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## Latina Young Adults' Use of Health Care During Initial Months in the United States

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### Abstract

We examined social ecological predictors of health care utilization among Latina young adults during their initial year after immigration to the United States. Participants were 530 Latinas (ages 18–23) who immigrated to Miami-Dade County, Florida, 11.5 months before assessment. We used multiple logistic regression to test predictors of health care usage. Approximately 36% utilized care. Dimensions of *marianismo* differentially associated with usage. Usage also was more likely for participants who reported more social network attachment, better health, greater neighborhood cohesion, and possessed a job and health insurance. Findings inform interventions to increase health care usage globally among women after immigration.

### Keywords

Latinas; marianismo; health care usage; immigrants; health disparities; social ecological theory

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Recent increased migration rates around much of the world resulted in immigration policies by numerous governments to inhibit migration, including limiting access to health care for immigrants [e.g., Canada, Costa Rica, several European countries, the United States (US), and Scandinavia; Hacker, Anies, Folb, & Zallman, 2015]. Insufficient health care can put migrants at great risk. In the US, insufficient health care is posited to cause several health disparities disproportionately affecting Latina women, including HIV/AIDS, diabetes, and several types of cancer (Centers for Disease Control and Prevention [CDC], 2015). An evidence base is needed to help prevent the “immigrant health paradox”—the well

documented decline in health of foreign-born Latina/os as they spend more time in the US (e.g., Flores, Simonsen, Manuck, Dyer, & Turok, 2012; Wieland et al., 2012). Thus, in the present study, we investigated social and cultural determinants of health care usage among young Latina women (ages 18–23) who had immigrated to the US in 2013–2014. Our aim was to elucidate proximal and distal correlates of young women's use of health care services soon after immigration. We also hoped to inform international interventions to foster alternate methods of health care for women immigrants with restricted access to care (Tian, Goovaerts, Zhan, Chow, & Wilson, 2012).

Latina/os are one of the most disadvantaged ethnic groups in the US concerning health care access and utilization (Paz & Massey, 2016). There has been a dramatic increase in the number of US Latina/os accessing health insurance via The Patient Protection and Affordable Care Act (ACA), a law enacted by the US federal government in 2010 to make health care coverage more equitable and affordable. However, almost one-third of the US Latina/o population remains uninsured – a higher rate than all other US ethnic groups (US Department of Health and Human Services, 2016; Vargas, Sanchez, & Juarez, 2017). Moreover, 39% of foreign-born, *non-citizen* Latinos and almost half of undocumented Latinos lack insurance due in part to ineligibility for the ACA and other government assistance (Krogstad & Lopez, 2014). Thus, Latina immigrants often lack a regular health care provider during their initial months in the US due to inability to afford care, as well as barriers such as (b) unfamiliarity with the US health care system, (c) preference for alternative forms of treatment, (d) difficulties due to language and cultural differences, (e) discrimination, and/or (f) unauthorized immigration status and fear of deportation (De Jesus & Miller, 2015; Escarce & Kapur, 2006; Gurman & Becker, 2008; Hacker, et al., 2015; Marshall, Urrutia-Rojas, Mas, & Coggin, 2005). These obstacles are especially problematic for Latina young adults in the US given that medical practitioners recommend that Latina young women receive regular cancer screening due to the disproportionately high prevalence rates in the US (Bickell, 2002; Nodora et al., 2015; Zhan & Lin, 2014).

Previous studies on social and cultural determinants of health care use among Latina immigrants in the US have primarily focused on older, US-born Latinas or Latina immigrants residing in the US for many years (Abraído-Lanza, Martins, Shelton, & Flórez, 2015; Asamoah et al., 2004; Fuentes-Afflick & Hessol, 2009; Garcés, Scarinci, & Harrison, 2006). Understanding potential determinants of health care soon after immigration to the US among young women may foster an evidence base for early interventions targeting health disparities affecting Latina young adults as well as similar immigrant populations internationally. Therefore, guided by Bronfenbrenner's (1986) social ecological theory, we hypothesized potential determinants of health care to be either proximal or distal during Latina young adults' first year in the US. Proximal factors are direct, reciprocal interactions between individuals and environmental contexts, whereas distal factors include constructs which affect an individual indirectly via her context. The four hypothesized proximal factors were (a) endorsement of *marianismo* (i.e., a traditional gender role in Latino culture; Castillo, Perez, Castillo, & Ghosheh, 2010); (b) commitment to ethnic identity (i.e., having a greater sense of belonging to one's cultural group; Phinney, 1992); (c) attachment or separation with social network after immigration (De La Rosa, Dillon, Schwartz, Rojas, & Duan, 2010); and (d) perceived health status (Shelton, Goldman, Emmons, Sorensen, &

