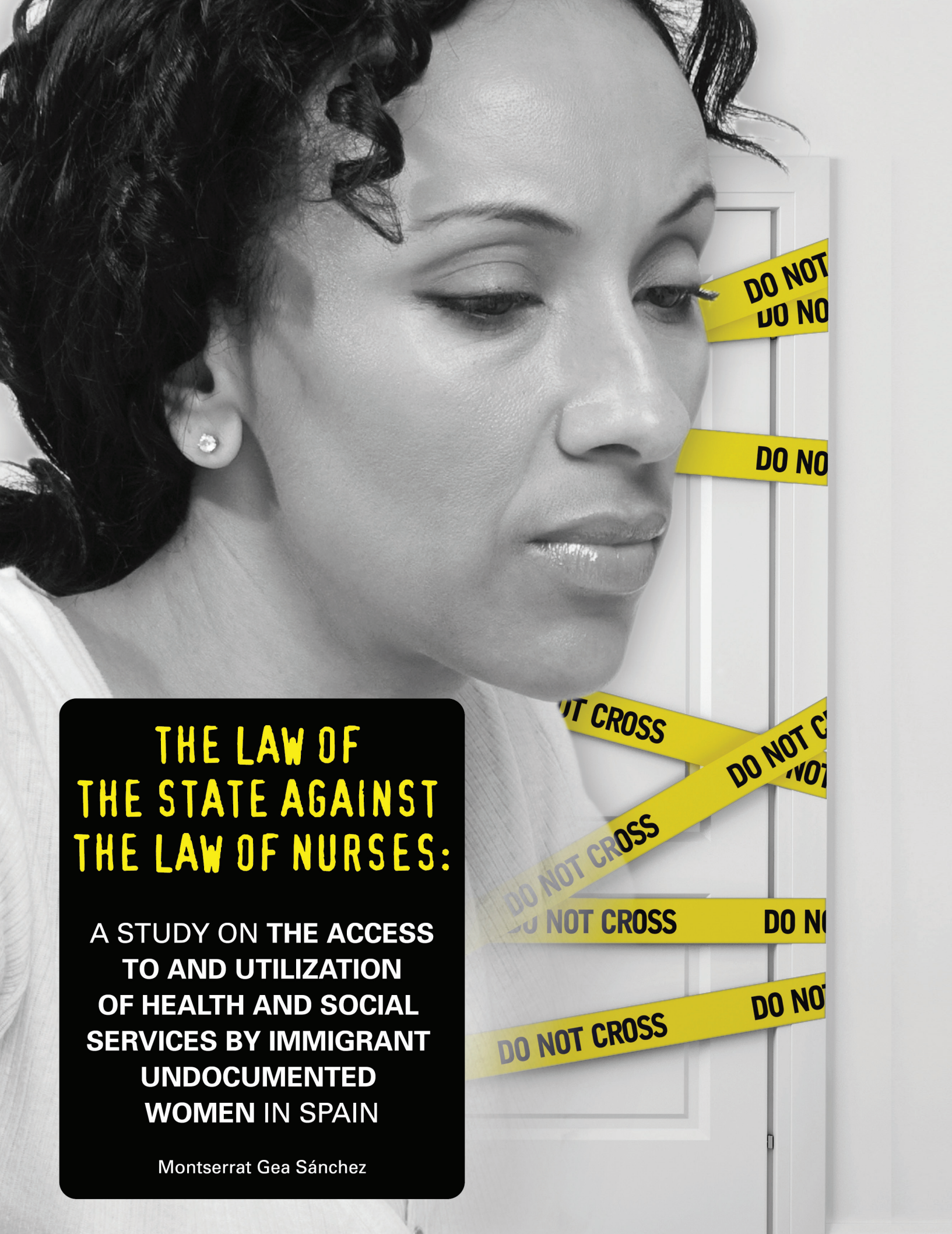
The Law of the State against the Law of Nurses: a study on the access to and utilization of health and social services by undocumented immigrant women in Spain

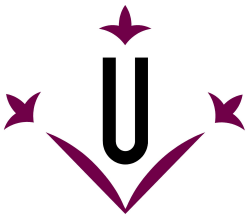
Montserrat Gea Sánchez



THE LAW OF THE STATE AGAINST THE LAW OF NURSES:

A STUDY ON **THE ACCESS TO AND UTILIZATION OF HEALTH AND SOCIAL SERVICES BY IMMIGRANT UNDOCUMENTED WOMEN** IN SPAIN

Montserrat Gea Sánchez



Universitat de Lleida

The Law of the State against the Law of Nurses: A Study on the Access to and Utilization of Health and Social Services by Undocumented Immigrant Women in Spain

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Health Doctoral Program
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Universitat de Lleida
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i Fisioteràpia

Memoria para optar al Grado de Doctor
por la Universitat de Lleida, presentada por
Montserrat Gea Sánchez

Directores:
Dr. Fidel Molina Luque. Universitat de Lleida
Dra. Denise Gastaldo. University of Toronto

Lleida, Octubre de 2015

Universitat de Lleida

El Professor Dr. Fidel Molina Luque i la Dra. Denise Gastaldo, directors de la tesi doctoral elaborada per la Sra. Montserrat Gea Sánchez, amb el títol "The Law of the State against the Law of Nurses: a Study on the Access to and Utilization of Health and Social Services by Immigrant Undocumented Women in Spain", inserita al Departament d'Infermeria, a la Universitat de Lleida,

Fem constar:

Que el treball reuneix els requisits necessaris per entrar en dipòsit i les condicions per ser defensat davant el tribunal corresponent a efectes d'optar al títol de doctora.

I perquè així consti, signem aquest document

Lleida, a 15 d'octubre de 2015

Professor Dr. Fidel Molina Luque

Universitat de Lleida

Professora Dra. Denise Gastaldo

University of Toronto

To my family

To all the people who believe that a better world is possible

Ruido de iluminados, gritan desde sus hogueras

que trae el fin del mundo la luz de la diferencia.

Ruido de inquisidores, nos hablan de libertades

agrietando con sus gritos su barniz de tolerantes.

Nunca pisa la batalla tanto ruido de guerreros,

traen de sus almenas la paz de los cementerios.

Háblame de tus abrazos, de nuestro amor imperfecto,

de la luz de tu utopía, que tu voz tape este estruendo.

