited for their individual needs, especially long-acting reversible contraceptive methods. Maribel from Brownsville went to a Planned Parenthood health center three years ago to implant a long-lasting contraceptive method in her arm for a reasonable cost. Now it is time for a replacement, but she cannot afford one because the procedure—which costs $500—is considered outpatient surgery and not covered by her insurance. "The thing is I have tried, but the pill and other stuff, my body just won't take it in," said Maribel. "My body gets some weird reactions, and I just can't. So this is a form that we tried and has been working for three years, so that's my only resource that I can use for birth control, but if I don't have the money for it or there's no services out there that can help me get it, I don't know what I'm going to do."[93] Aurora, a mother of five, has not been able to get a contraceptive shot at her local clinic because the clinic no longer offers the shot at a subsidized rate. "Compared to the cost of raising a child, covering one shot a month isn't too much to pay," she said. "But it is to me, because life here is different [than in Mexico] and services are expensive."[94]

Interviewees' Use of Contraception



Mobile Clinics

Mobile clinics providing free or low-cost reproductive and sexual health services help women avoid the costs and logistical problems associated with travel. A woman from a *colonia* near Mission said she hoped that "mobile clinics [will] come here to the *colonias* so that we can get our bodies checked.... We want there to be clinics close to us because many times we don't have transportation or gas."[101] A woman from Alamo explained that mobile clinics constitute her only access to preventive reproductive health services, even though they come rarely. "It's been three years since I've had a Pap smear because I haven't had money to get one," she said. "I used to go to the mobile bus that would come to the school in Riverside, but it's only here once a year, and if I don't have transportation or time to go, I miss it for the year."[102]

Other women living in *colonias* reported they can occasionally obtain free annual exams from a mobile clinic that comes to the community once a year, but any services beyond a basic Pap test, including contraception, medications, and additional testing, are not provided. "At the mobile clinic they don't charge you, unless you need an additional exam or you need labs or you need medication, then they just give you the prescription," said Ingrid, who lives in a *colonia* near Brownsville.[103] She got her annual Pap test from a mobile bus near San Benito, but when the test detected a vaginal ulcer, she could not afford the medication in the U.S. and decided to make the difficult journey to Mexico to fill the prescription. Nineteen-year-old Marcela went to a mobile clinic near her *colonia* to get a Pap test after experiencing abnormal menstrual pain. The exam detected an ovarian cyst that could turn cancerous and will require frequent follow-up tests and ultrasounds, but she does not know how she will be able to afford these or where she can go to get them.[104]

Daniela

Daniela lives in a *colonia* near Harlingen. For her, "[t]he biggest challenge is transportation.... We live out of town, and we don't have a lot of clinics or anything close by where we can ride a bike and go up there. Everything is far away for us." Sometimes she was able to get annual exams at a mobile clinic. "There is a mobile bus that comes here [to the *colonia*]. I think they come from, I don't know if it's Austin or Houston. They only come every year when the school is open, [during] the school year. They don't stay here all the time.... You have to set up an appointment and it's not there the whole year. It's only for a certain amount of time."

One year ago, Daniela's breast started to hurt, and the mobile bus was not in the community. She managed to get to a local clinic in Harlingen—which has since moved further away to Brownsville—but she was not able to get the care she needed there. "They charged me $30 that time just to have me checked, but they didn't have the mammogram machine or anything, so they sent me to the Valley Baptist [Hospital]. When I went there, they did the mammogram on me and everything and they said, 'It's going to be $800.' I go, 'I don't have the money. Can you tell me what's wrong at least or something?' They said, 'No. We need to send those records to the doctor, but you need to pay $800.' She showed the hospital a paystub for $200 per week as the sole family income for eight people. "They told me, 'You can pay that $800 with this money!'" Daniela has yet to receive the results.

Soon after, she called another clinic, which put her on a six-month waiting list for an appointment. When she finally went for the exam in January 2013, that clinic was not able to offer her a mammogram and referred her elsewhere because they no longer had the equipment. Daniela is beginning to worry: "Time is going by and what if I have something? And by the time I get checked they're going to tell me, 'You know what, you have cancer and this and that.' I don't even think about it. I try to live with it." She worries she will not be able to travel further away to see another doctor. "I don't have [a] vehicle. I don't have transportation. If I want to go somewhere, I would have to give someone gas [money] to take me. I'm not going to go walking all the way over there."[105]

"We live out of town, and we don't have a lot of clinics or anything close by."

Esmeralda

Esmeralda from Mission is a recent widow and mother of five children under age 11, the youngest of whom is three months old. "Gas is expensive and transportation is a struggle. Now that I'm widowed, it's even worse." She is unable to work because of her child care responsibilities, so a doctor's visit—which involves the cost of the appointment, gas money or bus fare for herself and her children, or arranging and paying for childcare—is simply too much. She admits that her youngest child was not a planned pregnancy. In the past she got her birth control pills from a Planned Parenthood health center, but things changed "when they took the funding for contraceptives away and I couldn't get them [for free] anymore.... [It costs] $50 a month, but I can barely make ends meet. [T]hat's when I got pregnant."[112]

> After four or five [children, many women] didn't want any more, but ironically, Medicaid covered childbirth but not the surgery not to have any more. So it seemed pretty unfair to me that Medicaid would cover childbirth every two years but not the surgery they needed when they felt they wanted no more [children].... We tried to find help for them but came up empty. No one is willing to foot the bill. There's no help for women who choose not to have more children... I say whether to have a child or not is a woman's right.[95]
> *—Marisela, Brownsville*

Fees for Tests, Follow-up Care, and Specialty Services

The cost of follow-up tests, lab fees, and any kind of specialty care is significantly more expensive than the cost of an annual exam. Women who receive abnormal results from their Pap tests are often unable to afford follow-up tests that will reveal more detailed information about the status of their health. According to a *promotora* in Brownsville, the few community health clinics where women can obtain reproductive health services charge a flat fee of $25 for the annual exam,[96] but then require an additional $25 for the results of a Pap test, and $10-20 per test for sexually transmitted infections.

Furthermore, when Pap tests or basic breast exams conducted as part of an annual exam reveal abnormalities, clinics usually refer to private doctors for follow-up ultrasounds and mammograms. The fees for these tests at private doctors' offices are generally prohibitively expensive, and much higher than the fees charged at the family planning clinics that used to provide them. Some women reported that the referral usually expires long before they are able to save enough money to pay for the tests or service. The same is true for women whose complication or recurring reproductive health needs require specialist care, such as a surgeon to perform a hysterectomy, an oncologist to treat reproductive system cancer, or a fertility specialist.

Liria needs to get a regular breast exam every six months to monitor a lump in her breast she has had for several years. She struggles to pay the $45 co-payment for specialists, but the lab work is the most burdensome expense. "I make $300 or $400 in a month, just imagine doing labs that cost $200 each.... About six months ago I paid about $245 in installments," said Liria. "That was the only way, because if I paid cash I had nothing left for food."[97]

TRANSPORTATION

Limited availability of public transportation and the high cost and difficult logistics of private transportation are key barriers to women's ability to obtain affordable reproductive health care in the Valley. The clinic closures and cuts in services since 2011 have exacerbated these problems, especially for women in isolated communities. The lack of transportation options prevents women from being able to seek services at the few clinics that are still open, which may be quite far from their homes. As Sandra from Brownsville explained, "Some people don't have a car and have no one to drive them, or sometimes [they] can't afford public transportation."[100]

Public and Private Transportation

Public transportation in the Valley is extremely limited. Only the two largest cities—Brownsville and McAllen—have city bus systems. The intra-county bus system called Valley Metro operates in Cameron and Hidalgo counties, on demand in Willacy, and not at all in Starr. Buses do not run every day, and the frequency of buses varies widely, from one per hour to twice daily. Most *colonias* are not located on intra-county bus routes. Women seeking to travel to a clinic in a different county may have to make one or more transfers, potentially between bus systems, not just bus lines. This significantly increases both travel time and costs. While some family planning clinics are located on bus routes, many require at least a 20-minute walk from the closest bus stop, and others are completely inaccessible by bus.

With the numerous barriers to public transportation, women frequently ask for assistance from family, friends, or neighbors with vehicles. However, arranging rides around others' availability—most commonly in the evenings after work—is often challenging due to limited appointments at clinics. Although women whose families own vehicles were less likely to report transportation as a key barrier to care, those who cannot drive are dependent on their partners or other family members to drive them to appointments and must schedule appointments accordingly. The cost of gasoline and vehicle maintenance burdens the family budget, even more so now that women are forced to travel longer distances for their appointments.

Many women arrange carpools and pool money for gas rather than endure long and unreliable public transportation. Ingrid relies on her sister to drive a group of people to

Mexico to get appointments at a clinic there, now that the local Planned Parenthood health center in San Benito has closed. "We all pitch in if we have to go to appointments," said Ingrid. "We all put gas in one vehicle and we all go."[106] But relying on others for rides has the disadvantage of leaving women dependent on others' schedules. Juanita from Mission reported a similar problem: "Sometimes it's a struggle, right, because [my husband] works and I don't drive. Most of the time we manage, but if he can't, then I just have to miss my appointment because we have no public transportation." Once the local clinic closed in Mission, her next closest option is a clinic in San Juan. "But it's a half-hour drive from Mission to San Juan, so right now we can't make it there. That's the biggest obstacle, that the accessible clinics in our area are all closed now."[107]

Although Medicaid enrollees may be eligible for reimbursement for transportation to the doctor,[108] the reimbursement procedure is largely unworkable for women who rely on neighbors and friends to drive them to appointments. Amanda lives in a *colonia* and needs gas money in advance to pay a driver: "[In the past] it was easier, you would call and they would send you gas money. They don't do that anymore.… They want you to go to the doctor first. But the neighbor's not going to wait, she wants to get paid for the gas."[109] Changes in the reimbursement procedure have made it too onerous. Said Amanda, "You go to the doctor first, you get the papers signed, you fax it to [the agency]. I don't even have a fax machine close by to fax it. And then in a week they would send you the money. No, it doesn't work."[110]

Child Care and Transportation

Dealing with poor transportation options in addition to childcare responsibilities adds another layer of difficulty for women who are primary caretakers to make and keep doctors' appointments. Getting to an appointment with several children in tow, especially without a car, is a huge deterrent. Mariana, a social worker from Pharr, empathizes with women trying to balance their health needs with caretaking responsibilities: "If I would put myself in their shoes, having to take all your kids with you to… a doctor's office and then having to come back, I mean, I don't know. In Mexico, everything is around the corner. Everything is so close by so people walk.… They don't have to put everything in their vehicle and carry everybody and be afraid, 'I'm driving without a license.' … Over here, everything is so far away and you have to ask somebody, 'Can you take care of my kids, I'm going to go see a doctor, I have a doctor's appointment?' The whole situation is very, very complicated."[111]

IMMIGRATION STATUS

Out of the 19 women interviewed who were undocumented, 11 reported that their unauthorized immigration status interfered in some way with their access to reproductive health services. The most common reasons were the fear of apprehension by immigration authorities and inability to produce required documentation in order to receive subsidized care, such as a valid government-issued identification card, proof of legal residency, or proof of income. Undocumented women are compelled to limit travel outside their communities, avoid cross-border travel for fear of not being able to return to the U.S., and guard their status carefully, even with health care providers.

Documentation Requirements

Women report that the few clinics offering affordable reproductive health care require proof of legal residency in the U.S. as a precondition for receiving services. At a minimum, a government-issued identification card is required as a condition for getting a subsidized rate at most clinics. Marisela, a *promotora* from Brownsville, goes into communities to educate women about their reproductive health because they face administrative barriers when they try to access care at clinics. "Many women are here illegally, which prevents them from seeking help at the clinics, because they don't have the ID clinics want," she said. "Before the clinic will provide services, they need to approve you. They ask for ID, right, and if people are not legal, if their immigration status is not right or if they have no ID, then it gets really hard.… They are refused service."[113] Another *promotora* from Pharr reported that there is only one clinic that accepts patients regardless of immigration status, "but the waiting time is very long. [Even] [i]f you have something really serious [wrong] with you, you have to wait three months before you can get an appointment."[114]

In addition to requiring government-issued ID or proof of legal residency, some clinics require proof of income and address to verify qualification for reduced-rate services based on need and local residency. Maritza from San Juan described these administrative hurdles: "The clinics that get government funding, they have a lot of requirements, notarized letters, all that. These are the clinics serving the reproductive needs of women."[115] Proof of income and address, she said, are "requirements that some people can't meet"[116] because undocumented immigrants work in the informal economy and frequently share accommodations and expenses without adding their names to a lease or utility bill. One woman from Alamo summed up the difficulties: "I've always had bad luck [accessing health care] because there's no funding, I don't qualify, you're not completely legal, you don't have [an] entry [visa], you live in someone else's house, etc."[117]