Allen, 2011). The four hypothesized distal determinants were: (a) perceived neighborhood collective efficacy (Sampson, Raudenbush, & Earls, 1997), (b) possessing health insurance (Krogstad & Lopez, 2014), (c) socioeconomic status (SES; Marshall et al., 2005), and (d) immigration status (Hacker et al., 2015).

## Potential Proximal Factors Affecting Latina Young Adult Health Care Utilization

Marianismo is an understudied cultural factor that may influence Latina young adults' health care utilization in the US and in Latin American countries. Marianismo beliefs may promote health care use by encouraging behaviors that are selfless, moral/religious, maternal, and healthy and discouraging health risk behaviors, such as alcohol and illicit drug use (Otero-Sabogal, Stewart, Sabogal, Brown, & Pérez-Stable, 2003). For example, the marianismo belief of selfless devotion to the maternal role tended to promote healthy behaviors in new Latina mothers in the US (McGlade, Saha, & Dahlstrom, 2004). Alternatively, marianismo also may inhibit health care utilization. The marianismo belief that a Latina should silence herself to maintain harmony in relationships is posited to explain why Latinas in the US with breast cancer were afraid of burdening their families with seeking treatment (Ashing-Giwa, Padilla, Bohórquez, Tejero, & Garcia, 2006). Furthermore, endorsement of the marianismo belief that Latinas should be spiritual leaders of the family may hinder use of conventional health care because more endorsement of spirituality is positively linked with use of alternative treatments for physical ailments among Latinas in the US (e.g., personal prayer, medicinal herbs) (Ransford, Carrillo, & Rivera, 2010). Marianismo also encourages Latina women to make sacrifices and endure suffering for the family. Thus, this value may influence Latina women in the US and internationally to delay seeking necessary care for themselves to take care of family members undergoing challenges after immigration (Garcés et al., 2006). Overall, we expected that higher endorsement of the different dimensions of marianismo would differentially associate with use of health care during initial months in the US.

Similar to marianismo, commitment to Latina ethnic identity may affect health care usage. Older Latinas in the US who indicated a greater sense of belonging to their ethnic group (i.e., ethnic identity) tend to utilize health care services less. A greater sense of ethnic identity is posited to cause less interaction with individuals from the receiving country (i.e., outside of one's immigrant/ethnic group), which often means less exposure to sources of information about health care resources (Keyes et al., 2012). Latina women in the US and in Latin American countries with a greater sense of ethnic identity also may not prioritize their health if doing so would conflict with the aforementioned marianismo and other collectivistic values (e.g., *familismo*; Lara, Gamboa, Kahramanian, Morales, & Hayes Bautista, 2005). Therefore, we expected that higher commitment to Latina ethnic identity would be inversely associated with use of health care during initial months in the US.

An influential proximal system in the lives of Latina immigrants in the US and other nations may be their attachment to their social network. Attachment, the emotional bond experienced between an individual and her family, close friends, and other significant people

(Bowlby, 1982), is posited to be influential across the lifespan (Szapocznik & Coatsworth, 1999). Social attachments promote cancer screenings (Suárez et al., 2000) and the avoidance of health risk behaviors among adult Latinas in the US (De La Rosa et al., 2010). This may be due, in part, to social networks providing information about health care services and encouraging loved ones to be healthy. Social networks may be the sole resource for information about health screenings or instrumental support that may promote use of care (e.g., money, transportation, emotional support) during the initial months in a new country. However, recent Latina immigrants may experience separation from social supports during immigration to the US or other countries (Ayala et al., 2004). Thus, we expected that weaker social network attachment bonds would be linked with less use of care in the present sample.