***Si se callase el ruido*. Ismael Serrano. Trovador**

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ACKNOWLEDGMENTS

I would like to begin by welcoming and thanking the readers, who I hope will gain an insight to the reality I wish to explain through the evidence and meanings obtained during the research process (2010-2015).

Different institutions have supported this Doctoral Thesis, which is composed of four studies in total. Study I and II were supported by *Instituto de Salud Carlos III. Ministerio de Innovación, Economía y Competitividad (NºRegistro 4669/RG943974),* CEJEM at the University of Lleida and the Lleida Institute of Biomedical Research. Study III was funded by *Instituto de Salud Carlos III. Ministerio de Innovación, Economía y Competitividad (PI: 080306)*. Finally, the Council of Nurses of Catalonia supported Study IV.

The Appendix contains manuscripts sent to different journals where acknowledgements to those who collaborated in the different studies are detailed. Additionally, I would like to acknowledge the support provided by my colleagues at Hospital Santa Maria, where I developed my clinical career as a nurse and my colleagues from the Council of Nurses of Lleida. I will always carry in my heart the generosity of so many people, impossible to mention them all; however, I would like to mention the fairest person I have ever met in my life: Carlos Cavero (wherever you may be): a model of ethical values, always working for equity and always caring for the most vulnerable patients.

I would like to extend my thanks to my colleagues from the GESEC research group at the University of Lleida, the members of the Faculty of Nursing at University of Lleida and Toronto, National School of Public Health, Institute of Health Carlos III and the Investen-Isciii Unit. And last but not least, my thanks to the midwives who kindly agreed to be interviewed and my special thanks to the undocumented immigrant women who opened the

doors of their homes with a smile in spite of the circumstances they lived in, which are later described. They are the real heroes of this story; therefore it is not by accident that the pseudonyms chosen for these women are names of some of the most significant people in my life (directors of thesis included). One name could belong to more than one person and might also be a feminization of a man's name. For example, Andrea's name is a tribute to my father, my son and my dear colleague from the Balearic Islands University.

Therefore to know who is included in the acknowledgments should be a matter of just reading through the articles arising from this thesis.

Montserrat Gea Sánchez

October, 2015

LIST OF ABBREVIATIONS

BHA	Basic Health Areas
CDA	Critical Discourse Analysis
EFN	European Federation of Nurses Associations
EU	European Union
GHL	General Health Law
ICN	International Council of Nurses
INE	Spanish National Institute of Statistics
IUD	Intrauterine Device
NGO	Non Governmental Organization
NHS	National Health Care System
OECD	Organization for Economic Co-operation and Development
RDL 16/2012	Royal Decree-Law 16/2012, of urgent measures to ensure the Sustainability of the National Health System
SDH	Social Determinants of Health
VTP	Voluntary Termination of Pregnancy
WHO	World Health Organization

PRESENTATION

"The law of the State against the law of nurses: A study on the access to and utilization of health and social services by immigrant undocumented women in Spain" is a research document on undocumented immigrant women's access to and utilization of health and social services in Spain. This study began at a time when increasing rumors and the perception of discrimination against immigrants – from my experience as a clinical nurse and as a citizen – drove me to uncover evidence as to what was really happening and what was behind the random discourses of health professionals, users and the general population regarding the use of public services. The first step took place, in 2006, when I was a postgraduate in an International Cooperation program at the University of Lleida, conducting a study about cultural competence and continuous education in Nursing. In this period, I had the good fortune of being led by Dr. Fidel Molina who became my (father) mentor until this day. Later in 2007, as a Master's student in Nursing Science I explored the perception and attitudes of nurses and nursing undergraduates about the migratory phenomenon. After analyzing quantitative data and validating a scale, one of the main conclusions was that I needed to search for other approaches to shed light on this very complex phenomenon. In this context, once I concluded my Master's degree I enrolled in a series of specialized courses on qualitative research in health science, gender and social determinants of health at the National School of Public Health. During this training period in 2008, I had the great pleasure of meeting and then working with Belen Sanz and Laura Otero, the leaders of study II. Later in 2009, responding to the need for greater in-depth studies on migration and gender issues that shape people's health and lives, I went to the University of Toronto where I met my (mother) mentor Dr. Denise Gastaldo. In this period I had the great honor of attending her lessons on qualitative perspectives in health research, public health and the seminars at the Center of Qualitative Research. This

period allowed me to design the research that is presented in this Doctoral Thesis.

The Doctoral Thesis is structured following classical chapters: 1- A brief introduction to the terminology and state of the art in terms of women immigration and health in Spain; 2- A theoretical framework where different perspectives are presented under the umbrella of social critical paradigm; 3- Objectives that oriented the general research and the specific studies; 4- Methodologies used to address and respond to different objectives; 5- Global and specific results from the data analysis (primary and secondary); 6- Discussion comparing findings with the existing evidence and consequences derived for different actors; 7- Limitations and strengths of the studies; 8-Conclusions and lessons learnt for action and future research; and 9- References.

Additionally, the Appendix section provides manuscripts derived from every single study:

From Study I derived: "**Undocumented Immigrant Women in Spain: A Scoping Review on Access to and Utilization of Health and Social Services"** under consideration by Journal of Immigrant and Minority Health. This scoping review was the first step on the way to explaining the use of health and social services by immigrant women. The search of the literature already published on that topic was planned according to the changing socio-political situation in the last decade.

From Study II derived: **"Access to and use of sexual and reproductive health services provided by midwives among rural immigrant women in Spain: midwives' perspectives"** published in Global Health Action (Gender Special Issue). In this research the focus was on the nurses' discourses and specifically on midwifes' perceptions. This was very interesting as reproductive services are the most used by immigrant women and it meant understanding the perception of experienced midwifes in the province of Segovia regarding this topic.

From Study III derived: **“Access and utilization of social and health services as a social determinant of health: The case of undocumented Latin American immigrant women working in Lleida (Catalonia, Spain)”** under consideration by Health and Social Care in the Community. This research allows me to analyze the reality from another perspective, and to compare it with the results obtained from nurses. Immigrants’ perceptions regarding access to health and social services were studied in order to obtain a wider perspective in a similar province in terms of low density population and rurality, but in another Spanish region, with a different regional Government.