Fear of Immigration Authorities

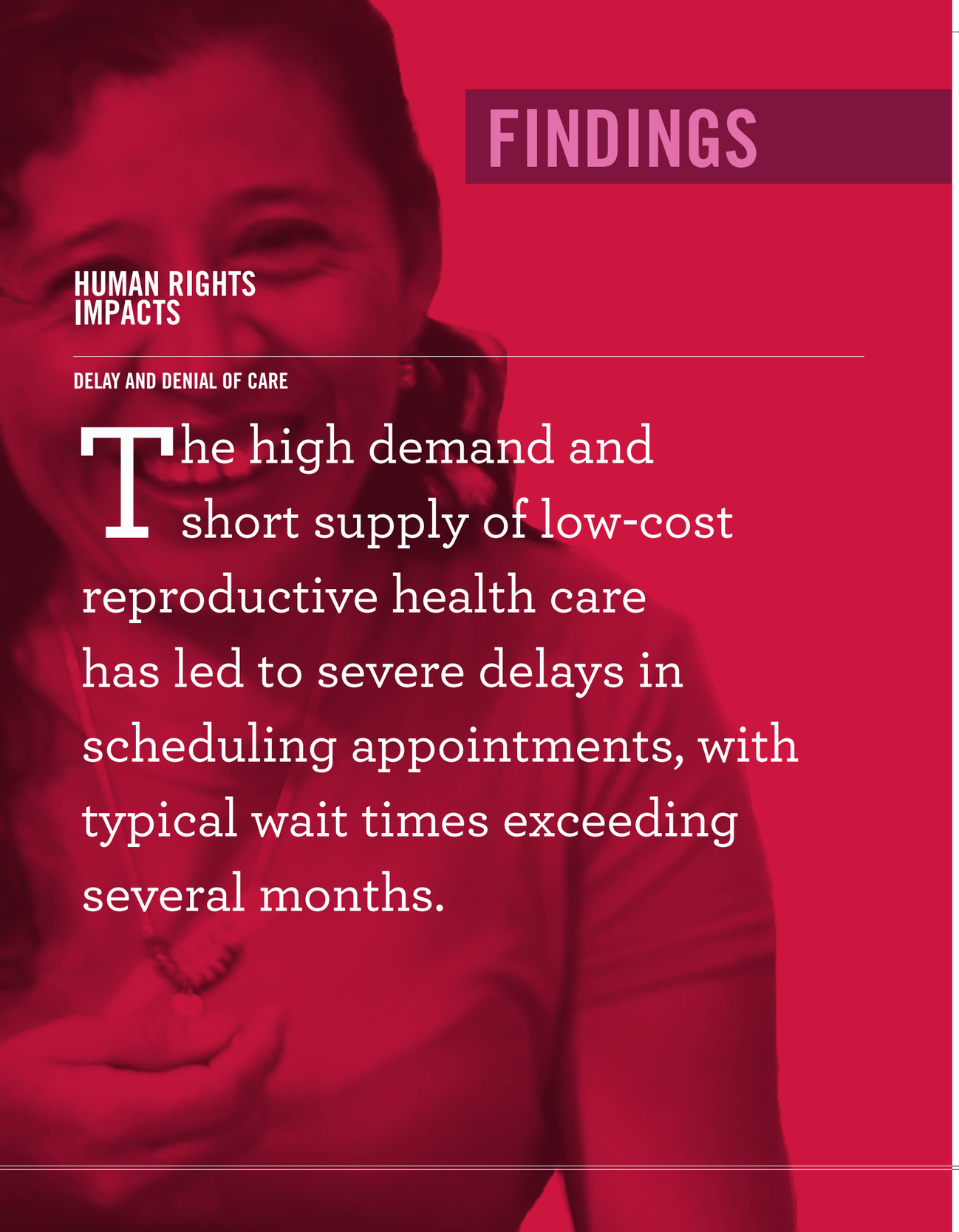
Many undocumented immigrants fear disclosing their immigration status to anyone, including health professionals, because they believe their information will be disclosed to immigration authorities. Sofia, a *promotora* from Edinburg, said that undocumented immigrants trusted Planned Parenthood health centers but are now unsure whether other clinics and providers can be similarly trusted. "They're afraid they'll be reported to immigration," said Sofia. "That's what many people are telling us. They fear that their names, their particulars, their addresses will end up in the wrong hands and that they'll be kicked out of the country as a result. They're very afraid of that."[118] Undocumented women say their lack of immigration status is closely connected to their ability to travel freely outside their communities. "We have a car, but it's a struggle," said Melissa from Edinburg. "Without papers we can't buy insurance or keep the license plate current."[119] Several *promotoras* who work regularly with undocumented populations confirmed that women who lack papers do not travel outside their communities for fear of being stopped by the police for traffic violations or by immigration authorities at checkpoints.[120]

Cross-Border Travel

Women with valid documentation status often choose to seek reproductive health care in Mexico because care is generally more accessible and affordable than in the U.S. But for those who lack papers, crossing the border to Mexico to seek health care carries the grave risk of not being able to return to the U.S. As Lorena from Alamo explained, "I can't go to Mexico. I mean, I can, but I wouldn't be able to get back in. That's why I don't go."[121]

The dramatic rise in violent crime in the border regions of Mexico over the past several years causes additional stress for all seeking affordable care across the border, undocumented and documented alike. Violence in the Mexican border states, including Tamaulipas—the state directly across the border from the Lower Rio Grande Valley—has spiked since 2007 due to a corresponding rise in organized crime.[122] The U.S. government recommends deferral of all non-essential travel to Tamaulipas due to the high rates of murder, armed robbery, and carjacking.[123] Many women who are able to travel to Mexico described a choice between crossing the border and encountering violence versus staying in the U.S. and not getting the care they need. Laura, a *promotora* from Brownsville, advises people to seek care in Mexico, but not without reservation: "I honestly do tell them if they have the possibility, because not everybody can cross, but if they can, for them to go into Mexico and get it done over there. But then another big barrier comes into play: violence. The violence in the border is terrible, and so a woman says, 'Well, should I get my Pap smear, or do I get a bullet?'"[124] One of the participants in the Rio Grande focus group expressed a sense of injustice about the choice she faces: "It does not seem fair for us as we are in a country of opportunities [and] we have to risk [our lives] to go to Mexico for services that they could give us here."[125]

Undocumented immigrants who seek reproductive health care in Mexico must take extreme measures to return to their families in the U.S., including swimming across the Rio Grande river.



FINDINGS

HUMAN RIGHTS IMPACTS

DELAY AND DENIAL OF CARE

The high demand and short supply of low-cost reproductive health care has led to severe delays in scheduling appointments, with typical wait times exceeding several months.

Problems that could have been diagnosed and treated early become much more serious, as in the case of women with chronic reproductive conditions or early signs of cancer. Later detection often results in more expensive care or the denial of treatment altogether for women unable to afford specialist fees. In some cases, the long delays are tantamount to a denial of reproductive health care because the window of opportunity to treat a serious condition such as a reproductive system cancer may close by the time a woman finally sees a doctor.

In other cases, the reason for the visit may be irrelevant by the time the long-awaited appointment arrives, as in the case of women who become pregnant before they are able to access family planning services. Many simply give up on finding timely and affordable reproductive care, opting instead for home remedies or to endure the pain and discomfort of untreated conditions rather than continue a futile search for medical treatment. The risk of being turned away from emergency facilities on the basis of immigration status or inability to pay also deters women from seeking care at health facilities.

Urgent Care

Some women seeking reproductive health care reported being turned away by hospitals and urgent care centers because they lack the ability to pay for services or because they are told that their lack of immigration status makes them ineligible for treatment. A woman from Rio Grande expressed a common view—those who are undocumented cannot be assured they will receive urgent care when they need it: "Sometimes they don't give help to the people because they do not have documents… They leave them to their fate."[126] Ana from Pharr recounted the story of a friend who needed urgent care and went to a clinic that provides services to low-income populations. The facility refused to treat her, even though she met income eligibility requirements, because of her immigration status. "She was illegal [*sic*] in the United States. They denied the services and then she couldn't go to Mexico. They were asking for either her birth certificate or her residency card."[127]

Amanda explained that even emergency services are not always available for those who cannot pay. "When you go to the emergency room, they ask you if you have Medicaid

Delia has uterine fibroids but cannot afford a Pap test or ultrasound to determine if they have grown.

and if you don't, they don't help you anymore. They don't admit you. I didn't know that, we found out that about eight months ago with my mom. She had real bad pain, and she doesn't have insurance. [Before] it wouldn't be like that. Even people that didn't have paper[s] and stuff, that weren't from here, they would go to the emergency room and they would help them out. Now they don't. They tell them you have to pay first and then you can be seen."[128]

Chronic Health Conditions

Most women reported that finding care for chronic health conditions proved a challenge due to the lack of low-cost preventive care. Additionally, having to wait to get treated—whether due to cost or other access issues—can lead to a worsening of their conditions. Delia, a migrant worker currently living in Edinburg, has myomas, or uterine fibroids: "I was told [by medical personnel] to have regular check-ups.... I have to have an ultrasound to see if they've grown, but I can't afford a doctor. It'd be $75 just for a Pap test. And the myomas would cost much more because I need an ultrasound. So I can't afford it. It's been more than three years since my last check-up."[129]

Some women reported that hospitals provide substandard care to women who cannot afford to pay. Isabel from Brownsville has a cousin with uterine cancer. She had surgery to remove a cancerous tumor, but her request for a hysterectomy was denied. "[At] the hospital, she told them to take her uterus out, but the hospital said no because she did not [have] enough money," said Isabel. "She is undocumented. They just did something—I don't know what they did to her. Sometimes my cousin, her sister, says that she can't stand the pain. She is bleeding a lot. They have taken her several times to the hospital because she has hemorrhages."[130] Isabel's cousin is the sole caretaker of her five children.

Cancer Screening and Treatment

Most of the women interviewed reported that the cost of a doctor's visit, combined with the long delay in securing an appointment at a low-cost clinic, deterred them from getting preventive screenings for cervical, breast, or uterine cancer or from obtaining necessary follow-up care with specialists. Women who had identified possible signs of cancer reported that the inability to get a timely appointment caused mental anguish and anxiety. A woman from Rio Grande expressed exasperation with the delay in getting a follow-up appointment: "You get cancer for waiting so long for an appointment with a specialist."[132]

As Sofia, a *promotora* from Mission explained, "Here in the *colonias* we have women who've been diagnosed with late-stage cancer, just because they didn't have a Pap test in time. And why was that? Because they had nowhere to turn, and by the time they sought help because the pain was too strong and [they] had other symptoms, by the time they went to emergency, that's when they heard they have terminal cancer—all because they didn't have a Pap test in time.... But if it's diagnosed at the terminal stage, what are they going to do? What's more expensive? What's worse? The desperation of realizing your children will be left to fend for themselves, or knowing that you can't afford a doctor, let alone chemotherapy?"[133]

Several women who were unable to find timely appointments, even after detecting lumps in a breast or other signs of severe conditions, had given up on trying to find a specialist to diagnose the problem. In 2010, Catalina went to her local family planning clinic in Lasara for a breast exam. A lump was discovered. "The doctor didn't know if it was just an abscess or a cyst. He said, 'Let's wait to see if it goes away on its own.'" Two years later, the lump is still there, and Catalina is still trying to get a mammogram. "I called for an appointment [with a specialist] and was told it would cost $160. I just don't have that kind of money. I asked, 'Isn't

Rosa

In November 2011, Rosa, a 32-year-old mother of three from Donna, felt a lump in her breast and went to the local Planned Parenthood health center in Weslaco to get it checked. They referred her for an ultrasound, but she was unable to pay the $500 fee to get it done. Four months later, she felt discomfort in her uterus and made another appointment at a Planned Parenthood health center, but they were unable to offer her reduced fee services because their funding had been cut. "Half a year later I went back in case they had funding again, because my problem was getting worse and I was feeling sick. But it was the same story again, no funding. Six months later I ended up in the hospital and they found out what I had. So I put in an application with the county [to cover surgery], because the doctors said that the cyst had grown, that it had affected an ovary, and that if I didn't have surgery in time they were going to have to remove my entire uterus." Fortunately, Rosa qualified for county assistance to cover the surgery through a program that covers certain health procedures for the indigent. But she has been unable to get a check-up since the surgery, as she is supposed to do every three months. "I went to the other clinics, but either I didn't qualify [for reduced fees] or the next appointment was for three months down the road, a year down the road, and I just couldn't wait that long. I don't know who has funding so I can have a check-up that I can afford."

Rosa's experience took a heavy toll on her family. "Not getting any help from the clinics, from doctors, from hospitals, is really getting to me, getting to my husband because he can't work, getting to my children because they see me sick, lying in bed in pain for a year, suffering, trying to save money to buy medication since I could not afford a clinic because they were too expensive. I saw my children and my husband looking at me in desperation, not knowing what to do.... Having doors shut on you everywhere you go makes you feel like you're in the desert, a desert where there's no help, no one to lend a hand."[131]

Brenda

Brenda from Edinburg is a single mother and domestic violence survivor who lacks health insurance. She found some lumps in her armpit in the spring of 2012 but has not been able to find an affordable place to get a proper breast exam. "[It costs] about $50, I think, just to see a doctor. If you need a mammogram or something, that's extra." She also had difficulty finding a clinic that would schedule an appointment. "I tried getting an appointment, but I was told all the slots were taken and to try again next month. Next month, same story." She was told the clinic had no more funding and would not schedule new appointments. "They told me to go to [Nuestra] Clinica del Valle, but it's overcrowded, they ask for a lot of papers and they don't take donations, like they used to here. They charge fees. You pay for every visit, plus meds if you have an infection or something."