Negative health status relates to greater utilization of health care among US Latinos (Garcini et al., 2015). However, Latina immigrants living in the US for decades report difficulty accessing care even when they have serious health problems (Shelton et al., 2011). For example, having a negative health status relates with economic difficulties, which may prevent utilization of expensive health care in the US (Shelton et al., 2011). Moreover, previous research has noted the general importance of health status as a variable in examinations of health care usage among US adults (Escarce & Kapur, 2006). Thus, we accounted for perceived health status as a proximal determinant in the present sample.

### Potential Distal Determinants Affecting Health Care Utilization

Latina immigrants often live in segregated ethnic enclaves in many US cities (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). These enclaves may foster neighborhood collective efficacy, defined as social cohesion and willingness to intervene on behalf of others in a community (Sampson et al., 1997). Individuals living in more cohesive, safe neighborhoods are more likely to obtain preventative health care because safe neighborhoods allow for walking to appointments or neighbors who may offer referrals and transportation (Prentice, 2006; Shelton et al., 2011). Based on these benefits, we expected collective efficacy to positively associate with use of health care among Latina young adult immigrants during initial year in US.

Health insurance status and SES also are expected to be positively linked with health care usage in the present study. As previously noted, seventeen percent of US-born Latinos lack health insurance, whereas 39% of foreign-born Latinos and 49% of undocumented Latinos in the US lack insurance (Krogstad & Lopez, 2014). Having health insurance is intertwined with SES in the US; Latina young adults in the US (ages 19–25) with higher SES are more likely to receive preventive care (González, Suárez, & Ortiz, 2015). Immigrants in the US tend to report lower income and educational levels in comparison to US-born Latinas (Marshall et al., 2005) making it difficult to afford health care (González et al., 2015). Consistent employment may foster routine medical care via employer-provided health insurance (Bustamante, Chen, Fang, Rizzo, & Ortega, 2014). However, Latina young women in the US are often unemployed after immigration or restricted from health insurance during their initial years in US due to undocumented or non-citizen status (Raymond-Flesch, Siemons, Pourat, Jacobs, & Brindis, 2014). In addition, length of time in the US may impact health care usage, as Latina immigrants who have spent longer in the US are more likely to

have an established source of care (Documét & Sharma, 2004). Thus, we expected certain distal factors (i.e., greater neighborhood collective efficacy; having health insurance; higher SES, including educational level and employment status; authorized documentation status; time in the US) to positively relate with use of health care.

## Material and Methods

### Recruitment and Procedure

The institutional review board of a large southeastern university in the US approved the study. Participants met eligibility criteria if they identified as a Latina woman, aged 18–23 years old, and immigrated to the US from a Latin American country within 36 months of recruitment.

Respondent driven sampling (RDS; Salganik & Heckathorn, 2004) was used to recruit participants. RDS involves asking each participant (or seed) to recruit three other women in her social network who meet study inclusionary criteria. This procedure is repeated up to five times, at which point a new seed begins to avoid skewing the respondent sample. Seed participants were recruited through advertisements at various community-based agencies (e.g., language schools) and online postings. Consent procedures and all survey interviews were in Spanish by four Latina research assistants. Assessors conducted interviews at a safe location chosen by participants or in university offices.

### Participants

The sample consisted of 530 Latina women who immigrated to Miami-Dade County, Florida, US in 2013–2014. Participants resided in the US for an average of 11.5 months ( $SD = 9.94$ ) at assessment. Participants' ages ranged from 18 to 23 years ( $M = 20.81$ ,  $SD = 1.80$ ). Fifty-seven percent completed the equivalent to a high school diploma in their countries of origin, and 30% had a bachelor's or trade school degree. Approximately 66% were unemployed. The most prominent ethnic group represented was Cuban at 34%, followed by Colombian (11.1%), Nicaraguan (7.5%), Honduran (6.4%), Peruvian (5.6%), Mexican (5.1%), Venezuelan (4.9%), Ecuadorian (3.8%), Panamanian (3.6%), and Dominican (3.0%). Approximately 17% were undocumented/not legally unauthorized to be in the US.

### Measures

We selected measures that either were validated in Spanish in previous research, or translated by present study researchers of various Latino ethnicities through a process of translation/back translation and checked for conceptual equivalence to ensure accurate translation (Behling & Law, 2000).