From Study IV derived: “**“The ethical conflicts of nurses faced with Royal Decree-Law 16/2012”** under consideration by Gaceta Sanitaria. In the context of the general research, widespread unsubstantiated rumors about the abuse of health and social services by immigrants led to an incomprehensible national law (in view of scientific evidence and experts’ position) imposed unilaterally by Royal Decree-Law 16/2012 (RDL 16/2012), to reduce the access to health and social services by immigrants. This legislation marked a milestone in health care and both immigrant and native population were put at a unnecessary health risk with no justification at all. It also meant a clash between the general law and health care professionals’ codes of ethics that lead to a stressful situation for nurses who were faced with dilemmas in their practice.

ABSTRACT

OBJECTIVES. The main objective of this Doctoral Thesis is to explore the access to and utilization of health and social services by undocumented immigrant women in Spain from the perspective of several actors. Specific objectives studied are as follows: 1) To identify, describe, and analyze recent evidence on undocumented immigrant women's access to and utilization of health and social services in Spain (Study I). 2) To know the perceptions of health care professionals (midwives) regarding access and utilization of sexual and reproductive health programs in an area with a widely dispersed population, in this case the rural environment of the province of Segovia (Study II) 3) To describe access and utilization of social and health care services by undocumented Latin American women working and living in rural and urban areas in Lleida, and the barriers these women may face (Study III). 4) To bring to light the ethical dilemmas that may arise from the contradiction between legal and ethical discourses, by exploring the contents of the Royal Decree-Law16/2012 and the nurses' codes of ethics (Study IV).

METHODOLOGY. Each one of these individual studies that comprise this Doctoral Thesis has been dealt with through diverse methodological approaches and sources of information. In the case of the first study, the methodology implemented was a scoping review of scientific and grey literature. Studies II and III share the qualitative inquiry, carrying out personal interviews with 7 midwives from a rural area of Segovia and 12 undocumented immigrant women working and living in Lleida. Finally, Critical Discourse Analysis of the Health Law (Royal Decree Law 16/2012) and Nursing Codes of Ethics were performed in Study IV.

RESULTS. The interlinked four studies of this Thesis evidenced that: 1) There is a knowledge gap in scientific literature in Spain regarding access and utilization of social and

health care services specifically oriented to undocumented immigrant women. 2) When immigrants access health and social services they use less primary and specialized health services and more the emergency services. The underutilization of the service of midwifery is also extended to a general underutilization of services by immigrants 3) Undocumented immigrant women follow the documented pattern of underutilization of health care services due to reasons linked to poor working conditions. Health is considered by them as a tool to work, in consequence they seek quick treatment for acute physical problems and they attend services for natal and postnatal care. 4) From 2012 on, the situation for undocumented immigrants in Spain changed from a global health care access focused on human beings regardless of legal status, to a health care system focused on the beneficiaries. Common to the four studies, a clear and crosscutting finding of the Thesis is the existence of specific barriers for being a woman and/or an undocumented immigrant.

CONCLUSIONS. These different approaches bring a wide perception of the access to and utilization of health care and social services by immigrant women in Spain before the implementation of RDL 16/2012, and explain the mismatch suffered by nurses when they have to choose between their ethical and professional commitment and the application of the general law in their practice. An important gap was confirmed between policy makers' perception of the use of services by undocumented immigrants and the real use they make. At the same time, these determinants interact and lead to situations that increase the vulnerability of immigrant women. Immigrant women are particularly vulnerable in this situation as they tend to work in irregular jobs cleaning and care-giving where they fall into a precarious cycle including their undocumented legal status that is in itself a social determinant of health. The RDL 16/2012 has consequences for the health of immigrants and probably natives but it also affects health care professionals. Nurses suffer an ethical and professional dilemma as this general law clashes with their deontological and ethical compromise. From these conclusions a call for action is required against the RDL 16/2012.

The results of this thesis and the conclusions achieved from its interlinked studies may influence political decisions in order to improve people's life quality, and to be a reference for future research.

KEY WORDS: Immigrant women, undocumented, access to health care, equity in health, working conditions.

RESUMEN

OBJETIVOS. El objetivo principal de esta Tesis Doctoral es explorar el acceso y utilización de los servicios de salud y sociales por parte de la mujeres inmigrantes indocumentadas en España, desde la perspectiva de diferentes actores. Los objetivos específicos son los siguientes: 1) Identificar, describir y analizar la evidencia científica más reciente, en cuanto a acceso y utilización de los servicios de salud y sociales, por parte de la mujeres inmigrantes indocumentadas en España (Estudio I). 2) Conocer las percepciones de los profesionales de la salud (matronas) en cuanto al acceso y utilización de los programas de salud sexual y reproductiva en una área de alta dispersión, en este caso, la zona rural de la provincia de Segovia (Estudio II). 3) Describir el acceso y utilización de los servicios de salud y sociales, por parte de las inmigrantes indocumentadas latinoamericanas que viven y trabajan en zonas rurales y urbanas y las barreras que deben afrontar (Estudio III). 4) Evidenciar los dilemas éticos que pueden surgir por la disyuntiva entre los discursos legal y ético, a través de explorar el contenido del Real Decreto-ley 16/2012 y de los éticos enfermeros (Estudio IV).

METODOLOGIA. Cada uno de los estudios individuales que componen esta Tesis Doctoral ha sido abordado desde diferentes perspectivas metodológicas y fuentes de información. En el caso del estudio I, la metodología implementada fue la revisión de alcance ("*scoping review"*) tanto en la literatura científica, como en la literatura gris. Los estudios II y III son estudios cualitativos llevados a cabo a partir de entrevistas personales dirigidas a 7 matronas de las zonas rurales de Segovia y 12 inmigrantes indocumentadas que trabajan y residen en la provincia de Lleida. Finalmente, en el estudio IV, se realizó un análisis crítico del discurso a partir del Real Decreto Ley 16/2012 y los códigos éticos enfermeros.