Brenda tried calling other clinics, but they either charged a high fee up front or asked her for paperwork to prove her income in order to qualify for reduced rate services. She could not provide such proof. "That got me really down, and in the end I just said, 'Well, I don't feel well right now, but whatever it is it's temporary, and I'll just wait till it goes away on its own. But things are all piling up and I'm starting to feel the impact.... I'm responsible for my girl, and if I don't [take] care of myself, I may not be there for her. A while back I attended a seminar on cancer and they told us about all these places, but they all charge fees. So, we have information but don't have a place to go for help. I don't want things for free, I can pay something. I can volunteer an amount, but it has to be accessible." Trying to schedule medical appointments is affecting her financial security. "It's been months without help and support. All this time I've been going from clinic to clinic, and they keep saying you need this and that piece of paper, you don't qualify, come back some other time. And all this is having an impact on my job, because all of these comings and goings keep me from making a living."[134]

there any way you can help, like put something down and let me pay the rest in installments, right?' But they said, 'No way. Funding's been cut.' So we cancel our appointments because we just can't afford them. We have to pay for everything ourselves now."[135]

Unintended Pregnancy

The inability to find low-cost contraception prevents many women from taking contraception regularly, or at all, leading to a great deal of anxiety among women seeking to avoid pregnancy and in some cases to unintended pregnancy. Of the 49 women interviewed, only four currently are using contraception consistently, although 26 others stated they had used contraception regularly in the recent past when it was affordable and easily obtainable at local family planning clinics. As a woman from Brownsville said, "I have five children and having another one didn't cross my mind. And due to not having that [family planning] support, I got pregnant and here I am."[136] One *promotora* said that having to pay any amount for contraceptives now, as opposed to obtaining it for free in the past, deters women from taking contraception regularly. [137]

Women also confronted long delays in accessing family planning services at the few clinics continuing to offer low-cost contraception, which made it very difficult for women to access contraception, especially those who had not been using it consistently due to pregnancy or other special circumstances. A *promotora* explained that "[Clinics] don't have appointments until a year later and by that time [women] have already become pregnant."[139] Maribel said the delays in accessing timely appointments led her cousin to experience two unintended pregnancies. "She tried to go to Planned Parenthood. I know that she tries to go to the other clinics, but she wanted to get one of the birth control methods, and they had given her an appointment [for] three months [later]. But in those three months she came out pregnant." After the birth of her second child, her cousin was unable to get an appointment for an annual exam for months after she requested one. "They're serving so many people that their appointments are very far away. So it's three months after she had the baby. So within those three months, that's when she was able to get pregnant again. And it happened twice."[140]

Many described the legislature's decision to cut preventive care as illogical and unfair. Said one woman from Brownsville, "Because we have no options or resources to buy pills, it makes no sense that the government wouldn't want to help with those costs. When the baby is born, then one really uses the government's resources, and it's more expensive to provide WIC and public benefits."[141] A woman from Alamo, when describing the inability to obtain affordable contraception to control her family size, said, "It seems like the government is more concerned that we continue to have more kids rather than take care of the ones we have."[142] "They say they're against abortion but don't want to help prevent unplanned pregnancies," one woman from Brownsville commented. "How are you just going to tell couples—married or not—to just not have sex?"[143]

Sexually Transmitted Infections

Some women raised concerns about the inability to afford treatment for STIs and health consequences that would result from this lack of treatment. A woman from Donna said, "Now there are many sexual diseases and we don't have adequate protection… since many people are suffering due to lack of funds to buy their family planning products."[144] Noemi, the *promotora* from Brownsville, reported that the cost of filling prescriptions to treat STIs was often too much for women in her community, especially for young women. Once she helped a 24-year-old woman from Brownsville obtain a free test for chlamydia at the Valley AIDS Council, which provides free tests for three main STIs. But the clinic does not offer reduced rates for medication. After the test came out positive, the young woman could not afford to buy the medication at a pharmacy until one year later.[145]

Fertility Treatment

Although most women are concerned with avoiding pregnancy, some desire children but have nowhere to seek infertility counseling and treatment—especially women with a history of reproductive health issues. Although infertility counseling is among the list of services provided by the DSHS family planning program and the TWHP, women are often unable to get appointments at clinics offering this service. The high cost of fertility treatment also makes this service effectively unavailable.

Isabel suffers from infertility and has experienced multiple miscarriages [see profile on page 26]. She is concerned about her recent abnormal Pap test because in the past doctors have warned her it would be dangerous to bear children. "I would like to know if I can have kids or not," she said. "I want answers.... I mean it is every woman's wish to have a child but, to adopt a kid, I mean it is hard. I told my husband, I guess we're going to have to be alone,

Fatima

Fatima is a 26-year old mother and has two girls ages nine and four. She has lived with undocumented status in the U.S. for 10 years in a *colonia* near Mission. Until February 2012, she used to go to a clinic near Mission. "There was a program where I qualified for a free Pap test. That's why I went, because I wouldn't have to pay. That's also where I used to get birth control [pills].... They gave them out for free. I used to get free checkups, and I'd go in every three months. I started using the three-month shots and I'd get them for free right there. But at one point they ran out of funding, and that was the end of it. Then they stopped.... There wasn't any more help for undocumented immigrants, only for legal immigrants." After that, she occasionally bought birth control bills from her aunt, who gets them in Mexico and brings them to the U.S. "But sometimes I just could not afford them.... The girls, they come first. If I needed that money to buy them shoes or something like that, the choice was clear. So sometimes I did [use birth control] and sometimes I didn't. I'd ask my cousins or someone for the contraceptives they weren't using, and they would bring them over [from Mexico] or give them to me.... I finished a month [of pills], then the next month I could not afford them. That's when I got pregnant."[138] Fatima recently gave birth to her third child.

I guess we are going to have to take care of each other. I don't know what's going on, but right now my main concern is to check my uterus and see if I have cancer or not."[146] Isabel cannot afford a sonogram or treatment at a private doctor, and the waiting time for an appointment at the local community health clinic is several months.

Similarly, Juanita from Mission has been trying to get pregnant for four years. Once her local Planned Parenthood health center closed, she went to Nuestra Clinica del Valle in Mission in hopes of getting an ultrasound, but she could not afford an extra fee beyond the Pap test. "I haven't had an ultrasound in four years, since my last boy was born," said Juanita. "I haven't a clue what's going on with my ovaries or my uterus. I can't get pregnant; it's been four years, and I don't get pregnant. I don't know if there's a problem with my ovaries, I just don't know.... Right now I've missed a visit and two tests because I haven't had the money for the visit, let alone the tests. I'm stuck right now, whatever health problems I have are up in the air because I just don't have the money to go."[147]

Sterilization

Women expressed a range of views on irreversible sterilization as a form of contraception. The majority expressed a strong preference for tubal ligation in order to limit their family size but faced numerous challenges in affording and obtaining the procedure. Norma was given the option of paying $300 to have a tubal ligation immediately following childbirth, compared to upwards of $1,000 at any another time. She paid for the procedure in small installments prior to the birth because "it seemed like a reasonable price not to have any more children."[148]

Some who would prefer sterilization to other contraceptive methods cannot afford to pay for the procedure out-of-pocket. Aurora, the mother of five from San Juan, said she would like to be sterilized because she has already been waiting several months for an appointment to get a long-acting contraceptive shot at a low-cost clinic. "I've often thought of getting surgery, but I'd need to go to Mexico," she said. "I can't do it here, I can't get surgery unless I put money down.... [Surgery] is just too expensive, and I can't travel to Mexico [to get surgery] because I wouldn't be able to get back."[149] Maritza, also a mother of five from San Juan, said she was on the waiting list for a reduced-rate sterilization, "but it never happened. Seems like they ran out of funding." She looked into getting the procedure with a private doctor, but it cost $8,000, far beyond her means. She tried using Depo-Provera, but she got pregnant while using

"I had surgery, but I still have a uterus!"

Many women who chose to be sterilized reported an unexpected dilemma: while they felt relief at no longer having to pay for contraception, now they do not qualify for reduced rates for breast exams and Pap tests. Regulations for the Texas Women's Health Program preclude women from eligibility if they have been sterilized. Since the 2011 budget cuts took effect, clinics that historically served all low-income women are now limiting the availability of reduced-rate cancer screenings only to women with reproductive capacity. For example, Planned Parenthood in McAllen used to provide low-cost services to all women but now only offers them to non-sterilized or premenopausal women.

Marisol from Mission scraped together money to get her tubes tied because she could not afford regular access to contraception and did not want more children. She was shocked to learn that other forms of reproductive health care were now unaffordable to her. "For Pap tests and all that I [used to] go to Planned Parenthood, that's where I had a breast exam. But not anymore. I went in to ask if I qualified and it turns out I don't because I had myself fixed [sterilized].... If I hadn't been fixed, then I'd qualify. I have to pay more [now], and since I can't afford it, I don't get check-ups."[151] Similarly, Esperanza from Mission was not able to find a place to get a Pap test after her local clinic stopped offering low-cost exams. "I don't have a place where I can go here.... Since I had surgery not to have more kids, I don't qualify [for reduced fees]. The first thing they ask is if you've had surgery, and if you say yes, then they don't do those tests. I tell them 'Yes, I had surgery, but I still have a uterus!'"[152]

PROMOTORAS: EDUCATING ON A SHOESTRING

Most women attributed their knowledge to the work of *promotoras*—mostly employed by Planned Parenthood—who traveled to their community to hold education workshops on sexual and reproductive health. However, most *promotoras* in the Valley lost their jobs as a result of budget cuts to family planning programming. One of these was Paula, who used to work at Planned Parenthood in Brownsville. "As a *promotora* sometimes I wonder if all this community education is even worth it," she lamented, "since most of the time I have nowhere to send the women to get the reproductive health care they need. I get very frustrated because I feel that we are just making people worry—many identify the signs and symptoms and then we have no place to send them to get checked. I often hesitate in conducting my presentations due to the lack of resources like clinics available in our area."[162]

The *promotoras* interviewed in this investigation also expressed concern about how cuts to the *promotora* program would impact access to information for particularly underserved women such as recent arrivals from Mexico, young women and those living in rural areas who lack transportation to clinics. Mariana from a *colonia* near Pharr noted that teen pregnancy is on the rise in her community in large part because adolescent girls have nowhere to access information about their bodies and health. "Those girls need assistance.... [Even] when there was assistance, it was not in our community, they still had to travel. So getting to those places was hard. Imagine now that it's been cut, totally cut. Those few who were having access to these programs, now they don't have access to anything and then they have to go to clinics really far away."[163]

Carmen, a *promotora* who worked for 13 years in the Education Department at Planned Parenthood Brownsville, lost her job along with all her co-workers when funding for her program was eliminated. She used to teach about contraceptive use, focusing her efforts on women and girls in isolated communities. "We used to go to the schools to speak to parents. That was part of the work I did when I was with the Education Department—educate parents so they could in turn teach their children. But those channels were cut. Schools stopped letting us in to speak to parents. And those talks were important for kids to know how to look after themselves."[164] Carmen wonders how these women will be able to protect against unintended pregnancy and sexually transmitted infections. "I really enjoyed the job," she said, "and I'd love to have it back.... It was very fulfilling."[165]

Paula fears that educating women only makes them worry, since she has nowhere to send them for care.

Lucy, coordinator of the Texas Latina Advocacy Network/Red de Abogacía de Tejas, explained that Valley residents are trying hard to compensate for the deep cuts in Planned Parenthood's *promotora* program in Hidalgo and Cameron Counties. Before the cuts, Hidalgo County had a network of 10 *promotoras* who traveled frequently to the *colonias* throughout the Valley to provide sex education. Now they have only two *promotoras*, and these are restricted to Hidalgo County. Lucy explained that activists and volunteers are stepping in to fill the void of trained *promotoras*: "[*Promotoras*] don't exist now, so we have to do it ourselves. We have to train leaders so they can educate their groups. What's really good here is that we won't stop the education, even if we no longer have access to organizations. We are educating and training people to do the job."[166]

it. She had three more children, all unplanned. "I cried all the way through my last two pregnancies because I didn't want any more children. People said, 'But you have your husband.' I don't care, I can't look after so many children on my own. How am I supposed to look after them? Having babies is easy, the question is raising them afterwards, giving them the attention they need. And so I'm still waiting for that surgery."[150]

HEALTH RISKS FROM LACK OF ACCESS TO TRUSTED PROVIDERS

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

Due to the lack of availability of contraception at family planning clinics, many women are resorting to taking whatever form of contraception they are able to obtain from friends or relatives who purchase it in Mexico. Contraception from Mexico is also widely available at local flea markets in the Valley. One *promotora* explained, "They have a contact person that goes [to Mexico] to buy quantities, and they distribute."[153] Aurora gets her contraceptive shot this way. "I administer it myself," she said.[154] Maritza from San Juan buys a long-acting shot for $15 or $20: "I have neighbors who go to Mexico. You can buy them at any drugstore, no need for a doctor, no need for a prescription.... I just need someone who knows how to give a shot, and that's that."[155]

Women who are able to purchase contraception in Mexico, or obtain it from others who have traveled there, can experience side effects from using forms of contraception that are not appropriate for their needs. Eighteen-year-old Michelle was able to have contraceptive shots covered by Medicaid after giving birth to her one-year-old daughter, but that support has now run out. She has resorted to taking unprescribed birth control pills even though her body experiences unwelcome side effects, including many urinary tract infections. "All of my symptoms are not normal," she said. "My body's been feeling very weird, weak, and I really don't like it. I would like to have insurance so I can provide for my birth control."[156] Laura, a *promotora* from Brownsville, reported that Michelle's experience is becoming more common: "[Women] are taking the birth control pill and they have the symptoms [that] are really bad, but they deal with it. They just say we put up with it because we don't want to put up with a whole bunch of kids. They put up with the side effects. They constantly have a headache; they feel like vomiting, things like that."[157]

A few women reported that contraception purchased in Mexico is also not as reliably effective as prescribed contraception in the U.S. Marisol from Mission used an IUD she got at a clinic in Mexico because it was cheaper than buying it in the U.S. While using it, she became pregnant with her last child, now age 11. Eventually, she said, "I had myself fixed because it was always a struggle to scrape together enough money for those pills." She also feared giving birth by Cesarean section if she became pregnant a fourth time.[158]

LACK OF INFORMATION

The vast majority of women interviewed understood the importance of preventive reproductive and sexual health care but had no ability to access it due to cost and other factors. A woman from Edinburg summed up the problem: "We have all the information we need on reproductive health but have no access and no money. What good is the information if we don't have help or access?"[159] Similarly, a woman from San Juan said, "We have all the information we need, but the system doesn't function for us.... When we go to try and access services, we don't qualify for anything."[160] A woman from Brownsville said, "We're all informed and educated on our own health care, but the issue is, where do we go to access it?"[161]

CONSEQUENCES FOR FAMILY AND COMMUNITY

Financial Insecurity

Women spoke about the challenges of paying for health care on a very limited income, and the painful decisions about spending on their own health care versus caring for their families' needs. As Liria from Brownsville explained, "To pay for contraceptives, [women] have to go hungry.... Either they eat or buy birth control, but not both."[167]

Aurora, like the majority of women, said she prioritized her children's needs over her own health care. "You never take