**Use of Health Care.**—Use of health care since arriving to the US was measured using an item from the fifth edition of the Addiction Severity Index (ASI; McLellan et al., 1992) that asked, “Have you visited a doctor since your arrival to the US?” (1 = *Yes*, 0 = *No*). This item enabled us to measure whether participants had been to a health care appointment for necessary or preventative care, as suggested by the CDC (i.e., annual medication checkup; 2015b).

## Proximal Factors of Health Care Use

**Marianismo Beliefs.**—Marianismo beliefs were measured using the Marianismo Belief Scale (MBS; Castillo et al., 2010). The MBS measured the extent to which participants endorsed five dimensions of traditional gender role beliefs about Latina women. Five subscales assessed participants' endorsement of (a) the belief that Latinas are the main source of strength of the family and are responsible for keeping the family unified and happy (Family Pillar), (b) the belief that Latinas should be morally pure in thought and sexuality (Virtuous and Chaste), (c) the belief that Latinas must show obedience and respect to the Latino hierarchical power structure (Subordinate to Others), (d) the belief that Latinas should not share personal thoughts or needs to maintain harmony in relationships (Self-Silencing to Maintain Harmony), and (e) the belief that Latinas are the spiritual leaders of the family and are responsible for the family's spiritual growth (Spiritual Pillar). In the present study, internal consistency estimates (Cronbach's alphas) for the Family Pillar, Virtuous and Chaste, Subordinate to Others, Self-Silencing to Maintain Harmony, and Spiritual Pillar subscales were .92, .89, .92, .95, and .90 respectively.

**Ethnic Identity.**—The Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992; Roberts et al., 1999) assessed participants' ethnic identity. Higher scores indicated stronger endorsement of commitment to one's ethnic identity. The measure asked participants to rate their feelings about (and affiliation with) their ethnic group on a scale ranging from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). A total mean score of MEIM items was analyzed in the present study, which yielded a Cronbach's alpha of .97.

**Attachment and Separation with Social Network.**—Attachment with social network was measured using the Trust and Communication subscales of the Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987). Participants were asked to assess their level of trust and communication in current relationships with their mothers, fathers, partners, and friends. More specifically, they were asked to assess the accuracy of 25 questions for each of the four types of relationships (i.e., total of 100 questions), with responses on a scale ranging from 1 (*Never or almost never true*) to 5 (*Always or almost always true*). Items from the trust and communication subscales for each relationship were averaged to arrive at a total attachment with social network score. It yielded a Cronbach's alpha coefficient of .97.

Separation from social network was calculated by asking each participant where her mother, father, partner, and close friends were located at the time of assessment (1 = *In the same city*, 2 = *In the US*, 3 = *Outside the US*, 4 = *In an unknown place*). The mean of the responses for each of the four types of social network members reflected a total score for separation.

**Health Status.**—Perceived health status was measured by an item from the ASI (McLellan et al., 1992). Participants were asked, "How would you evaluate your health status?" They rated their responses on a scale from 1 (*Poor*) to 5 (*Excellent*). A higher score indicated better perceived health status.



## Distal Factors of Health Care Use

**Neighborhood Collective Efficacy.**—Neighborhood collective efficacy was measured using the Collective Efficacy Scale (CES; Sampson et al., 1997). The CES measured participants' perceived social cohesion among their neighbors on a scale ranging from 1 (*Very Unlikely*) to 5 (*Very Likely*). A total score was calculated by averaging CES items. Higher scores indicated more perceived community solidarity. The present sample demonstrated adequate internal consistency ( $\alpha = .79$ ).

**Health Insurance.**—Participants responded to an item from the fifth edition of the ASI (McLellan et al., 1992): “Do you have health insurance at this moment?” (0 = *No*, 1 = *Yes*).

**Distal Sociodemographic Variables.**—Information was asked about participants' perceived SES of family of origin (1 = *Poorer than others*, 2 = *Like others*, 3 = *Richer than others*), education level, employment status, immigration authorization status, and length (in months) of time in the US at assessment. Perceived SES of family of origin was utilized in the present study as opposed to other measures, such as current income, because participants were living in the US for less than a year on average and lacked variability in income.