RESULTADOS. Los cuatro estudios entrelazados evidencian que: 1) Existe un vacío de conocimiento en la literatura científica española en cuanto a acceso y utilización de los servicios de salud y sociales por parte de las mujeres inmigrantes indocumentadas. 2) Cuando las mujeres inmigrantes acceden a la salud y a los servicios sociales, utilizan menos la atención primaria y especializada y más los servicios de urgencia. La infrautilización que realizan del servicio de matronas se extiende a la utilización de los servicios en general en el caso de las inmigrantes. 3) Las mujeres inmigrantes indocumentadas siguen un patrón de infrautilización de los servicios de salud que está estrechamente vinculado a unas condiciones de trabajo precarias. La salud se considera como una herramienta para trabajar, en consecuencia las mujeres buscan un tratamiento rápido para los problemas físicos agudos o bien cuando precisan cuidados pre y post parto. 4) Desde el año 2012, la situación para las inmigrantes indocumentadas en España ha cambiado de un acceso universal enfocado en el ser humano, independientemente de su estatus legal, a un sistema de salud enfocado a los asegurados. De manera común en los cuatro estudios, se identifican claramente y de forma transversal las barreras específicas vinculadas al hecho de ser mujer y/o inmigrante indocumentada.

CONCLUSIONES. Las diferentes perspectivas aportan una amplia percepción sobre el acceso y utilización de los servicios de salud y sociales por parte de las inmigrantes indocumentadas en España antes de la implantación del RDL 16/2012 y explican la disyuntiva que sufren las enfermeras cuando en su práctica diaria tienen que elegir entre el cumplimiento de sus códigos éticos y compromiso profesional, o el cumplimiento de la ley general. Se confirma la existencia de una brecha entre lo que los diseñadores de políticas perciben y el uso real que se hace de los servicios por parte de las personas indocumentadas. Al mismo tiempo, estos determinantes interaccionan y llevan a situaciones que incrementan la vulnerabilidad de la mujeres inmigrantes. Las mujeres inmigrantes son particularmente vulnerables en esta situación ya que suelen emplearse

en trabajos irregulares del sector de la limpieza y el cuidado, cayendo en un círculo de precariedad que incluye el estatus legal de indocumentado, que es por sí mismo un determinante social de salud. El RDL 16/2012 conlleva consecuencias para la salud de los inmigrantes y probablemente de los nativos, pero también afecta a los profesionales de la salud. Las enfermeras sufren dilemas éticos por la disyuntiva entre los códigos éticos y compromiso profesional y la ley general. En base a estas conclusiones se precisa de una llamada para la acción en contra del RDL 16/2012. Los resultados de esta Tesis y las conclusiones que se derivan de los diferentes estudios que contiene pueden influir en las decisiones de los políticos con el fin de mejorar la calidad de vida de las personas, así como servir de referencia para futuras investigaciones.

Palabras clave: Mujer inmigrante, indocumentado, acceso a cuidados en salud, equidad en salud, condiciones de trabajo.

RESUM

OBJECTIUS. L'objectiu principal d'aquesta Tesi Doctoral és explorar l'accés i utilització dels serveis de salut i socials per part de les dones immigrants indocumentades a Espanya, des de la perspectiva de diferents actors. Els objectius específics són els següents: 1) Identificar, descriure i analitzar l'evidència científica més recent pel que fa a accés i utilització dels serveis de salut i socials per part de les dones immigrants indocumentades a Espanya (Estudi I). 2) Conèixer les percepcions dels professionals de la salut (llevadores) pel que fa a l'accés i utilització dels programes de salut sexual i reproductiva en una àrea d'alta dispersió, en aquest cas, la zona rural de la província de Segòvia (Estudi II). 3) Descriure l'accés i utilització dels serveis de salut i socials per part de les immigrants indocumentades llatinoamericanes que viuen i treballen en zones rurals i urbanes, i les barreres que han d'afrontar (Estudi III). 4) Evidenciar els dilemes ètics que poden sorgir per la disjuntiva entre els discursos legal i ètic, a través d'explorar el contingut del Reial decret llei 16/2012 i dels codis ètics infermers (Estudi IV).

METODOLOGIA. Cadascun dels estudis individuals que componen aquesta Tesi Doctoral ha estat abordat des de diferents perspectives metodològiques i fonts d'informació. En el cas de l'estudi I, la metodologia implementada va ser la revisió d'abast ("scoping review") tant en la literatura científica com en la literatura grisa. Els estudis II i III són estudis qualitatius portats a terme a partir d'entrevistes personals dirigides a 7 llevadores de les zones rurals de Segòvia i 12 immigrants indocumentades que treballen i resideixen a la província de Lleida. Finalment, en l'estudi IV, es va realitzar una anàlisi crítica del discurs a partir del Reial decret llei 16/2012 i els codis ètics infermers.

RESULTATS. Els quatre estudis entrellaçats evidencien que: 1) Hi ha un buit de coneixement en la literatura científica espanyola pel que fa a accés i utilització dels serveis de salut i socials per part de les dones immigrants indocumentades. 2) Quan les

dones immigrants accedeixen a la salut i als serveis socials, utilitzen menys l'atenció primària i especialitzada i més els serveis d'urgència. La infrautilització que fan del servei de llevadores s'estén a la utilització dels serveis en general, en el cas de les immigrants. 3) Les dones immigrants indocumentades segueixen un patró de infrautilització dels serveis de salut que està estretament vinculat a unes condicions de treball precàries. La salut es considera com una eina per treballar, en conseqüència les dones busquen un tractament ràpid per als problemes físics aguts o bé quan necessiten cures pre i post part. 4) Des de l'any 2012, la situació per a les immigrants indocumentades a Espanya ha canviat d'un accés universal enfocat en l'ésser humà independentment del seu estatus legal, a un sistema de salut enfocat als assegurats. De manera comuna, en els quatre estudis, s'identifiquen clarament i de forma transversal, les barreres específiques vinculades al fet de ser dona i / o immigrant indocumentada.

CONCLUSIONS. Les diferents perspectives aporten una àmplia percepció sobre l'accés i utilització dels serveis de salut i socials per part de les immigrants indocumentades a Espanya, abans de la implantació del RDL 16/2012 i expliquen la disjuntiva que pateixen les infermeres quan, en la seva pràctica diària han de triar entre el compliment dels seus codis ètics i compromís professional, o el compliment de la llei general. Es confirma l'existència d'una bretxa entre el que els dissenyadors de polítiques perceben i l'ús real que es fa dels serveis per part de les persones indocumentades. Alhora, aquests determinants interaccionen i porten a situacions que incrementen la vulnerabilitat de les dones immigrants. Les dones immigrants són particularment vulnerables en aquesta situació ja que solen emprar-se en treballs irregulars del sector de la neteja i la cura, caient en un cercle de precarietat que inclou l'estatus legal de indocumentat, que és per si mateix un determinant social de salut. El RDL 16/2012 comporta conseqüències per a la salut dels immigrants i probablement dels nadius, però també afecta els professionals de la salut. Les infermeres pateixen dilemes ètics per la disjuntiva entre els codis ètics i

compromís professional i la llei general. En base a aquestes conclusions es precisa d'una crida per l'acció en contra del RDL 16/2012. Els resultats d'aquesta Tesi i les conclusions que es deriven dels diferents estudis que conté, poden influir en les decisions dels polítics per tal de millorar la qualitat de vida de les persones, així com servir de referència per a futures investigacions.