Lorena

Lorena from Alamo has an 18-year-old son with severe physical disabilities for whom she is a full-time caretaker. Her son is undocumented but receives some help with medications from a county program for indigent residents. "I always worry about his meds. He needs five and I have to... buy two myself, because the county will only approve three a month.... It's a struggle sometimes, when I can't manage to get him his meds. They are very expensive. He just spent two months in hospital from November to January. He had pneumonia; he was released just last Wednesday." She is worried about how she will be able to afford the $300 fee per month for oxygen tanks once the loan from the hospital runs out. With his medical costs totaling approximately $550, Lorena has very little left of her monthly income to attend to her own needs. She used to get medications and a checkup from a mobile clinic that came once a year, but that program was cut. In the past she also qualified for a county program that covered Pap tests and mammograms for low-income people, but the last time she applied she was told there was no more funding. "It's been about five years since my last Pap test.... Between my son's expenses, paying rent and all that, I just haven't been able to afford it.... I am worried. I really want to see a doctor because when I touch my breast I can feel a sort of lump. I don't know if it's an abscess or something more serious. So I need to see a doctor but haven't been able to.... Right now I'm concerned because I need a Pap test, I need a mammogram, but I just can't afford them. I've asked around, and they're really expensive. I just don't have the money. And yes, it's upsetting because I used to have them for free, four or five years ago."[168]

the time, with our living conditions.... Even if you have the money, you always think about your children first.... You work so hard for the family, sometimes you don't give a thought to your own health."[169] Felicia from Edinburg explained that for her family of six, $25 is all the family can afford per month on health care, and this goes towards medication for her daughters. She has not had a Pap test since her twin daughters were born in 2009 because she cannot afford to pay out-of-pocket for a checkup.[170] Aida from Lasara said, "It's always something with kids, there's always something. So I'd rather save up for them for hard times than to use it on myself."[171]

Many live in fear of getting pregnant because of the financial consequences to their families. Maribel from Brownsville said, "Maybe there's a big chance I probably won't have any birth control, and that really scares me because I don't want another child right now. I don't feel financially ready for another child."[172] Illness can also have major ramifications for the entire family's economic and emotional well-being. A woman from Alamo expressed concern about the financial stress her sister's illness had caused the family: "My sister got cancer and had no money for her treatment or medicines and suffered terribly. She had to sell everything to pay for it, which doesn't only affect her but all of the family who watches her suffer."[173]

Stress and Anxiety

High rates of poverty in the Rio Grande Valley make it difficult for women to prioritize their own preventive care over the competing needs of their children and families. Without preventive care, women face anxiety about becoming ill and the social and economic ramifications of illness. Delays in diagnosing cancer or other chronic conditions caused particular stress. A woman from Rio Grande said, "If you don't have [the $25 consultation fee], you will... get sick, and then it will be something more serious, and well, you die."[174] Another from Alamo described the stress of getting sick as its own illness to bear. "We're going to get worse because we're going to think we're going to get sick. And if we get sick, how will we cure ourselves, of cancer or other illnesses? You then tend to yourself when it's too late."[175]

Depression and feelings of hopelessness surfaced as common themes in the interviews and focus groups, particularly among women who had identified clear warning signs of cancer. A woman from Edinburg talked about her fear that benign tumors she once had removed will one day return: "I don't know if they're [still there] and growing, or if they were removed.... You get depressed, it affects your daily life. I'm supposed to be getting checkups frequently and I can't afford them. When I found out about the tumors, I got depressed and cried immediately, thinking I was going to die."[176]

Women's anxieties about their own health are deeply connected to their children's well-being and future. "Women are at risk of contracting cancer," said a woman from Donna, "And now when the reports of women's cancers are coming out is when funding gets cut. It's worrisome because as women we are the ones who have to be healthy to see after our children.... All of the family falls apart if a woman gets sick."[178] A woman from Brownsville said that when a parent falls sick, the responsibility of feeding the family falls to the children. "You wait three, six months, well something grows—the illness develops more and that is when it becomes cancer. What happens to the children? They stop studying to go work because mom or dad cannot, and it is a cycle that starts increasing major, bad consequences."[179]

Physical Safety

Violence in Tamaulipas State traumatizes those who travel across the border to seek affordable reproductive health care and supplies, while deterring many others from obtaining such services. Some women cross over to Mexico because they would rather risk the violence than remain without health care in the United States. Esperanza from Mission said, "It's scary, but not being able to get medical help is even scarier." She continues to cross the border because clinics in the U.S. will not give her a reduced rate for screening now that she is sterilized. "I'll go to Mexico but I won't take my children."[180] Cost is also the primary concern for a woman in Rio Grande, who said "To pay $120 [for an appointment in the U.S.] or cross the bridge, it is better to cross the bridge and pay $50."[181]

When Erlinda was a recent immigrant to the U.S. about 10-15 years ago, she regularly put herself at risk to access reproductive health care in Mexico that was unavailable to her in the U.S. "When I started menopause I was sick a lot, and as a result I had to cross into Mexico all the time for treatment, said Erlinda. "I couldn't see a doctor here, I couldn't get checkups, so if I got sick the only thing I could do is cross over. But without papers crossing is really tough, and then getting back is another struggle. I went to Reynosa for checkups, then I went back across the river, running a terrible risk. My husband and my nephew helped me cross, then my husband waited for me on this side." The fear of violence and uncertainty of her ability to return to the U.S. was very stressful for Erlinda's family: "It was very, very tough for my husband and for myself because it was difficult for him to be taking time off work all the time to help me get there and back, or to find someone to help me back instead so I wouldn't run the risk of... you know, it's tough, you can get caught, or beaten up, even raped sometimes."[182]

Top: Rosa, at home with her children, worries about the impact her health problems will have on them.

Bottom: Houses in *colonias*, like this one near Edinburg, are usually made from found materials and therefore prone to mold and structural problems.

Such fear and anxiety is by no means isolated to Erlinda's experience. Amanda crossed over to get her monthly contraceptive shot, taking her three-year old daughter with her. "The crime situation in Mexico is so bad," she said. "I've been in three shootouts, really traumatic. I shudder from fear every time I go to Reynosa. As a woman and a U.S. resident, why would I have to go to another country to see a doctor? I live in this country, I should be able to see a doctor here. The cost is too high here, but I risk my life if I go across the border. ... Yes, it scares me stiff to go but what can I do, I just have to."[183] Amanda was on her way to the pharmacy when a shootout erupted. "People just started running and saying there was going to be a shooting, and so we took off. When we crossed the border, we did hear shots, but we were already across. So I couldn't get my [long-acting contraceptive] shot.... I've seen a lot of bad things. These people just walk around with guns in the street in Reynosa."[184] That experience has deterred her from going to Mexico again. However, because she cannot always afford contraception in the U.S., she now takes it inconsistently.

Women traveling to Mexico, especially women traveling alone, also fear being targeted with gender-based crimes including sexual violence. Gloria from Brownsville expressed fear that "young girls who go there can be raped."[185] Erlinda from Mission has two daughters who seek reproductive health care in Reynosa. "The way things stand right now in Mexico, they could be mugged or worse," she said. "I'm on pins and needles every time they go."[186]

But those who refuse to go to Mexico are traumatized by the lack of access to care. Liria from Brownsville said her cousins weigh the fear of getting pregnant against the fear of violence in Mexico: "It's hard on them. They make minimum wage, have to take time off work, and sometimes they're refused that time [from their employers]. They have big families, and in order to get birth control they have to go to a dangerous place where violence is rampant. One of them stopped going because of that and now is under the stress and fear of getting pregnant again, which she doesn't want."[187]

Adriana

Adriana, age 41, has lived in the U.S. for 22 years and raised her two children in the Brownsville area. Five years ago, Adriana was diagnosed with ovarian cysts and told she needed an operation to remove them. Having nowhere to go for affordable services in the U.S., she decided to cross to Mexico for the operation and follow-up services despite the risk that she might not be able to return. "My cysts were removed in Mexico because I [only] had the possibility of going and coming there by river. I would go by myself twice a year and return via [swimming across] the river. ... I risked everything crossing that way via river—I risked my life, risked drowning, [being] assaulted or killed. These days it is too difficult to do that because of how dangerous it has become. It's much worse now with the violence than it was before."

Last year, Adriana, along with her husband and two children, were deported to Mexico. Later, her husband was kidnapped, and Adriana believes he has been killed. Because her husband was the family breadwinner, Adriana was left with nothing when he died and was evicted from the family's home. "It was very difficult for me to start over again, after having been left on the streets."

Adriana is now the sole caretaker and breadwinner for her family, including her two young grandsons. She makes approximately $250 per month cleaning people's homes. Without a car or the support of family or friends to drive her around, she walks where she needs to go or uses public transportation. "Sometimes I take my grandkids (to Brownsville), and I have to catch the bus at 7:00 a.m. to get there more or less by 12:00 p.m. I have to take two buses. If I arrive late to the bus station, the next bus doesn't come until 5:00 p.m. and I would have no way to get back home. It's the only way I have to get around."

Adriana continues to feel pain and would like to receive follow-up care. "It was a difficult process. They performed a biopsy on my uterus to remove my cysts. I have to continue my checkups because both my parents suffered from cancer. My mom died from uterine cancer." She dares not cross the border again to receive care after what happened to her husband. "I'm supposed to be getting check-ups, but I have no money. The last time I got a check-up was last year in Mexico. I don't think I'm going to be able to get a check-up until there are funds here in the U.S. because it's too dangerous in Mexico." Adriana is starting to worry about the lack of care. "Currently I feel a little sick. I honestly don't know if I have other cysts because the right side of my abdomen hurts. I'm going to go to a low-income clinic but the only thing they can do is diagnose me and tell me what's wrong. But since I don't qualify for any kind of insurance, they can't tend to me."

Adriana works with the NLIRH Texas Latina Advocacy Network/Red de Abogacía de Tejas to organize other women who have been affected by lack of access to health care. "We are writing letters and collecting signatures so that at some point there will be resources to be able to help many, many women who need assistance. There are so many women who are suffering, including ones who are sick with tumors or issues with their uterus or breasts, and they say they can't get help. They have four or five kids. It's really, really difficult."

HUMAN RIGHTS ANALYSIS

U.S. INTERNATIONAL HUMAN RIGHTS OBLIGATIONS

All individuals have reproductive rights. Reproductive rights include the right to make fundamental decisions about one's life and family, to access the reproductive health services necessary to protect one's health, and to decide whether and when to have children.[188]

These rights are grounded in fundamental human rights guarantees in the Universal Declaration of Human Rights, international and regional human rights treaties, and the U.S. Constitution.[189] They include the rights to life and health, equality, privacy, information, and education, as well as freedom from discrimination, violence, and torture or ill treatment.

The United States has ratified three international human rights treaties that protect reproductive rights: the International Covenant on Civil and Political Rights (ICCPR), the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), and the Convention against Torture (CAT). Ratification confers an international legal obligation to respect, protect, and fulfill the rights contained in the treaty,[190] and to create an enabling environment in which rights can be enjoyed.[191] In addition, the U.S. has signed and expressed its intent to abide by the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), which also confer important reproductive rights such as the right to health.[192]

Rights to Health and Life

Reproductive rights include first and foremost the fundamental human right to life.[193] The Human Rights Committee (HRC), the body that monitors the ICCPR, has said the right to life should not be narrowly interpreted, and that fulfillment of this right requires governments to take proactive measures to reduce unintended pregnancies and unsafe abortion, which place women's lives at risk.[194]

The human right to the highest attainable standard of health[195] requires that governments ensure that health facilities, goods and services are *available* in sufficient quantity throughout the state, *accessible* to all, ethically and culturally *acceptable*, and of good *quality*.[196] Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility, and information accessibility.[197]

Human rights bodies explicitly recognize that the right to health includes sexual and reproductive health.[198] The right to sexual and reproductive health derives from the right to freely decide the number and spacing of one's children, and to have the information, education and resources to do so.[199] Making reproductive and sexual health care accessible includes the following governmental duties: to ensure access to a full range of contraceptive information and services,[200] including low-cost contraception to women who would not otherwise be able to afford it;[201] to address the geographic barriers to care for women living in rural areas;[202] and to disseminate information about sexual and reproductive health and how to access services.[203]

Governments also have a duty to remove barriers that interfere with access to health-related services, education, and information pertaining to reproductive health.[204] This includes addressing non-legal barriers to ensure, for example, that all reproductive health services that are legal are also available and accessible in practice.[205] Because the right to health rests on the principle of equity, governments are required to take positive measures to ensure equitable distribution of reproductive health goods and services, such as prioritizing health resource allocation to the most socially disadvantaged groups.[206] Fulfilling the right to health requires addressing the *underlying determinants of health*, including access to water and adequate sanitation, safe and nutritious food, adequate housing, healthy occupational and environmental conditions, and access to health-related education and information.[207]

Rights to Equality and Non-Discrimination

Cutting across all human rights, including reproductive rights, is the guarantee of equality and the ability to exercise one's rights free from discrimination of any kind.[208] Discrimination on many grounds—including on the basis of gender, sexuality, race, ethnicity, religion—is prohibited under human rights law. Human rights bodies also acknowledge that these forms of discrimination intersect to affect some groups differently.[209] Accordingly, the government's obligation to ensure equality requires reforming discriminatory laws and policies, as well as taking *proactive measures* to address discrimination in practice, particularly for groups that have faced "historical or persistent prejudice."[210]

Discrimination in the area of reproductive health care can take multiple forms. It may include delays or denial of reproductive health care for certain individuals or groups,[211] budgetary cuts to health care and other social programs that benefit women,[212] or discriminatory treatment on the part of health care professionals.[213] The duty to ensure equality in access to health care therefore obligates a government to make reproductive health services available and accessible for all women.[214] This includes providing free or low-cost contraception for women unable to afford it,[215] addressing access barriers faced by rural and otherwise marginalized women,[216] and eliminating legal barriers to affordable health insurance that disproportionately impact women of color and immigrants.[217]

Because human rights extend to everyone within a nation's territory, regardless of nationality,[218] human rights standards include equal access to reproductive health services for immigrants and migrants.[219] Generally, distinctions in access to social services on the basis of immigration status do not comport with human rights law.[220] Although some countries, including the United States, provide emergency treatment to undocumented immigrants regardless of their ability to pay, this population also has a human right to preventative, curative, and palliative health services.[221]

Freedom from Ill Treatment

The ability to exercise one's reproductive rights includes the ability to make and act on one's reproductive decisions free from violence, coercion, and torture or ill treatment.[222] Under Article 1 of the Convention against Torture, a situation can rise to the level of ill treatment where there is 1) intentional infliction; 2) of severe pain and suffering (physical or mental); 3) for a specific purpose (i.e. to obtain information, intimidate, punish, or discriminate); 4) with the involvement, instigation, consent, or acquiescence of a state official or person acting in an official capacity.[223] The U.N. Special Rapporteur on Torture has found that denial of legally available reproductive health services may constitute ill treatment when the harm caused rises to a certain level of severity.[224]

Human rights bodies have recognized that governments have a heightened responsibility to protect those who are marginalized or experience discrimination because these groups are more at risk of ill treatment in the area of health.[225] In health care settings, ill treatment may exist even though the government did not have the intent or purpose to pass a law that degrades or punishes a specific group of people, but the law has that result nonetheless.[226] For example, legal and policy restrictions on contraception have the discriminatory purpose and effect of denying women services that only they need, and legislators who pass such laws knowing that they are likely to have a detrimental effect on the health of women and girls arguably act with the intent to inflict harm for a discriminatory purpose.[227]

Similarly, denying women access to pain treatment, such as medications to treat women recovering from surgery or dealing with recurring pain caused by reproductive illnesses or chronic conditions, can constitute ill treatment in certain cases where the physical suffering is severe, when the government is or should have been aware of the suffering, and when the government failed to take all reasonable steps to protect women's physical and mental health, including when no appropriate treatment was offered or available.[228] In certain circumstances, the mental anguish caused by the denial of reproductive health services[229] or access to essential medicines to control pain and suffering[230] may also constitute ill treatment.