## Analytic Strategy

The analytic plan consisted of three major steps. First, correlation coefficients between all study variables were calculated to assess evidence of discriminant validity and multicollinearity. Two Marianismo Belief Scale subscales (Subordinate to Others and Self-Silencing to Maintain Harmony) were found to highly correlate with each other ( $r = .88$ ). The scales were combined by calculating an average of the two scale scores for each participant. The new scale, termed “Subordinate/Self-Silencing,” yielded a Cronbach's alpha of .97 and was used in subsequent analyses. Third, the hypothesized proximal and distal predictor variables were entered into a multiple logistic regression analysis accounting for hypothesized potential social and cultural determinants of health care usage.

## Results

### Preliminary Analyses

Descriptive statistics and correlations are presented in Table 1. Thirty-six percent ( $n = 191$ ) of participants reported visiting a doctor since immigrating to the US. Only 18.9% ( $n = 100$ ) reported having health insurance at the time of assessment.

### Multiple Logistic Regression for Use of Health Care

Results of regression analysis are presented in Table 2. Of the proximal determinants, use of health care during initial months in the US was associated with (a) endorsing the Family Pillar marianismo belief [OR = 2.66, 95% CI (1.39 – 5.06),  $p = .003$ ]; (b) more attachment with social network [OR = 2.32, 95% CI (1.38 – 3.89),  $p = .001$ ]; (c) less separation from social network [OR = 0.58, 95% CI (0.39 – 0.87),  $p = .008$ ]; and (d) better perceived health status [OR = 1.35, 95% CI (1.05 – 1.73),  $p = .02$ ]. Not using health care since immigration was related with endorsing two dimensions of marianismo: Subordinate/Self-Silencing to

Maintain Harmony [OR = 0.36, 95% CI (0.23 – 0.55),  $p < .001$ ] and Spiritual Pillar [OR = 0.63, 95% CI (0.41 – 0.99),  $p = .04$ ].

Distal determinants of health care utilization included: (a) reporting more collective efficacy [OR = 1.51, 95% CI (1.03 – 2.20),  $p = .04$ ]; (b) possessing health insurance [OR = 4.36, 95% CI (2.40 – 7.93),  $p < .001$ ]; and (c) being employed [OR = 2.24, 95% CI (1.31 – 3.85),  $p = .003$ ]. Finally, women who spent more time in the US at assessment were more likely to have used health care since immigrating [OR = 1.05, 95% CI (1.02 – 1.07),  $p < .001$ ].

## Discussion

We believe our findings contribute to the understanding of social ecological systems influencing utilization of health care during Latina young adult women's initial months in the US. We find fewer young Latina women in our sample visited a doctor during their first year in the US than the national average of 78% of young women (aged 19–25) who report annually seeking health care (Kirzinger et al., 2012). Given that Latinas' health tends to deteriorate after immigrating to the US (i.e., immigrant health paradox; Flores et al., 2012), a low health care utilization rate may account for health disparities affecting this population and other immigrants after arrival to host countries (Loue, 2008).

We found that Latina young women differed in their utilization of health care depending on their endorsement of marianismo. Participants used health care services approximately three times more often when they more strongly endorsed the belief that women should be a source of strength in the family. This is consistent with previous findings that Latina immigrants **in the US** engage in healthy behaviors for their families' wellness (McGlade et al., 2004). In contrast, those who more strongly endorsed the belief that women should silence themselves and respect the familial hierarchy were 64% less likely to use care. This behavior may reflect the cultural norm for Latina women to delay their own needs for the good of their family (Garcés et al., 2006). Similarly, greater endorsement of the belief that Latina women should be the spiritual pillars of the family related with 36% lower chance of health care usage. This link may be due to spiritually-inclined young women using home remedies, medications/herbs, or folk healers first or in lieu of conventional health care (Wallace, Torres, Beltran, & Cohen-Boyar, 2014; Garcés et al., 2006; Mikhail, Wali, & Ziment, 2004).

Our findings concerning separation with social network are consistent with findings that companionship provided by close friends and family contributes to health (e.g., Alegría, Sribney, Mulvaney-Day, 2007). Functional support (e.g., emotional assistance) and structural support (e.g., size/agency of supports) are the mechanisms underlying this well-established link (Alegría et al., 2007). Hence, informational, encouraging social networks seem critical for Latinas who possess limited knowledge of the US health care system (Suárez et al., 2000).