Paraules clau: Dona immigrant, indocumentat, accés a les cures en salut, equitat en salut, condicions de treball.

INTRODUCTION

1 STATE OF THE ART

1.1. CONCEPTUALIZATION OF TERMINOLOGY IN MIGRATIONS: Who are undocumented immigrants?

In spite of the magnitude of international migrations in general (232 million people in the world) (United Nations. Department of Economic and Social Affairs, 2013) and of irregular migrations in particular (4 to 8 million estimated people in Europe), there are no universally accepted definitions or terminologies on this subject (International Organization for Migration, 2011; Rechel et al., 2011, p. 3).

Definitions such as “migration” and “migrant” can be very different when constructed in different political, social, economic and cultural contexts (International Organization for Migration, 2011). In this sense, when we refer to human beings, anyone leaving their own country to live somewhere else would be called an “emigrant”, while in the host country, this person would be an “immigrant” (International Organization for Migration, 2011).

In our case, an irregular immigrant would commonly be defined as a “person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. The definition covers inter alia those persons who have entered a transit or host country unlawfully; people who try to obtain asylum without a due cause; and other people not authorized to remain in the host country” (International Organization for Migration, 2015).

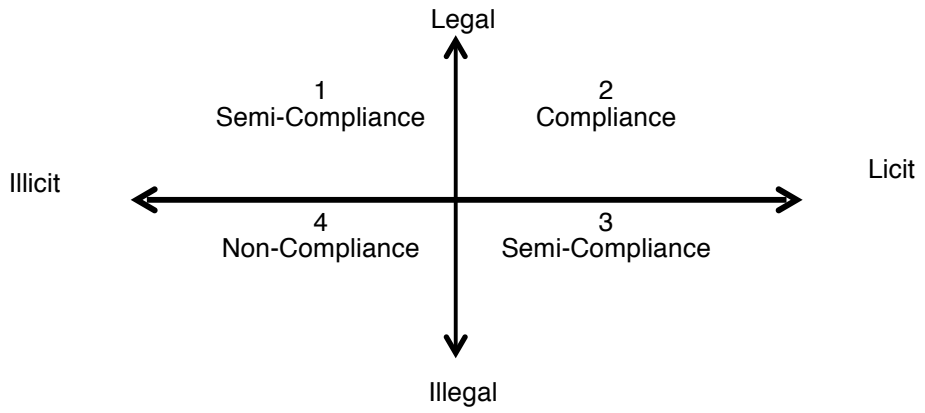
In spite of the definition given above, the most frequently used terms in the scientific literature are “"clandestine migration", "illegal migration", "unauthorized migration", "undocumented migration" and "irregular migration".

The term "illegal" is used from a legal and political point of view, while “undocumented” and “irregular” are more common in social sciences in order to avoid stigmatization, criminalization and marginalization of immigrants, and to emphasize that no human being

is illegal, just the manner of entry, residence or work in a given country (Juss, 2006, p. 1; Nyers, 2010).

Some authors have stressed the dynamic nature of legal status. Lund-Thomsen (2012) adapted the model suggested by Van Schendel and Abraham (2005), that goes beyond the concepts "legal-illegal" by offering a broader approach, not only from the perspective of a person's legal situation, but encompassing other social actors that participate in the process (policy makers and employers principally), and socially accepted ethical values. Therefore, this approach can be useful for analysis (Figure 1).

Figure 1 - Types of compliance connected to the different spaces



As can be observed in the figure 1, the concept "compliance" would be divided into three levels: compliance, semi-compliance and non-compliance. The situation of compliance would be when immigrants reside and work in compliance with the conditions established by their legal status. Non-compliance would refer to immigrants residing in the host country irregularly. Finally, semi-compliance would refer to people who have the right to reside, but not to work or carry out other activities.

That which is legal, however, would be marked by the State laws and regulations, while that which is licit is legitimized by society and, as a consequence, it can vary according to the ethical and moral values set in a given country or society.

Thus, what is considered legal may be in conflict with what is considered licit, leading to situations of civil disobedience.

Going back to the graphical representation of the Lund-Thomsen model (figure 1), we can observe that 4 different situations (spaces) arise:

Space 1: would be related to the situation of Semi-compliance according to the State legislation, but deemed illicit by society. For example, in the case mentioned above, if the restrictions of access to health care were applied to undocumented people, we would face a legal situation, but illicit, hence not legitimized by society.

Space 2: represents fully legal, fully licit immigration, as a result of a regular situation.

Space 3: would be that of immigrant people in an irregular situation, but carrying out socially accepted activities. A clear example of that would be immigrant women dedicated to doing domestic work. According to the regulations these women should have a contract and should be registered in the Social Security system, but it is considered "normal" that they don't, as this is a habitual and socially accepted practice.

Finally, space 4 would be occupied by people in a totally irregular situation who are also involved in illicit activities. The case of human trafficking would be included here, as it would be illegal and also morally and ethically despised by society.

Since the present document has a social perspective, we will refer to participants as undocumented immigrants.

1.2. Major theories about migrations in the present research

Ernest Georg Ravenstein formulated his famous “laws of migration” on 17th March 1885 in a presentation to the Statistical Society. Although this was more than one hundred years ago, his theory is still a point of departure in the research of migration, partly due to the lack of sufficient theoretical body or, as Arango (1985) would say, due to “the clear divorce between theory and empirics” (Arango, 1985; Alejandro Portes, 1997; Ravenstein, 1885).

Several points in Ravenstein’s synthesis deserve highlighting; the creation for the first time of the analytical framework “push-pull”, and the empirical detection of a series of characteristics related to the migrating process, among which the economic motivation stands out. Thus, the factors perceived as negative would predominate in the areas of origin, these would be the *push factors*, and, in the perception of the potential immigrant, positive factors or *pull factors* would predominate in the chosen destination (Dorling et al., 2007; Greenwood & Hunt, 2003; Ravenstein, 1885).