VIOLATIONS OF HUMAN RIGHTS

The findings in this report demonstrate widespread violations of women's rights to life and health, non-discrimination and equality, autonomy in reproductive decision-making, and freedom from ill treatment.

The state budget cuts in the 2011 legislative cycle and the concurrent enforcement of the affiliate rule tipped the scale from an untenable situation for low-income Latinas in the Valley to an urgent reproductive health crisis. The closure of at least nine clinics in the Valley and deep cuts in funding to remaining clinics have placed an unsustainable strain on the family planning safety net, which had been the one consistent source of affordable health care for most poor women ineligible for Medicaid and other affordable coverage. The funding crisis and provider shortage have made critical reproductive health services unavailable for large numbers of poor, low-income, rural, Latina women in the Valley. This government divestment in women's health services, combined with the government's failure to address persistent structural barriers such as poverty and the lack of public transportation that inhibit access to health care, violates women's rights to health and life.

The government has failed to address legal barriers that discriminate in purpose and effect against immigrant women and low-income Latinas in access to reproductive health care. These include, most notably, eligibility exclusions that bar access to affordable health insurance coverage through Medicaid and CHIP for undocumented women and women legally residing in the U.S. for under five years (and in Texas, even longer if they arrived post-1996). Though the Affordable Care Act will help many more low-income people obtain coverage, the law preserves eligibility barriers for these categories of immigrants. In addition, many poor and low-income Latinas with legal status and in need of government-supported health insurance are unable to obtain coverage due to Texas' extremely low-income eligibility requirements for Medicaid. These policy barriers make preventive reproductive health care such as contraceptive supplies and services, reproductive system cancer screenings, and STI testing, unaffordable, and therefore inaccessible. Texas' decision to opt-out of the ACA's Medicaid expansion program denies affordable insurance options to low-income women who earn too much to qualify for Medicaid but not enough to afford other types of coverage. This decision has a disproportionate impact on low-income women who live in medically underserved areas such as the Valley. Texas and the federal government have failed to take all appropriate legal and non-legal measures to ensure that women who are most in need of affordable reproductive health services are able to exercise their reproductive rights without discrimination and on an equal basis with others.

Unintended pregnancy caused by the inability to obtain affordable contraception violates a woman's rights to health and life, equality and non-discrimination in access to reproductive health care. The lack of family planning services and supplies in the Valley deprives women of the information, education, and resources to plan their families and their futures. Women in the Valley face both short-term anxiety about avoiding an unintended pregnancy and long-term socio-economic effects of carrying an unintended pregnancy to term. Although some are able to find alternate ways to procure affordable contraception, these supplies are not consistently available, nor always effective or appropriate for their individual needs. Moreover, these women's resourcefulness does not mitigate a government obligation to ensure the widespread availability of affordable and high-quality contraception.

In a few cases, the denial of reproductive health care documented in this report rises to the level of ill treatment. For example, the denial of reproductive health care to treat emergency or chronic situations due to women's inability to pay or lack of authorized immigration status violates the government's duty to take all steps to prevent women from experiencing suffering when such pain or suffering is evident and options to treat it are available. In addition, the lack of affordable and available services to diagnose severe reproductive health illnesses such as breast and cervical cancer forces women with identifiable symptoms of cancer to delay obtaining care—often until their condition becomes too serious or expensive to treat. Some women experience physical pain caused by this delay, as well as severe mental anguish from the inability to confirm whether they in fact have a life-threatening illness. Policies and practices that deny tests—such as ultrasounds and mammograms—to women with reason to believe they may have cancer or similarly serious chronic conditions, or deny access to essential medicines and pain treatment to women suffering from such conditions, violate their right to be free from ill treatment.

RECOMMENDATIONS

RECOMMENDATIONS

RIGHTS VIOLATIONS

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

TO THE STATE OF TEXAS

Expanding Access to Health Coverage, Services, and Information

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

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

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

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

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

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

Monitoring and Evaluation

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

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

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

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

Capacity Building and Training

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

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

TO CONGRESS

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

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

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

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

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

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

TO THE OBAMA ADMINISTRATION

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

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

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

TO CIVIL SOCIETY

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

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

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

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

GLOSSARY

GLOSSARY

Affiliate Rule: A state regulation that went into force in 2012 that prohibits any health provider that performs or promotes elective abortions from participating in the state-funded Medicaid family planning expansion program for low-income women (formerly the Women's Health Program, now the Texas Women's Health Program). In effect, this rule prohibits the distribution of state family planning funds to health providers, including Planned Parenthood health centers, that do not perform abortions but share a name or trademark with clinics that do. Tex. Admin. Code. §§ 39.33, 354.1362 (2012).

Affordable Care Act (ACA): Federal health reform law passed in 2010 that represents the most significant government expansion and regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965. The ACA aims to increase the rate of health insurance coverage for Americans, thus reducing the overall costs of health care by improving health care outcomes and streamlining the delivery of health care. Women's preventive care, including contraceptive coverage without cost-sharing, is considered an Essential Health Benefit that must be included in all plans regulated in state insurance exchanges. The ACA incorporated pre-existing legal bans on eligibility for Medicaid and tax credits to purchase private insurance that have excluded certain classes of immigrants, regardless of their income status, from many federal social benefits since 1996 welfare reform.

Colonia: A residential area along the U.S.-Mexico border that is unincorporated and unregulated, and therefore often lacks basic infrastructure and necessities, such as potable water and sewer systems, electricity, paved roads, and safe and sanitary housing. Texas has the largest population of *colonias* of any U.S. border state with Mexico, the majority of which are located in the Lower Rio Grande Valley.

Department of State Health Services (DSHS): A state agency of Texas that provides state-operated health care services, including hospitals, health centers, and health agencies. DSHS administers the state's family planning program and the expanded primary care program, which received $100 million for women's health care (60 percent earmarked for family planning) in the 2013-2015 biennium state budget.

Medicaid: Medicaid is the largest source of funding for medical and health-related services for low-income and indigent people in the United States. Under the federal Medicaid program, federal and state governments jointly pay for health care services for individuals who meet income and other eligibility requirements. Federal law bars Medicaid eligibility for undocumented immigrants and those who are "lawfully present" but have yet to reside in the U.S. for five years, although some states use state Medicaid funds to cover these groups. Texas limits income eligibility for Medicaid to those making 25 percent of the federal poverty level—a much higher threshold than other states. It participates in a family planning expansion program under Medicaid for women earning up to 185 percent of poverty, but the federal government withheld matching funds for this program in 2013 because of the affiliate rule.

Medicaid Expansion: The federal Affordable Care Act authorizes states to expand Medicaid coverage to all adults under age 65 with incomes up to 138 percent of the federal poverty level ($26,347 for a family of three and $15,417 for an individual) and provides significant federal funding to help states achieve such coverage. In 2012 the Supreme Court upheld the Affordable Care Act but gave states the choice to opt out of this provision. Governor Rick Perry announced in April 2013 that Texas would not participate in the ACA's Medicaid Expansion program.

Planned Parenthood Health Center: Planned Parenthood affiliates operate health centers around the country that provide a range of affordable, high-quality sexual and reproductive health services to millions of women and men. Services vary by location but typically include comprehensive contraception, testing and treatment for sexually transmitted infections, HIV testing, pregnancy testing and services, general health screenings, preventive women's health care including life-saving cancer screenings, and abortion. As of September 2013, Planned Parenthood operates 48 health centers in Texas through five independent local affiliates.

Promotora de Salud (Promotora): A volunteer community member or paid frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served due to shared ethnicity, language, socioeconomic status, and life experiences. These social attributes and trusting relationships enable these community health workers to serve as a liaison between health and social services and the community to facilitate access to and enrollment in services and to improve the quality and cultural competence of service. They also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. [Note: definition from the U.S. Department of Health and Human Services, Office of Minority Health.]

Reproductive Rights: Reproductive rights include the rights to health, life, equality, information, education, privacy, freedom from discrimination, freedom from violence, and self-determination, including the decision regarding whether and when to have children. These fundamental rights are found in national laws as well as international human rights treaties and consensus documents, including ones the U.S. has ratified such as the International Covenant on Civil and Political Rights, the International Convention on the Elimination of Racial Discrimination, and the Convention against Torture.

Lower Rio Grande Valley (the Valley): A region at the southernmost tip of Texas consisting of four counties—Cameron, Hidalgo, Starr, and Willacy—and separated from Mexico by the northern bank of the Rio Grande River. As of 2012, approximately 1.3 million people—a population that is overwhelmingly Latino—live in the Valley.

Texas Women's Health Program (TWHP): Texas' Medicaid-funded family planning program for low-income women that launched on January 1, 2013, replacing the former Women's Health Program (WHP). The program covers basic reproductive health care services such as contraception (except emergency contraception). Unlike its predecessor program, the TWHP is entirely state-funded, and is therefore free to set provider qualification standards independent from the federal government. According to state regulation, the TWHP does not contract with health care providers that provide abortions or are affiliated with organizations that provide abortions, such as Planned Parenthood health centers.

Title X: Title X of the federal Public Health Services Act was enacted in 1970 to provide comprehensive family planning and other preventive reproductive health services to low-income men and women at reduced or no cost. Title X-supported health centers provided contraceptive care to over 221,000 women in 2008, or about one-quarter of all poor women in Texas. Texas has received a Title X grant from the federal government since 1982 to support its family planning program administered through the Department of State Health Services, but in 2012, the Centers for Medicaid and Medicare awarded a $32 million grant to a consortium of family planning providers rather than to the state directly.

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ENDNOTES

1 U.S. Census Bureau, Population Div., Annual Estimates of the Resident Population: Apr. 1, 2010 to July 1, 2012 (2010), http://factfinder2.census.gov/bkmk/table/1.0/en/PEP/2012/PEPANNRES/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed Sept. 25, 2013).

2 U.S. Census Bureau, Population Div., ACS Demographic and Housing Estimates, 2009-2011 (2007-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/11_5YR/DP05/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed Sept. 25, 2013). Hispanics comprise between 87 percent (Willacy Co.) and 98.4 percent (Starr Co.) of the population in the four counties; *see also* Pew Research Hispanic Trends Project, *Demographic Profile of Hispanics in Texas, 2011*, http://www.pewhispanic.org/states/state/tx/ [hereinafter Pew Research Project].

3 Migrant Health Program, The Lower Rio Grande Valley, http://www.migranthealth.org/index.php?option=com_content&view=article&id=39&Itemid=31 (noting that nearly one-third of the Lower Rio Grande Valley's population depends on agricultural employment); *see also* Alice Larson, *Migrant and Seasonal Farmworker Enumeration Profiles Study: Texas*, Nat'l Ctr. for Farmworker Health, Inc., Migrant Health Program 13-17 (2000), http://www.ncfh.org/enumeration/PDF10%20Texas.pdf (estimating a total of 56,954 migrant and seasonal workers in Cameron, Hidalgo, Starr, and Willacy counties in 2000); *but see* U.S. Dep't of Commerce, Bureau of Economic Analysis, CA25N Regional Data, Total Full-time and part-time employment by NAICS industry (2012), http://www.bea.gov (follow "State and Local Area Personal Income" hyperlink; select "Local Area Personal Income and Employment"; select "Total full-time and part-time employment by industry (CA25, CA25N)"; select "NAICS (2001 forward)" and click "Next Step"; select "County" and click "Next Step"; select "Texas" and click "Next Step"; select "Cameron," "Hidalgo," "Starr," and "Willacy" counties and click "Next Step"; select "2011" and click "Next Step") (showing an official count of agricultural laborers as 7,000 people across all four counties or approximately 1 percent of the population).

4 U.S. Census Bureau, Educational Attainment – 2009-2011 American Community Survey 3-year Estimates, 2009 – 2011 (2009-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/11_3YR/S1501/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed Sept. 25, 2013).

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6 U.S. Census Bureau, Poverty Status in the Past 12 Months (2009-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/11_3YR/S1701/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed Sept. 25, 2013). In Hidalgo and Cameron counties, 35 percent of the population lives in poverty. Of all four counties in the Valley, Willacy has the highest rate of poverty at 39 percent of the population.

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11 In Health Region 11 which includes the four counties of the Valley, the prevalence was between 12.5–15.3 percent, statistically higher than the state prevalence rate of 9.7 percent and the national rate of 9.3 percent. *See also* Univ. of Texas-Pan American (UTPA) Border Health Office, Statistics: Diabetes Registry (2006), https://www.utpa.edu/bho/Statistics.htm (showing the estimated diabetes prevalence rate in the Lower Rio Grande Valley, as estimated by the UTPA Border Health Office in 2006, as high as 26 percent).