Unexpectedly, healthier participants were more likely to utilize care. Health status tends to inversely predict health care among US-born Latinos and immigrants residing in the US for decades (Garcini et al., 2015). Less healthy participants may not use care due to the barriers



to accessing health care in the US that are described in our study and others (e.g., Shelton et al., 2011). Alternatively, those who accessed care may perceive themselves as healthier because they received health services. Regardless, this finding increases health professionals' awareness of young women who are not utilizing care even when it may be needed.

Women who reported more collective efficacy were more likely to utilize health care. Living in a cohesive community may support trusting interpersonal connections and better access to health services for immigrants in the US and other countries (Alegría et al., 2007; Haas et al., 2004). Latina immigrants living in more cohesive neighborhoods may learn of Spanish-speaking, culturally congruent health care providers (Kershaw, Albrecht, & Carnethon, 2013). Supportive enclaves may facilitate dissemination of information about such providers, encourage healthier lifestyles, and ease Latina immigrants' transition into the labor market in the US and in other countries (Dubowitz, Subramanian, Acevedo-Garcia, Osypuk, & Peterson, 2008).

Employment and health insurance were overlapping distal factors related to utilization of care. In the US health care system, employment may provide access to insurance that makes health care more affordable (Marshall et al., 2005; Richardson & Norris, 2010). Future studies are encouraged to clarify this finding, as low rates of health insurance coverage among Latino immigrants exist even when participating in the US workforce due to government program restrictions, such as differing definitions of noncitizen status (DuBard & Gizlice, 2008). For instance, even authorized immigrants are currently ineligible for some forms of government assistance (Medicaid) within their first five years of legal residence and often have difficulty paying for or obtaining health insurance (Raymond-Flesch et al., 2014).

The strengths of this study include the size of the sample and the recent immigration of participants. Additionally, 17% of the sample consisted of understudied, unauthorized immigrants. However, study limitations should be noted. First, the sample did not include some Latino immigrant groups in the US due to their underrepresentation in Miami-Dade County area in comparison to other areas of the US (US Census Bureau, 2010). Second, health care usage was operationalized using a dichotomous measure and a cross-sectional design. Future studies need to elucidate type and frequency of care accessed over time via longitudinal designs.

### **Implications for Practice and/or Policy**

Findings provide a multitude of potential determinants of health care usage among an underserved population in the US. On an international level, medical practitioners and researchers are encouraged to attend to traditional cultural gender role beliefs that may influence access to health care resources. Professionals also should increase their awareness of potential alternatives to traditional medicine used among Latina/o immigrants and similar immigrant populations (Engelman, Cizik, Ellerbeck, & Rempusheski, 2012). Additionally, findings support the development of structural interventions to increase social network attachment and neighborhood collective efficacy in the US and other nations (e.g., Rhodes et al., 2012; Suárez et al., 2000; Viruell-Fuentes, Ponce, & Alegría, 2012). For example, interventions could promote health benefits of neighborhood collective efficacy by

developing capacity-building partnerships that foster civic activities for greater sense of cohesive community and concern and support for community members (e.g., Rusch, Frazier, & Atkins, 2015). Structural interventions also could educate community agencies [e.g., dominant (English) language schools, legal and employment assistance offices] about the importance of personal and social connections that foster wellness after immigration for information dissemination.

We recommend future interventions to facilitate utilization of health care by young adult women with perceived negative health status during their initial time in receiving countries globally. These women may be most in jeopardy of developing the health disparities affecting this population. Community-based participatory methods, which include building strong relationships with communities, empowering communities to determine their own areas of need, and establishing priorities for health concerns, have demonstrated success with underserved Latina women in the US for issues such as HIV/AIDS (e.g., Rhodes et al., 2012), nutrition (e.g., Wieland et al., 2012), cancer screening (e.g., Larkey et al., 2012), maternal health (Rios-Ellis, Nguyen-Rodriguez, Espinoza, Galvez, & Garcia-Vega, 2015), and access to high-quality health care (Moreno, Rodríguez, Lopez, Bholat, & Dowling, 2009). We also suggest potential novel skill building areas (e.g., offering employment assistance through resume workshops and job skill building) to inform these interventions. Such initiatives are critical, as they may promote the health of the largest and growing in the US as well as promote the health of similar immigrant populations of women in other countries.

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Table 1.