According to Zolberg et al. (1989), after the classical theory based on individual decisions to emigrate started by Ravenstein and continued by Lee (1966), the theory of migration has been approached from different perspectives, but with some common characteristics, such as the tendency to become historical and structural.

The historical dimension of the phenomenon of migration makes us pay special attention to the specific changes in time and space. Poverty and unemployment are not enough to explain migration flows. These conditions are subject to broader political economic dynamics, such as the ties created by the old colonial period (Grosfoguel, 2004). Thus, we find a majority of Algerian emigrants in France and those from the Indian sub-continent in the United Kingdom (Sassen, 2004a, 2004b).

The structural characteristic of migration is a consequence of a series of social forces that influence individual actions, especially capitalism and the state. Thus, the sending countries would not be getting any economic or social development from having a

workforce abroad; instead, they would be consolidating harmful dynamics for their development (loss of qualified workforce, increase in inflation, increase in social inequalities, etc.) and a position of subordination within the global system and greater economic dependence from outside, which has been called covert Neo-colonialism (Gastaldo, 2000; Portes, 2007).

The United Nations (UN) report on International Migration and Development (2006) states that migrants with a higher education account for nearly half of the total increase in international migration of people aged over 25 in Organization for Economic Co-operation and Development (OEDC) countries during the 1990s. In the year 2000, almost six out of ten immigrants with a higher education living in an OEDC country came from a developing country. Therefore, as stated in the above-mentioned report, higher levels of poverty in the place of origin do not automatically produce higher rates of migration, as poorer people do not have the means to meet the cost or the risks involved in international migration. On the contrary, international immigrants tend to come from middle-class families (Asamblea General de las Naciones Unidas, 2006, p. 13).

Along these lines, studies within the framework of the Theory of Human Capital maintain that the level of education plays a role in migration decisions, so that the greater the human capital, the smaller the “psychic” cost (breakdown of family and affective bonds, loss of information involved in changing from a well-known environment to a new environment, etc.) and the greater the benefits expected. Thus, the economic tradition suggests that the potential emigrant will assess the usefulness of living in a different region according to the goods and services he/she can consume in it, under the income conditions in each region (García Lozano, Gómez García, Muñoz Sánchez, & Solana Ibañez, 2001; Milne, 1991).

This theory has clear deficiencies in not taking into consideration the particularities of the region towards which migration leads. One clear example is that of immigrants living in

Canada, where immigration legal requirements include having a high level of education and a level of financial solvency. Gastaldo et al. (2005) describe the frustration and low self-esteem that immigrant women in Ontario suffer when they have to accept jobs below their educational level (such as cleaning and baby-sitting, etc.) or in the worst case scenarios being unemployed for years, with the subsequent decrease in social position they possessed in their countries of origin.

Bourdieu however, offers an explanation for social phenomena such as migration from the perspective of the effects that different capitals or powers have over the structure, dynamics and reproduction of social classes (Fine, 2008; Piñero Ramírez, 2008). From this perspective, the cultural, economic, social and symbolic capitals are transformed and lead to different results (Bourdieu, 1986, 2000, p. 148). Social capital and the social networks in particular, would explain, for example, how two immigrants with the same economic and cultural capital obtain unequal results as a consequence of the migrating process.

Social networks and belonging to a group may have positive effects as long as they can eventually provide meaningful support. Magalhaes et al. (2008) outlines that 45% of Brazilian immigrants getting their first job in Canada do so thanks to their social networks. However, social capital may also have a "negative side" due to the bonds and the reproductive phenomenon of power derived from belonging to a group (group pressure, exclusion of people not belonging to the group or network) (Evergeti & Zontini, 2006; Molyneux, 2001; Portes, 1998). Hellermann's analysis (2006) of immigrant Eastern European women in Portugal shows social networks as a force oppressing and controlling the behavior of their fellow country women.

1.3. Characteristics of immigration in Spain

Here I focus on undocumented immigrant women, as stated in the objectives of this study; therefore, other migrations within the established criteria of legality are discarded from the study.

Since the mid-1980s, Spain has shifted from being a source country of workers to being a receiving country (Massey, 1990). In the first years of the new millennium, the sociodemographic reality changed dramatically when a large number of coming from Latin American, African, Asian and Eastern European immigrants became part of the Spanish population (Smaje & Le Grand, 1997). Their reasons for emigrating were mainly economic, given that Spain was at the time an attractive destination for those looking for job opportunities. Foreign residents with residence permits showed a steady increase until 2008 coinciding with the economic growth the country was experiencing. Later, with the beginning of the economic recession this tendency started to reverse slowly until Spain reached a negative migration balance of -256,846 people, of which 82% were foreigners. Thus, the number of foreigners living in Spain in 2014 decreased by 4.90% to 4,447,852 registered people (Instituto Nacional de Estadística, 2015), although other sources maintain that figures have remained stable (Càtedra Repsol de Competitivitat i Desenvolupament Regional, 2013) or even contend that the decrease is due to more people in an irregular situation as a result of being unemployed (Colectivo Ioé, 2012).

Immigration in Spain has two basic characteristics: first, the rapid increase and settlement, so that within a decade Spain became the second leading country in number of foreign residents in the European Union, only surpassed by Germany (Zimmermann & Centre for Economic Policy Research (Great Britain), 2005); second, their geographical distribution with a clear tendency to concentrate, thus, Madrid and Catalonia are the Autonomous Communities with the largest immigrant population, accounting for more than one million people (Encarnación, 2004).

What needs to be taken into consideration is that such a concentration responds to the labour market, which is clearly acting as a labour segregation mechanism by sex, nationality and sphere of activity, so that there is overrepresentation of immigrants in agricultural and domestic jobs (Moreno Fuentes & Bruquetas Callejo, 2011). In relation to the latter, there is a clear specialization by women, who accounted for at least half of all foreigners that arrived in Spain during the last decade (Instituto Nacional de Estadística, 2014). These women come from Latin America principally, but they have also emigrated from other countries such as Romania, China, and North Africa (Instituto Nacional de Estadística, 2014).

The role of caregiving and house cleaning has especially been delegated to Latin American women, due to their cultural proximity, as they speak Spanish, and coinciding with the increase of autochthonous women joining the labour market (Bover, 2011).