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13 For more information about the designation process for Medically Underserved Areas and Populations, *see* Dep't of Health & Hum. Services, Health Resources & Services Admin., *Medically Underserved Areas & Populations (MUA/Ps)*, http://bhpr.hrsa.gov/shortage/muaps/ (last updated June 1995). For information about Texas counties with this designation, *see* Texas Dep't of State Health Servs., *MUA and MUP Designations*, http://www.dshs.state.tx.us/CHS/hprc/MUAlist.shtm (last updated April 10, 2012).

14 Texas A&M Univ. Sys. Health Science Ctr., Sch.of Rural Pub. Health, *Rural Healthy People 2010: A Companion Document to Healthy People 2010 Vol. I.* 19, 20 (2003), http://srph.tamhsc.edu/centers/rhp2010/Volume1.pdf (stating "Health insurance is a critical factor in influencing timely access to health care. Persons without healthcare coverage are less likely to… obtain preventive care…"); *see also* Aishia Glasfor & Priscilla Huang, *Women's Health Activist Newsletter - Immigrant Women's Health a Casualty in the Immigration Policy War*, Nat'l Women's Health Network (2008), http://nwhn.org/immigrant-womens-health-casualty-immigration-policy-war (noting that increased restrictions in the Welfare Reform Act, which excluded immigrant women who had entered the U.S. after August 22, 1996 and had not lived in the country for at least five years, limited and discouraged that population's access to health insurance and their use of Medicaid for preventive services); *see also* Nat'l Latina Inst. for Reprod. Health, *Prenatal Care Access Among Immigrant Latinas* (2005), http://latinainstitute.org/sites/default/files/publications/PrenatalCare-2_0.pdf (explaining that a lack of healthcare coverage and poor access to culturally competent and linguistically appropriate health information coalesce to make immigrant Latinas more likely to forgo essential preventative care, including prenatal care").

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18 Texas Dep't of State Health Servs. (DSHS), 2009 Health Facts Profiles for Texas, http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc. Compared to Texas' overall uninsured rate of 26.3 percent, the rate of uninsured in each county of the Valley is as follows: Hidalgo, 37.9%; Cameron, 36.6%; Starr, 34.6%; and Willacy, 32.4%.

19 Chris Tomlinson, *S. Texas Counties among Highest Rates of Uninsured*, Bloomberg Businessweek News (Aug. 30, 2013), http://www.businessweek.com/ap/2013-08-30/s-dot-texas-counties-among-highest-rates-of-uninsured; *see also* U.S. Census

Bureau, Health Insurance Coverage Status (2012), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/12_1YR/S2701/0500000US48215 (last accessed Sept. 26, 2013).

[20] Adam Sonfield, *Evidence Mounts of Recession's Impact on Women of Reproductive Age*, 13 Guttmacher Pol'y Review 17, 18 (2010), http://www.guttmacher.org/pubs/gpr/13/4/gpr130417.pdf. Texas has one of the highest immigrant populations in the United States, accounting for 16.4 percent of its population.

[21] U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE) Interactive Data Tool (2008-2011), http://www.census.gov/did/www/sahie/data/interactive/#view=data&utilBtn=&yLB=0&stLB=44&aLB=1&sLB=2&iLB=0&rLB=3&countyCBSelected=false&insuredRBG=pu_&multiYearSelected=false&multiYearAlertFlag=false (last accessed Sept. 26, 2013). Nationally, immigrant women of reproductive age are approximately 70 percent more likely than their U.S.-born peers to lack health insurance. Adam Sonfield, *The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care*, 10 Guttmacher Pol'y Review 7, 8 (2007), http://www.guttmacher.org/pubs/gpr/10/1/gpr100107.pdf [hereinafter Sonfield, Impact of Anti-Immigrant Policy].

[22] KFF, State Health Facts, No Personal Doctor/Health Care Provider for Women, by State and Race/Ethnicity, 2006-2008 (2004-2006), http://kff.org/disparities-policy/state-indicator/no-personal-doctor/ (last accessed Sept. 20, 2013).

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[25] Jennifer Frost et al., *Contraceptive Needs and Services, 2010*, Guttmacher Inst. 10, 33 (2013), http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf [hereinafter Frost, Contraceptive Needs]. In contrast, 14.5 percent of the total number of women in need of publicly supported contraception in Texas were non-Hispanic Black and 30 percent were white.

[26] *Id.* at 7. Demand among Hispanic women grew 46 percent from 2000 to 2010; the next highest increases were among poor women (37%) and women in their 20s (16%).

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[28] Guttmacher Inst., *State Facts about Unintended Pregnancy: Texas*, http://www.guttmacher.org/statecenter/unintended-pregnancy/pdf/TX.pdf (2012).

[29] Kathryn Kost & Stanley Henshaw, *U.S. Teenage Pregnancies, Births and Abortions, 2008: State Trends by Age, Race and Ethnicity*, Guttmacher Inst. 1, 7 (2013) (In 2008, the teen pregnancy rate in Texas was 85 per 1,000 women aged 15-19 compared to the national rate of 68 per 1,000 women in the same age group).

[30] John Santelli et al., *Changing Behavioral Risk for Pregnancy Among High School Students in the United States, 1991–2007*, 45(1) J. of Adolescent Health 25-32 (2009); Centers for Disease Control & Prevention (CDC), Youth Risk Behavior Surveillance System, Texas 2011 Results, http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=TX (last accessed Sept. 20, 2013) (showing no statistically significant difference between Latina girls and non-Hispanic white girls in sexual behavior or condom use but showing a statistically significant difference in whether they used contraception the last time they had sex); *see also* Guttmacher Inst., State Data Ctr., http://www.guttmacher.org/datacenter/servlet/CreateTable?action=doTable (last accessed Sept. 20, 2013) (showing Latina teens have a pregnancy rate of 118 per 1,000 pregnancies compared to 58 per 1,000 for their non-Hispanic white teen counterparts).

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[32] Comm. on Health Care for Underserved Women, *Health Care for Undocumented Women*, Am. Cong. of Obstetricians & Gynecologists 1, 2 (2009), http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Health_Care_for_Undocumented_Immigrants.

[33] Nat'l Latina Inst. for Reprod. Health, *Latinas and Cervical Cancer in Texas: A Public Health Crisis* 2 (2013), http://latinainstitute.org/sites/default/files/publications/fact-sheets/Latinas-and-Cervical-Cancer-inTexas-NLIRH-Fact-Sheet-January-2013.pdf (Data was generated for the years 2000-2009 from the Texas Cancer Registry. Note that Veterans Health Administration and military hospital reporting is incomplete for 2008-2009 Texas Cancer Registry cancer cases. Therefore, case counts and incidence rates in 2008-2009 are underestimated and should be interpreted with caution. Data is age adjusted to the 2000 U.S. Standard Population).

[34] Cancer Prevention & Research Inst. of Texas, *Cervical Cancer in Texas: A Closer Look* 3 (2010), http://www.cprit.state.tx.us/images/uploads/report_cervical_a_closer_look.pdf. *See also* Texas DSHS, *Texas Chronic Disease Burden Report* 23 (2010), http://www.dshs.state.tx.us/diabetes/tdcdata.shtm.

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[36] 8 U.S.C. §§ 1611-13 (1996).

[37] Ctr. for Public Pol'y Priorities, *The Texas Health Care Primer* 43 (2011), http://library.cppp.org/files/3/TxHlthPrimer_2011_Side_by_Side.pdf; *see also* Nat'l Immigrant Law Ctr., Medical Assistance Programs for Immigrants in Various States, *at* www.nilc.org/document.html?id=159 (last accessed Sept. 26, 2013).

[38] Emergency Medicaid covers pregnancy-related services including prenatal, delivery, and postpartum family planning services for up to 60 days after birth. *See* State Policies in Brief, *Medicaid Family Planning Eligibility Expansions*, Guttmacher Inst. 2 (2013). Texas has elected to extend Emergency Medicaid to cover uninsured women with incomes up to 185 percent of the federal poverty level. In 2010, Medicaid financed nearly 57 percent of the births in Texas and non-citizens accounted for half of these. Texas Health & Hum. Servs. Comm'n, Medicaid and Healthy Babies, Address at Expert Panel Meeting Summary (Jan. 6-7, 2011) (slides available at http://alt.coxnewsweb.com/statesman/politifact/012011_hhscmedicaidhealthybabiespresentation.pdf); *see also* Thanh Tan, *Texas 'Border' Checkpoints Deter Noncitizens Seeking Second-Trimester Abortions*, Texas Tribune (Aug. 24, 2012), http://newamericamedia.org/2012/08/border-checkpoints-deter-noncitizens-seeking-later-abortions.php; PolitiFact Texas, *Democratic Legislators Say More Than Half of Texas Births Funded by Medicaid*, Austin-American Statesman, http://www.politifact.com/texas/statements/2012/mar/24/elliott-naishtat/democratic-legislators-say-more-half-texas-births-/.

[39] A 2002 federal rule grants states the option under the Children's Health Insurance Program (CHIP) to provide prenatal care to women regardless of their immigration status by covering the fetus as an "unborn child." 42 C.F.R. § 457.622 (2012); *see also* Kinsey Hasstedt, *Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants*, 16 Guttmacher Pol'y Review 2-3 (2013), http://www.guttmacher.org/pubs/gpr/16/1/index.html. Texas is one of 15 states that has elected to extend such coverage, although it declined an option afforded in the 2009 reauthorization of CHIP to cover all the health needs of low-income pregnant women—not just their fetuses—who would otherwise be subject to the five-year bar on benefits. For more information about the change in policy and particular benefits to lawfully present immigrant women, *see* Ctr. for Children & Families, *The Children's Health Insurance Program Reauthorization Act of 2009: Overview and Summary* (2009), http://ccf.georgetown.edu/index/chip-law.

[40] Between 1994 and 2005, enrollment of Medicaid and CHIP dropped from 26 percent to 17 percent among lawfully present immigrants, but it also had the unanticipated effect of curbing enrollment in legal residents who should not have been impacted by the rule change (decreasing from 41 percent to 22 percent). Adam Sonfield, Impact of Anti-Immigrant Policy, *supra* note 21, at 7, 8 (2007).

[41] Kaiser Comm'n on Medicaid & the Uninsured, *Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities* 3, 13 (2012).

[42] Yasmeen Abutaleb, *U.S. Community Health Centers Eye Obamacare's Newly Insured*, Reuters (Jul 14, 2013), http://www.reuters.com/article/2013/07/14/us-usa-healthcare-community-idUSBRE96D03U20130714.

[43] Memorandum from Janet Napolitano, Sec. of U.S. Dep't of Homeland Security, Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children (June 15, 2012), *available at* http://www.dhs.gov/xlibrary/ assets/s1–exercising–prosecutorial–discretionindividuals–who–came–to–us–as–children.pdf.

[44] Proposed Rule 78 Fed. Reg. 4613, (Jan. 22, 2013) (to be codified at 42 C.F.R. §435.4(4)(vi)) and the amendment to the interim final rule, 77 Fed. Reg. 52614 (Aug. 30, 2012) (to be codified at 45 CFR §152.2(8)). The administration issued this interim rule on August 30, 2012 and it became effective immediately.

[45] Jeanne Batalova & Michelle Mittelstadt, *Relief from Deportation: Demographic Profile of the DREAMers Potentially Eligible under the Deferred Action Policy,* Migration Pol'y Inst. 7 (2012), http://www.migrationpolicy.org/pubs/FS24_deferredaction.pdf.

[46] The Immigration Policy Center estimates that 68 percent of DACA eligible beneficiaries are from Mexico and another 13 percent are from North and Central America, including the Caribbean. Am. Immigration Council, *Who and Where the DREAMers Are: A Demographic Profile of Immigrants Who Might Benefit from the Obama Administration's Deferred Action Initiative*, Immigr. Pol'y Ctr. 4 (2012), http://www.immigrationpolicy.org/sites/default/files/docs/who_and_where_the_dreamers_are_0.pdf.

[47] Texas is tied at 48th for the state with the lowest percentage of its low-income population covered by Medicaid. Women who are 18 years and older, have incomes up to 185 percent of the federal poverty level, and have resided legally in Texas for five years are eligible for enrollment in the Women's Health Program (WHP) and its successor, the Texas Women's Health Program (TWHP). Texas Legislative Study Group, Texas on the Brink: A Report from the Texas Legislative Study Group On the State of our State, 83rd Sess., 2 (2013), *available at* https://leafmedium-live.s3.amazonaws.com/blog/texaslsg/TexasOnTheBrink2013.pdf.

[48] Crystal Conde, *Physicians Worry About Women's Access to Care*, 108(7) Tex Med. 18-25 (2012), http://www.texmed.org/Template.aspx?id=24707#sthash.cp6ROmCl.dpuf; Kari White et al., *Cutting Family Planning in Texas*, 367(13) New Engl. J. Med. 1179 (2012) [hereinafter White, Cutting Family Planning].

[49] Act of May 31, 2011, ch. 1355, 2011 Tex. Gen. Laws 4025, 4228 (effective Sept. 1, 2011).

[50] Act effective Sept. 1, 2005, ch. 816, § 1(h), 2005 Tex. Gen. Laws 2818; Tex. Admin. Code §§354.1361-64 (2012).

[51] Planned Parenthood challenged the affiliate rule in court, but a federal appeals court found the rule to be constitutional. Planned Parenthood Ass'n of Hidalgo Cnty. Texas Inc. v. Suehs, 828 F.Supp.2d 872 (W.D. Tex. 2012), *vacated and remanded*, 692 F.3d 343 (5th Cir. 2012) (holding "that Texas may deny WHP funds from organizations that promote elective abortions through identifying marks").

[52] Tex. Hum. Res. Code Ann. §32.0248(a) (2005).

[53] Planned Parenthood health centers served 45 percent of women in the WHP in 2011—by far the dominant provider in the state. Peter Shin et al., *Deteriorating Access to Women's Health Services in Texas: Potential Effects of the Women's Health Program Affiliate Rule*, Dep't of Health Pol'y, George Washington Univ. Sch. of Pub. Health & Health Servs. 13 (2012), http://www.rchnfoundation.org/wp-content/uploads/2013/02/Texas-WHP-study-FINAL-FINAL-pdf-10.10.12.pdf.