Means, Standard Deviations, and Correlations of Study Variables

Variable	M, Mdn or %	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Use of health care since immigration <sup>a</sup>	36% Yes	-	1.00														
<b>Proximal Factors</b>																	
2. Ethnic identity	3.69	0.98	.13**	1.00													
3. Marianismo – Family Pillar	3.27	0.65	.13**	.50**	1.00												
4. Marianismo – Virtuous and Chaste	2.98	0.71	-.08	-.35**	.69**	1.00											
5. Marianismo – Subordinate and self-silencing	2.31	0.85	-.33**	.13**	.19**	.52*	1.00										
6. Marianismo – Spiritual Pillar	2.86	0.77	-.20**	.33**	.63**	.66**	.54**	1.00									
7. Attachment with social network	3.55	0.63	.36**	.27**	.19**	.02	.22**	-.04	1.00								
8. Separation from social network	1.93	0.70	-.22**	-.02	.02	.04	.10*	.16**	-.03	1.00							
9. Perceived health status	1.71	1.01	.22**	.22**	.04	.02	-.05	-.01	0.02	-.08	1.00						
<b>Distal Factors</b>																	
10. Neighborhood Collective Efficacy	3.38	0.70	.18**	.29**	.27**	.18**	.09*	.24**	.22**	-.02	.06	1.00					
11. Health insurance <sup>a</sup>	34% insured	-	.38**	.06	.03	-.13**	-.18**	-.06	.23**	-.13**	.13**	.19**	1.00				
12. Childhood socioeconomic status	2.00	0.48	.12**	.08	.03	.01	-.08	-.03	.06	-.07	.06	.05	.10*	1.00			
13. Education level <sup>b</sup>	Mdn = 2	-	-.06	.05	.01	-.06	-.02	.03	.03	.01	-.10*	.05	-.09*	.05	1.00		
14. Employment status <sup>c</sup>	34% employed	-	.12**	.04	.06	.07	-.03	.05	0.05	.06	.05	.02	-.03	-.02	.25**	1.00	
15. Immigration status <sup>d</sup>	83% authorized	-	.20**	.05	-.07	-.09	-.15**	-.13**	.15**	-.27**	.11*	.13**	.21**	.13**	.04	.05	1.00
16. Time in the U.S.	11.52	9.94	.46**	.14**	.10*	-.09*	-.031	-.16**	.32**	-.21**	.09*	.13**	.24**	.04	-.14**	.03	.18**

\* Note. p < .05

\*\* p < .01

<sup>a</sup> 0 = No, 1 = Yes

$q_1$  = Less than high school, 2 = Completed high school, 3 = Some college, 4 = Bachelor's degree, or 5 = Postgraduate

$q_0$  = Unemployed, 1 = Employed

$p_0$  = Unauthorized, 1 = Authorized.

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**Table 2.**

Results of multiple logistic regression organized by proximal and distal factor categories: Associations between proximal and distal factors and utilization of health care during Latina young adults' initial months in the US.

	<i>B</i>	<i>S.E.</i>	<i>p</i>	<b>Odds Ratio</b>	<b>95% Confidence Interval</b>
<b>Proximal Factors</b>					
Marianismo beliefs					
1. Family Pillar	.98	.33	.003	2.66	1.39, 5.06
2. Spiritual Pillar	-.46	.23	.04	0.63	0.41, 0.99
3. Subordinate/Self-Silencing to Maintain Harmony	-1.03	.22	.001	0.36	0.23, 0.55
4. Virtuous and Chaste	.24	.26	.35	1.27	0.77, 2.10
Ethnic identity					
Attachment with social network	.84	.26	.001	2.32	1.38, 3.89
Separation from social network	-.55	.21	.008	0.58	0.39, 0.87
Perceived health status	.30	.13	.02	1.35	1.05, 1.73
<b>Distal Factors</b>					
Collective efficacy	.41	.20	.04	1.51	1.03, 2.20
Health insurance	1.47	.31	.001	4.36	2.40, 7.93
Socioeconomic status	.45	.31	.15	1.56	0.86, 2.84
Educational level	-.21	.16	.19	0.81	0.59, 1.11
Employment status	.81	.28	.003	2.24	1.31, 3.85
Immigration status	.07	.41	.86	1.08	0.49, 2.39
Time in the US	.05	.01	.001	1.05	1.02, 1.07