Demographic data available show that these women tend to prefer living in big cities in the first place (of more than 200.000 inhabitants) and then, with time, and based on job offers, they move to smaller cities in rural areas (of less than 200.000 inhabitants) and to a lesser extent they move to rural villages (less than 20.000 inhabitants) (Càtedra Repsol de Competitivitat i Desenvolupament Regional, 2013; Moreno Fuentes & Bruquetas Callejo, 2011).

A significant portion of job opportunities for these women workers is in the underground economy; therefore, an irregular immigrant could lose her visa if she cannot demonstrate that she's working, and a regular immigrant will keep this status, thus not having any labour rights or social security. Evidence has shown that migrant workers are disproportionatelly affected by and exposed to risks in the work place, and this is particularly true in the case of undocumented migrants who are usually employed in "3-D" jobs ("dangerous, dirty and degrading") in under-regulated sectors, such as domestic and agricultural work (Benach, Muntaner, Delclos, Menéndez, & Ronquillo, 2011; Gastaldo,

Carrasco, & Magalhães, 2012; Vives et al., 2011). The European Parliament's Committee on Employment and Social Affairs (2011) pointed out that the situation of domestic workers, many of whom are immigrant women, is particularly difficult. Many of them are impacted by physical and psychosocial problems, but data about their situation is minimal.

Estimations of undocumented people living in Spain range between four hundred thousand (Guijarro, 2013) and one million three hundred thousand (Moreno Fuentes & Bruquetas Callejo, 2011), although it is difficult to verify the accuracy of these data for obvious reasons: on the one hand, some foreigners get registered in Spain but then move somewhere else in Europe; on the other, some do not get registered for fear of being located and repatriated to their countries of origin.

1.4. Social and health service provision for undocumented immigrant population in Spain

1.4.1. Health Legislation in Spain

The legislative framework on health care in Spain has undergone many changes over time. The Social Security Health System was created in 1963; it covered part of the employed population, based on their contribution and offered health care in case of illness. Private medicine and charity, for people with no resources, coexisted with this system. In 1976 Spain signed the International Covenant on Economic Social and Cultural Rights, which recognizes in chapter 12 the right of all people to the enjoyment of the highest attainable standard of physical and mental health. All the signatory countries undertook to create the conditions to ensure medical care and service in case of illness (United Nations General Assembly, 1966). Article 43 of the Spanish Constitution also acknowledges the right to the protection of health and the competence of public authorities to organize and protect public health with preventive measures and the provision of the necessary services (España, 1978). In 1986 the General Health Law (GHL) was passed (España, 1986), to

secure universal and free access to health care for all Spaniards. Free access to the public health care system for foreigners was upon condition of their contribution to the social security system. Consequently, undocumented immigrants were excluded and only had access to emergencies services and the treatment of infectious or contagious diseases.

Later on and thanks to the 1996 Child Protection Act (Espanya, 1996) and the Rules for implementation of the Foreigners Act 7/1985 (España, 1985), the first undocumented immigrants formally getting equal access to the National Health Care System (NHS) were pregnant women and minors. The insufficiency and unbalance created by this measure led to the passing of Organic Law 4/2000 on Rights and Liberties of Foreign Nationals in Spain (España, 2000) that extended health care to any person that could demonstrate their residence in Spain. Through their registration in the municipal census, undocumented immigrants could obtain their health card, and access to the health care system. Care was integral and free for all citizens at all levels of care: health promotion, illness prevention and treatment and rehabilitation. Access was with the same conditions for the entire resident population; therefore, it was a universal, free, integrating measure In spite of that, Non Governmental Organizations (NGO) informed of informal barriers that prevented access, although such barriers were not specific (Doctors of the World, 2013; World Health Organization, 2010b).

In the framework of the Spanish economic recession, the "Royal Decree-Law 16/2012, of urgent measures to ensure the Sustainability of the National Health System and to improve the Quality and Security of its Provisions" was approved in April 2012. In this decree-law measures are applied with the aim of undertaking a structural reform, and the status of policyholder is regulated in order to limit the access of citizens to health benefits (España, 2012).

With the current legislation, the non-policyholders can only access emergency services in cases of severe illness or in the event of an accident, and only women in pre-natal, natal

and post-natal situations, and people under 18 years of age can have general access to health care services (España, 2012). Therefore, primary health care, specialized care and hospitalization, as well as pharmaceutical and sanitary supplies are excluded.

Social reactions to the implementation of this regulation have been fervent: first, a large number of health care professionals, with the support of their professional associations, unions, and the 15-M movement declared that they would refuse to stop giving care to foreign patients due to administrative irregularities. The second reaction took the form of legal challenges, when the governments of Catalonia, the Basque Country and Canaries appealed the Constitutional Court because the Royal Decree-Law contravened their autonomy statutes, where it is explicitly stated that "each individual has the right of equal access, free of charge, to health care services provided under public provision" (Catalunya, 2006, art. 23; España, 2013). The result of these acts of resistance in Catalonia have been that health care continues to be provided and health cards are still provided to undocumented persons with the same conditions as prior to the law approved by Spain (Servei Català de la Salut, 2012).

1.4.2. Legislation concerning access to social services

As happened with the right of access of undocumented immigrants to the health care system, Law 4/2000 (España, 2000) established that immigrants in a precarious administrative situation had the right to the provision of basic social services through the mechanism of registering in the census. However, the equal application of this right between immigrants and Spanish nationals has never been fully accomplished, as the Law did not specify what a basic service entailed. As a consequence, autonomous communities have resolved access to their social service network in different ways, thus giving rise to inequalities between geographical regions: while some communities grant access, others have established a parallel network usually nurtured by NGOs (Cáritas

Española, 2012; Pérez Orozco, 2009).

1.4.3. Utilization of health care and social services

Although it is true that the immigrant population is young and, as a consequence is expected to enjoy better health, there is evidence showing that their health status deteriorates once in the host country, due principally to the characteristics and demands of their labour activities (Aerny Perreten et al., 2010; Benach et al., 2011; C Borrell et al., 2008; Casado-Mejía, Ruiz-Arias, & Solano-Parés, 2012; García Mainar & Montuenga Gómez, 2009).