[54] Social Security Act §2105(c)(7)(a)-(c), 42 U.S.C. §1397(e)(e) (2006), *available at* http://www.ssa.gov/OP_Home/ssact/title21/2105.htm; *see also* Texas Women's Healthcare Coalition, *Texas Women's Healthcare in Crisis* 6 (2013), http://www.texaswhc.org/wp-content/uploads/2013/01/Texas-Womens-Healthcare-in-Crisis.pdf; Tex. Health and Hum. Res. Comm'n, *Rider 48 Report: 2011 Annual Savings and Performance Report for the Women's Health Program* 3 (2012), *available at* http://www.hhsc.state.tx.us/reports/2013/Rider-48-Annual-Report.pdf.

[55] Jordan Smith, *State Blackmail on Health Care Funds?*, Austin Chronicle (June 28, 2013), http://www.austinchronicle.com/news/2013-06-28/state-blackmail-on-health-care-funds/; Carolyn Jones, *Texas Women's Health Advocates to Bypass State in Bid for Federal Funds*, Texas Observer (Nov. 19, 2012), http://www.texasobserver.org/texas-womens-health-advocates-to-bypass-state-in-bid-for-federal-funds/.

[56] Becca Aaronson, *Legislature Restores Some Family Planning Cuts*, N.Y. Times (Aug. 8, 2013), http://www.nytimes.com/2013/08/09/us/legislature-restores-some-family-planning-cuts.html?pagewanted=all.

[57] Univ. of Texas Population Research Ctr., TXPEP Family Planning Data Finder, *State: DSHS Family Planning Clinic Closure,* http://www.prc.utexas.edu/txpep/#state (last accessed Sept. 19, 2013) [hereinafter TXPEP Family Planning Data Finder].

[58] *Id.*

[59] Texas Pol'y Evaluation Project, *Survey of Reproductive Health Clinics in Texas Research Brief* (2013), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/TxPEP-ResearchBrief-SurveyofReproductive-HealthClinics.pdf [hereinafter TXPEP, Survey of Reproductive Health Clinics].

[60] DSHS-funded facilities that no longer receive Title X dollars are no longer bound by Title X's confidentiality provision that attaches to all their clients, including teens seeking services without parental consent. That federal provision serves as an exemption from state laws like one in Texas that requires parental consent for minors under 18 years old seeking contraception. *See Id.* (showing that 40 percent of organizations providing family planning services required parental consent for teens after the cuts took effect compared to only 25 percent of organizations prior to the cuts).

[61] TXPEP Family Planning Data Finder, *supra* note 57 (last accessed Sept. 30, 2013) (showing that the number of women statewide served by DSHS between 2010 and 2012 dropped from 234,738 in 2010 to 90,681 in 2012).

[62] Even as the need for affordable contraception increased by 30 percent from 2000-2010, the number of clinics providing such services in Texas between 2001 and 2010 decreased by 12 percent, and the number of women receiving publicly supported contraceptive services decreased by 20 percent during the same time period. Frost, Contraceptive Needs Report, *supra* note 25, at 16-17; *see also* TXPEP Family Planning Data Finder, *supra* note 57 (showing that the number of women served under Texas' DSHS Family Planning Program in 2010 was 234,738) (last accessed Sept. 20, 2013).

[63] TXPEP Family Planning Data Finder, *supra* note 57, *County: DSHS Family Planning Clinic Closures*, http://www.prc.utexas.edu/txpep/#county

[64] TXPEP, *How Abortion Restrictions would Impact Five Areas of Texas* 3 (2013), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/ImpactBrief-ProposedHB2-SB1AbortionBill.pdf.

[65] White, Cutting Family Planning, *supra* note 48, at 1179-80.

[66] *Id.*

[67] TXPEP Family Planning Data Finder: County, *supra* note 63. Note: this figure does not include women served through the Women's Health Program.

[68] Becca Aaronson, *Restoring Family Planning Services through Primary Care*, Texas Tribune (Mar. 1, 2013), http://www.texastribune.org/2013/03/01/restoring-family-planning-services-through-primary/.

[69] *See* 25 Tex. Admin. Code. §39.6 (2013); Texas Women's Healthcare Coalition, *Legislature Restores Funding for Preventive Care* 1 (2013), http://www.texaswhc.org/wp-content/uploads/2013/06/TWHC-PostSession-1Pager-Final.pdf [hereinafter TWHC, Legislature Restores Funding]. This program contracts with primary community health centers and non-profit organizations to provide basic health services including family planning to Texas residents with incomes up to 150 percent of the Federal Poverty Level. *See also* Texas DSHS, Primary Health Care in Texas, http://www.dshs.state.tx.us/phc/.

[70] TWHC, Legislature Restores Funding, *supra* note 69, at 1.

[71] *Id.*

[72] Because Planned Parenthood health centers served 45 percent of women who received care in 2011 through the WHP, an independent study by George Washington University estimated that the affiliate rule excluding Planned Parenthood from receiving state funds may jeopardize access for 52,000 women—nearly half of those currently served by the new TWHP. Peter Shin et al., *An Early Assessment of the Potential Impact of Texas' "Affiliation" Regulation on Access to Care for Low-income Women*, Dep't of Health Pol'y, The George Washington Univ. Sch. of Pub. Health & Health Servs. 2 (2012) [hereinafter GW Early Assessment Report].

[73] *Id.* at 8.

[74] The two clinics that closed were Southmost (Cameron Co.) and Generation Y (McAllen Co.) (Information obtained from a conversation with researchers from the TXPEP at the University of Texas, Austin, on July 23, 2013).

[75] GW Early Assessment Report, *supra* note 72, at 9 (showing that in 2010, community health centers under the WHP program served 10,130 patients to Planned Parenthood clinics' 51,953 patients).

[76] Susan Wood et al., ***Health Center and Family Planning: Results of a Nationwide Survey***, Dep't of Health Pol'y, George Washington Univ. Sch. of Pub. Health & Health Servs. (2013), http://www.rchnfoundation.org/wp-content/uploads/2013/04/Health_Centers_and_Family_Planning-final-1.pdf.

[77] Rachel Benson Gold, ***Besieged Family Planning Network Plays Pivotal Role,*** 16(1) Guttmacher Pol'y Review 14 (2013), http://www.guttmacher.org/pubs/gpr/16/1/gpr160113.pdf; Jennifer Frost, et al., ***Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs***, 22(6) Women's Health Issues 520, 523-24 (2012), http://download.journals.elsevierhealth.com/pdfs/journals/1049-3867/PIIS1049386712000734.pdf.

[78] The state's loss of Title X funding carries consequences for facilities still contracted through DSHS. In addition to the loss of grant money, these clinics are now ineligible to receive a deeply discounted rate for medications, which allows them to stock a wide range of contraception and tailor prescriptions to women's needs. White, Cutting Family Planning, *supra* note 48; Texas Policy Evaluation Project, *Postpartum Contraception Access in Austin: Research Brief* (2013), http://www.utexas.edu/cola/orgs/txpep/_files/pdf/TxPEP-ResearchBrief-PostpartumContraceptionAccess.pdf (finding that lack of insurance coverage, inability to afford co-pays, and difficulties getting to a clinic were the main barriers preventing women from using preferred long-acting contraceptive methods or sterilization).

[79] Jordan Smith, ***Texas Women's Health Care: Costs More, Does Less***, Austin Chronicle (Nov. 30, 2012), http://www.austinchronicle.com/blogs/news/2012-11-30/texas-womens-health-care-costs-more-does-less/.

[80] Edinburg, Int. 6.

[81] Brownsville Focus Group (Dec. 5, 2012).

[82] Brownsville, Int. 7.

[83] Edinburg Focus Group (Dec. 7, 2012).

[84] Brownsville Focus Group (Dec. 5, 2012).

[85] Brownsville Int. 2.

[86] Brownsville, Int. 6; Mercedes, Int. 1.

[87] Rio Grande Focus Group.

[88] Brownsville, Int. 4.

[89] Mission Int. 2.

[90] Edinburg Focus Group (Dec. 7, 2012).

[91] Brownsville, Int. 13; Edinburg, Int. 5.

[92] Mission Focus Group (Dec. 5, 2012).

[93] Brownsville, Int. 3.

[94] San Juan, Int. 4.

[95] Brownsville, Int. 5.

[96] Brownsville, Int. 12; Brownsville, Int. 13.

[97] Brownsville, Int. 6.

[98] Brownsville, Int. 11.

[99] Mission, Int. 8.

[100] Brownsville, Int. 7.

[101] Mission Focus Group (Jan. 31, 2013).

[102] Alamo Focus Group.

[103] Brownsville, Int. 10.

[104] Brownville, Int. 14.

[105] Brownsville, Int. 9.

[106] Brownsville, Int. 10.

[107] Mission, Int. 1.

[108] The Texas Health and Human Services Commission and the Texas Health Steps program provide free transportation for Texas Health Steps patients and most others who use Medicaid medical and dental services, provided they have no alternate way to get to their doctor's visit. The service only reimburses patients who are enrolled in Medicaid, and it will not process requests for transportation money in advance for adult Medicaid patients. *See* Texas Health & Hum. Servs. Comm'n & Texas Health Steps, Free Rides from Medicaid: A Remedy for Missed Appointments (2010), http://www.txhealthsteps.com/static/mtp/_pdf/STEPS-0267_DeskReference_Eng_lo.pdf.

[109] Donna, Int. 3.

[110] *Id.*

[111] Lasara, Int. 1.

[112] Mission, Int. 4.

[113] Brownsville, Int. 5.

[114] Lasara, Int. 1.

[115] San Juan, Int. 5.

[116] *Id.*

[117] Alamo Focus Group.

[118] Mission, Int. 9.

[119] Edinburg, Int. 4.

[120] Lasara, Int. 1; Brownsville, Int. 12.

[121] Alamo, Int. 1.

[122] *See* Adam Isacson & Maureen Meyer (Washington Office on Latin America), ***Beyond the Border Buildup: Security and Migrants along the U.S.-Mexico Border*** 5 (2012), http://www.wola.org/files/Beyond_the_Border_Buildup_FINAL.pdf. In 2010, for example, the homicide rate on the Mexican side of the border was 96 per 100,000 people compared to 3.6 on the U.S. side.

[123] U.S. Dep't of State, Bureau of Consular Affairs, *Travel Warning: Mexico*, http://travel.state.gov/travel/cis_pa_tw/tw/tw_6033.html (last updated July 12, 2013).

[124] Brownsville, Int. 8.

[125] Rio Grande Focus Group (Dec. 5, 2012).

[126] *Id.*

[127] Pharr, Int. 1.

[128] Donna, Int. 3.

[129] Edinburg, Int. 1.

[130] Brownsville, Int. 11.

[131] Donna, Int. 2.

[132] Rio Grande Focus Group.

[133] Mission, Int. 9.

[134] San Juan, Int. 1.

[135] Lasara, Int. 4.

[136] Brownsville Focus Group (Dec. 7, 2012).

[137] Brownsville, Int. 4.

[138] Mission, Int. 7.

[139] Brownsville, Int. 12.

[140] Brownsville, Int. 3.

[141] Brownsville Focus Group (Dec. 5, 2012).

[142] Alamo Focus Group.

[143] Brownsville Focus Group (Dec. 5, 2012).

[144] Donna Focus Group.

[145] Brownsville, Int. 4.

[146] Brownsville, Int. 11.

[147] Mission, Int. 1.

[148] San Juan, Int. 2.

[149] San Juan, Int. 4.

[150] San Juan, Int. 5.

[151] Mission, Int. 6.

[152] Mission, Int. 2.

[153] Brownsville, Int. 12.

[154] San Juan, Int. 4.

[155] San Juan, Int. 5.

[156] Brownsville, Int. 1.

[157] Brownsville, Int. 12.

[158] Mission, Int. 6.

[159] Edinburg Focus Group (Dec. 7, 2012).

[160] San Juan Focus Group.

[161] Brownsville Focus Group (Dec. 5, 2012).

[162] *Id.*

[163] Lasara, Int. 1.

[164] Brownsville, Int. 13.

[165] *Id.*

[166] *Id.*

[167] Brownsville, Int. 6.

[168] Alamo, Int. 1.

[169] San Juan, Int. 4.

[170] Edinburg, Int. 6.

[171] Lasara, Int. 2.

[172] Brownsville, Int. 3.

[173] Alamo Focus Group.

[174] Rio Grande Focus Group.

[175] Alamo Focus Group.

[176] Edinburg Focus Group (Dec. 7, 2012).

[177] Edinburg, Int. 5.

[178] Donna Focus Group.

[179] Brownsville Focus Group (Dec. 5, 2012).

[180] Mission, Int. 2.

[181] Rio Grande Focus Group.

[182] Mission, Int. 5.

[183] Edinburg, Int. 2.

[184] Donna, Int. 3.

[185] Brownsville, Int. 2.

[186] Mission, Int. 5.

[187] Brownsville, Int. 6.

[188] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16 at 52, arts. 2(1), 6(1), 17, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR]; International Convention on the Elimination of All Forms of Racial Discrimination, *adopted* Dec. 21, 1965, G.A. Res. 2106 (XX), Annex, U.N. GAOR, 20th Sess., Supp. No. 14 at 47, art 5(e)(iv), U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, (*entered into force* Jan. 4, 1969) [hereinafter ICERD]; Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, G.A. res. 34/180, U.N. GAOR, 34th Sess., Supp. (No. 46) at 193, arts. 1, 10, 12, U.N. Doc. A/34/46, 1249 U.N.T.S. 13, 19 I.L.M. 33 (1980), (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16 at 49, arts. 2(2), 12, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *reprinted in* 6 I.L.M. (1967) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]; *Programme of Action of the International Conference on Population and Development, Cairo, Egypt*, Sept. 5-13, 1994, Principle 8 and para. 7.2, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter ICPD Programme of Action]; *Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-15 1995, paras. 89-92, U.N. Doc. A/CONF.177/20 (1995); *Vienna Declaration and Programme of Action, World Conference on Human Rights*, Vienna, Austria, June 14-25, 1993, para. 18, U.N. Doc. A/CONF.157/23 (1993).

[189] ICPD Programme of Action, *supra* note 188, para. 7.3 ("[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.").

[190] Human Rights Committee (HRC), *General Comment No. 31: Nature of the General Legal Obligation on States Parties to the Covenant* (18th Sess., 2004), paras. 3-6, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004); HRC, *General Comment No. 3: Implementation at the National Level (Art. 2),* (13th Sess., 1981), para. 1, *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 4 (1994).

[191] Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms, *adopted* Mar. 8, 1999, G.A. Res. 53/144, annex, 53 U.N. GAOR Supp., art. 2, U.N. Doc. A/RES/53/144 (1999).

[192] Signing confers an obligation to uphold the object and purpose of these treaties. Vienna Convention on the Law of Treaties, art. 18, May 23, 1969, 1155 U.N.T.S. 331, reprinted in 8 I.L.M (*entered into force* on Jan. 27, 1980).

[193] Universal Declaration of Human Rights, *adopted* Dec. 10, 1984, art. 3, G.A. Res. 217A(III), U.N. Doc. A/810 (1948) [hereinafter UDHR]; ICCPR, *supra* note 188, art. 6(1), Convention on the Rights of the Child, art. 6, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989), *reprinted* in 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990) [hereinafter Children's Rights Convention]; Convention on the Rights of Persons with Disabilities, art. 10, *adopted* Dec. 13, 2006, G.A. Res. 61/106, U/N. Doc. A/RES/61/106 (2006), 1249 U.N.T.S. 13 (*entered into force* May 3, 2008) [hereinafter Disability Rights Convention].

[194] HRC, *General Comment No. 6: The Right to Life (Article 6),* (16th Sess., 1982), para. 1, *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) at 176; HRC, *General Comment No. 28: Equality of Rights between Men and Women (Art. 3)*, (68th Sess.), para. 10, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1Rev.5 (2001) at 1668 [hereinafter, HRC General Comment No. 28]; *see also Report of the Special Rapporteur on violence against women, its causes and consequences, in accordance with Commission on Human Rights resolution 1997/44 – Addendum - Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women*, para. 66, U.N. Doc. E/CN.4/1999/68/Add.4 (Jan. 21, 1999) (by Ms. Radhika Coomaraswamy) [hereinafter SR – VAW Report] (noting "[g]overnment failure to take positive measures to ensure access to appropriate health-care services that enable women to safely deliver their infants as well as to safely abort unwanted pregnancies may constitute a violation of a woman's right to life…").

[195] *See, e.g.,* ICESCR, art. 12; ICERD, art. 5; CEDAW, *supra* note 188, arts. 12, 14; Children's Rights Convention, art. 24; Disability Rights Convention, art. 25. *See also* UDHR, art. 25(1).

[196] Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14, The Right to the Highest Attainable Standard of Health (Art. 12),* para. 12, U.N. Doc E/C.12/2000/4 (2000) [hereinafter CESCR General Comment No. 14].

[197] *Id.*

[198] CEDAW Committee (CEDAW), *General Recommendation No. 24, Article 12 of the Convention (Women and Health)* (20th Sess.), U.N. Doc. A/54/38/Rev.1, chap. I (1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. II), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) at 358, para. 1 [hereinafter CEDAW *General Recommendation No. 24*]; CESCR General Comment No. 14, *supra* note 196, para. 8.; Report of the Special Rapporteur on the right to health, *Report on the right of everyone to enjoyment of the highest attainable standard of physical and mental health*, para. 6, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover) [hereinafter SR-Health Annual Report 2011].

[199] *See* ICPD Programme of Action, *supra* note 188, para. 7.3 (affirming that "the aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and to make available a full range of safe and effective methods"). The first conference to recognize this right was the International Conference on Human Rights in Teheran, followed by the 1974 World Population Conference in Bucharest. The right was first codified in the 1994 ICPD Programme of Action (Principle 8 and para. 7.12), followed by the Beijing Platform at the Fourth World Conference

on Women in Beijing in 1995.

[200] CEDAW, art. 12; CEDAW, ***General Recommendation No. 21: Equality in marriage and family relations***, (13th Sess. 1994), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies (Vol. II), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (1994) at 337, para. 22, (noting "women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services"); HRC, ***Concluding Observations: Philippines***, U.N. Doc. CCPR/C/PHL/CO/4, para. 13 (2012); HRC, ***Concluding Observations: Peru***, UN Doc.CCPR/C/PER/5, para. 14 (urging the government to ensure access to free emergency contraception in order to reduce the risk of maternal death from unsafe abortion); CESCR General Comment No. 14, *supra* note 196, paras. 14, 21; SR-VAW Report, *supra* note 194, para. 76; SR-Health Report 2011, *supra* note 198, para. 65.

[201] *See, e.g.*, CEDAW, ***Concluding Observations: Hungary***, para. 254, U.N. Doc. A/51/38 (1996); ***Kazakhstan***, paras. 105-06, U.N. Doc. A/56/38 (2001); ***Slovakia***, paras. 42-43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008). *See also* HRC, ***Concluding Observations: Poland***, para. 9, U.N. Doc. CCPR/CO/82/POL (2004); Children's Rights Committee (CRC), ***General Comment No. 3: HIV/AIDS and the rights of the child***, para. 20, U.N. Doc. CRC/GC/2003/3 (2003); CESCR General Comment No. 14, *supra* note 196, paras. 12(b)(iii), 43; ***Resolution 1607: Access to Safe and Legal Abortion in Europe***, para. 7.6, Eur. Parl. Doc., (2008), ***available at*** http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta08/ERES1607.htm; SR-Health Report 2011, *supra* note 199, at para. 11. *See also* World Health Organization (WHO), ***Fact Sheet No. 31: The Right to Health***, 15 [hereinafter WHO Fact Sheet].

[202] CEDAW, art. 14(2)(b) (explaining governments have a duty to ensure women in rural areas "have access to adequate health care facilities, including information, counselling and services in family planning…"); CESCR, ***Concluding Observations: Colombia***, para. 775, E/2002/22 (2001); CERD Committee, ***Concluding Observations: Colombia***, para. 22, CERD/C/COL/CO/14 (2009). *See also* CEDAW, ***Concluding Observations: Armenia***, para. 58, A/57/38 part III (2002); ***Uganda***, para. 152, A/57/38 part III (2002); ***Guatemala***, para. 195, A/57/38 part III (2002); ***Yemen***, para. 400, A/57/38 part III (2002).

[203] CESCR General Comment No. 14, *supra* note 196, paras. 36-37.

[204] ***Id.*** at para. 21.

[205] ***Id.***; HRC, ***Concluding Observations: Jamaica***, para. 14, CCPR/C/JAM/CO/3 (2011); ***Philippines***, U.N. Doc. CCPR/C/PHL/CO/4, para. 13 (2012) (urging the city government of Manila to reverse its ban on funding and disseminating contraceptives).

[206] CESCR General Comment No. 14, *supra* note 196, paras. 12(b), 19.

[207] ***Id.*** at para. 11.

[208] ICCPR, arts. 2, 3; ICERD, arts. 2, 5; CEDAW, arts. 10, 11, 12, 14(2); ICESCR, art. 2(2), 10(3), 12.

[209] HRC General Comment No. 28, *supra* note 194, para. 30 (recognizing that "discrimination against women is often intertwined with discrimination on other grounds" including race, national or social origin, property, and other status).

[210] ***Id.*** at para. 3; CESCR, ***General Comment No. 20: Non-discrimination in economic, social and cultural Rights (art. 2, para. 2)***, para. 8, U.N. Doc. E/C.12/GC/20 (2009); CESCR, ***General Comment No. 16: Article 3: the equal right of men and women to the enjoyment of all economic, social and cultural rights*** (34th Sess., 2005), para. 7, U.N. Doc. E/C.12/2005/3. *See also* CEDAW, ***General Recommendation No. 25 on art. 4, para. 1, on temporary special measures***, *in* Compilation of Gene. Comments & Gen. Recommendations Adopted by Human Rts. Treaty Bodies, paras. 4, 10, U.N. Doc. HRI/GEN/1/Rev.7 at 282 (2004).

[211] CEDAW, ***Communication No. 17/2008, Maria de Lourdes da Silva Pimentel v. Brazil***, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) (finding Brazil failed in its obligation to prevent discrimination in its maternal health care system, leading to the premature death of an Afro-Brazilian woman).

[212] HRC, ***Concluding Observations: Canada***, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999).

[213] CEDAW, ***Communication No. 22/2009, L.C. v. Peru***, U.N. Doc. CEDAW/C/50/D/22/2009 (2011) (finding Peru violated the petitioner's rights to non-discrimination and equality because the state failed to establish an appropriate legal framework to enable women to exercise their legal right to therapeutic abortion, thereby subjecting L.C. to the biases of medical professionals and depriving her of an appropriate and timely medical procedure to which she was legally entitled).

[214] HRC ***Concluding Observations: Philippines***, U.N. Doc. CCPR/C/PHL/CO/4, para. 13 (2012).

[215] HRC ***Concluding Observations: Poland***, para. 9, U.N. Doc. CCPR/CO/82/POL (2004); HRC, ***Concluding Observations: Poland***, para. 11, U.N. Doc. CCPR/C/79/Add.110 (1999); ***Argentina***, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000); ***Georgia***, para. 12, U.N. Doc. CCPR/C/79/Add.75 (1997); ***Peru***, U.N. Doc. CCPR/C/PER/CO/5, para. 14 (2013). *See also* CEDAW, General Recommendation No. 24, ***Women and Health*** (20th Sess., 1999), U.N. Doc. A/54/38 at 5 (1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 21 at 271, U.N. Doc. HRI/GEN/1/Rev.6 (2003).

[216] CERD, ***Concluding Observations: United States of America***, para. 33, U.N. Doc. CERD/C/USA/CO/6 (2008); *see also* CEDAW, ***Concluding Observations: Cypress***, CEDAW/C/CYP/CO/6-7, para. 30 (2013); ***Hungary***, para. 31, U.N. Doc. CEDAW/C/HUN/CO/7-8 (2013); ***Lichtenstein***, CEDAW/C/LIE/CO/4, para. 39 (2011).

[217] CERD Concluding Observations: United States, para. 33, U.N. Doc. CERD/C/USA/CO/6 (2008).

[218] ICCPR, art. 2(1) (emphasis added); *see also* HRC, ***General Comment No. 15: The position of aliens under the Covenant*** (1986), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 1, 4, U.N. Doc. HRI/GEN/1/Rev.6 at 140 (2003) ("[i]n general, the rights set forth in the Covenant apply to everyone, irrespective of reciprocity, and irrespective of his or her nationality or statelessness" and "[t]he Covenant gives aliens all the protection regarding rights guaranteed therein, and its requirements should be observed by States parties in their legislation and in practice as appropriate.").

[219] *See* CEDAW, ***General Comment No. 26 on Migrant Women Workers***, U.N. Doc. CEDAW/C/2009/WP.1/R, para. 17 (2008) (noting "[w]omen migrant workers often suffer from inequalities that threaten their health. They may be unable to access health services, including reproductive health services, because insurance or national health schemes are not available to them, or they may have to pay unaffordable fees. As women have health needs different from those of men, this aspect requires special attention.").

[220] HRC, ***Concluding Observations: Republic of Korea***, para. 12, U.N. Doc. CCPR/C/KOR/CO/3 (2006) (noting "[t]he State party should ensure to migrant workers enjoyment of the rights contained in the covenant without discrimination," and "[in this regard, particular attention should be paid to ensuring equal access to social services and educational facilities."); ***Latvia***, para. 18, U.N. Doc. CCPR/CO/79/LVA (expressing concern "over the perpetuation of a situation of exclusion, resulting in lack of effective enjoyment of many Covenant rights by the non-citizen segment of the population, including… social benefits" and recommending that the State party "limit the number of… restrictions on non-citizens in order to facilitate the participation of non-citizens in public life in Latvia."); ***Thailand***, para. 23, U.N. Doc. CCPR/CO/84/THA (2005) (noting serious concern with "the lack of full protection of the rights of registered and unregistered migrant workers… particularly with regard to… access to social services and education" and recommending that "[m]igrant workers should be afforded full and effective access to social services, educational facilities, and personal documents in accordance with principles of non-discrimination.").

[221] CESCR General Comment No. 14, *supra* note 196, para. 34 (explaining that governments have a duty to "refrain[] from denying or limiting equal access — on economic, physical and cultural grounds— for all persons, including… illegal immigrants, to preventive curative and palliative health services."). *See also* Special Rapporteur on the human rights of migrants, ***Annual Report of the Special Rapporteur on the human rights of migrants to the Human Rights Council***, para. 28, U.N. Doc. A/HRC/14/30 (Apr. 16, 2010) (by Jorge Bustamonte) (stressing that States have an obligation under human rights law to go beyond a "mere commitment to emergency care" and to ensure instead the "the critical importance of providing migrants with essential primary health care," which reduces costs and health risks to the benefit of everyone).

[222] CESCR General Comment No. 14, *supra* note 196, para. 8; WHO Fact Sheet, *supra* note 201, pg. 3.

[223] ***Report of the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment to the Human Rights Council***, para. 17, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) (by Juan Mendez) [SR Torture Annual Report 2013].

[224] ***Id.*** at para. 46.

[225] CAT, ***General Comment No. 2: Implementation of article 2 by States parties*** (39th Sess., 2007), paras. 20-23, U.N. Doc. CAT/C/GC/2 (2008); Ximenes Lopes v. Brazil, Merits, Reparations, and Costs, Inter-Am. Ct. H.R., (ser. C) No. 149, para. 103 (July 4, 2006).

[226] *See* SR Torture Annual Report 2013, *supra* note 223, para. 18 (noting the European Court of Human Rights' ruling in Peers v. Greece, App. No. 28524/95, 2001-III Eur. Ct. H.R. para. 34, that a violation of article 3 may still exist where a victim is degraded, humiliated or punished even where a State's act or omission did not have that intended purpose or intention).

[227] ***Id.*** at paras. 36-38.

[228] ***Id.*** at para. 54.

[229] ***Id.*** at para. 49 (citing the example of K.L. v. Peru, wherein the HRC found that the denial of a safe abortion in the case of rape constituted a violation of the victim's right to be free from ill-treatment).

[230] ***Id.*** at paras. 54-56.


CONVERSE
ALL★STAR