Moreover, Aerny Perreten and collaborators (2010) in a study carried out in the Community of Madrid, ascertained that immigrant women with a length of stay in Spain of over 5 years had the worst self-perception of their general and mental health state. Casado-Mejía et al. (2012) identified in a study carried out in the city of Sevilla that family caregiving entrusted to immigrant women, together with migratory grief, had important repercussions for their health status. Regarding workplace accidents, García and Montuenga (2009) stated in a longitudinal study how the fact of being immigrant increased the risk of suffering a workplace accident. It is important to have in mind that Spain is the leading European country in terms of workplace accident rates and that accidents suffered by undocumented workers may not be accounted for.

The contribution of Sousa et al. (2010) is especially important, as in a cross-sectional study they disaggregated the data according to the legal status of the immigrants, demonstrating that undocumented workers had the worst working conditions, the lowest salaries and the worse self-perceived physical and mental health. However, this study sample was exclusively from big cities and there were no data on how the immigrants used the health system once they were ill. Besides, it had limitations acknowledged by the authors themselves with regard to the possibility of having a reliable sample of

undocumented workers, as they are not included in any worker registry system.

There are few studies in the scientific literature that focus on the access and utilization of health services by the immigrant population in Spain. Most of them focus on immigrant population as a whole, but do not offer disaggregated data about immigrants' status. In general though, these studies show a minor utilization of services, both in the area of hospital emergencies and in primary health and pharmaceutical expenses compared to local population (Arizaleta et al., 2009; Cheikh et al., 2011; Enrique Regidor et al., 2009; Soler-González et al., 2008). According to the inverse care law, vulnerable population groups need more health care, but are those receiving the least; while groups with more social advantage enjoy more health care with less need for it. This situation violates the so-called horizontal equity, that is, an equitable use of health services for an equivalent need (Fiscella & Shin, 2005; Sanz-Barbero, Regidor, & Galindo, 2011). An opposite idea is that on "the healthy immigrant"; several authors have associated this lower utilization rate to the commonly healthier status of the immigrant population, compared to the native-born. Although it is true that the immigrant population is young and, as a consequence is expected to enjoy better health, there is evidence showing that their (physical and mental) health status worsens once in the host country, mainly due to the characteristics and demands of their labour activities (Aerny Perreten et al., 2010; Benach et al., 2011; C. Borrell et al., 2008; Casado-Mejía et al., 2012; García Mainar & Montuenga Gómez, 2009). Other explanation is the existence of barriers to access and use of health services (Hirmas Adauy et al., 2013; Torrús, 2013). Despite international laws, policies and institutions which state that health is a fundamental human right (United Nations General Assembly, 1966, 1989), in practice there are several barriers that limit health care access to undocumented migrants, mainly resulting from the context of migration associated with situations of greater social vulnerability, such as the lack of a residence permit, existence of language barriers and the lack of support networks (Briones-Vozmediano, La Parra, &

Vives-Cases, 2014; Derose, Escarce, & Lurie, 2007). Spanish studies reveal that immigrants have different health care utilization pathways than natives and that they under-utilize health care services because they face substantial access barriers (Llop-Gironés, Vargas Lorenzo, Garcia-Subirats, Aller, & Vázquez Navarrete, 2014; Enrique Regidor et al., 2009). These barriers gain more relevance in rural areas with high population dispersion where the distance to reach health facilities alone limits access and use of services (Sanz-Barbero, Otero García, & Blasco Hernández, 2012).

Regarding sexual and reproductive health services, immigrant women residing in Spain exhibit different patterns from native-born Spaniards: greater fertility, lower age at first birth, greater rates of premature births and more births to infants with low birth weight (Gispert Magarolas, Clot-Razquin, del Mar Torné, Bosser-Giralt, & Freitas-Ramírez, 2008; Instituto Nacional de Estadística, 2012; Luque Fernández & Bueno-Cavanillas, 2009; Río et al., 2010) as well as a higher proportion of voluntary terminations of pregnancies (VTP) (Gispert Magarolas et al., 2008). The fertility rate rebound observed in Spain from 2006 until today (1.38 children/woman) is a reflection of the recent substantial increase in immigration rates (Zurriaga et al., 2009), but recent studies show a lower rate of participation in gynecological cancer screening programs among these women (Instituto Nacional de Estadística, 2012; Otero, Sanz, & Blasco, 2011).

With regards to social services, the situation is worse. Immigrant population access to social services has always been accompanied by the fear of a massive consumption of resources, given the needs of this vulnerable group, as their income is low and unstable and they have poor social and family networks. The data provided by Moreno Fuentes and Bruquetas Callejo (2011) show that from the total number of interventions that social services carried out in Spain in 2008, only 6.85% were addressed towards the immigrant population. At the same time, these are characterised by being of short duration, with a quick exit into the labour market, and usually with the collaboration of Civic Associations or

NGOs. The latest data by the Ministry (Ministerio de Sanidad Política Social e Igualdad, 2012), corresponding to 2009, reveal that 86.31% of social services users are Spanish, and no information is given about the legal status of the immigrants.

Despite having quantitative data on differences among natives and regularized immigrants in the utilization of health services, information on access to health and social services and participation in sexual and reproductive health programs by immigrant women in Spain is very scarce. Little is known especially among immigrant women living in rural areas, and specially talking about undocumented immigrant women.

Given this gap in the literature, it becomes interesting to examine the perceptions of: first, the professionals providing sexual and reproductive health services, the midwives; and second, the own immigrant undocumented women using health and social services. The actual implementation of public health programs is strongly dependent on service providers, who may observe, adapt or completely ignore the programs (Dutton, 1978). Their attitudes and practices can enhance or hinder women's access to and use of services. As with other professions, nurses join a professional college that regulates their professional practice, represents and defends members and, among other competences, sets out their code of ethics, at the core of their professional activity (Barrio, Molina, Sánchez, & Ayudarte, 2006). Nursing practice is also subject to the health care regulations in force in the country; therefore, objectives and interests may differ between the two regulating bodies.

The present study stems from the need to understand i) the evidence on immigrant undocumented women´s access to and utilization of health and social services, ii) midwives´ perspectives regarding access and participation in sexual and reproductive health programs offered, iii) immigrant undocumented women perspectives regarding their access to and utilization of health and social service, and iv) the National and International codes of ethics and the legal conditions under which nurses assist undocumented people.

2. THEORETICAL FRAMEWORK

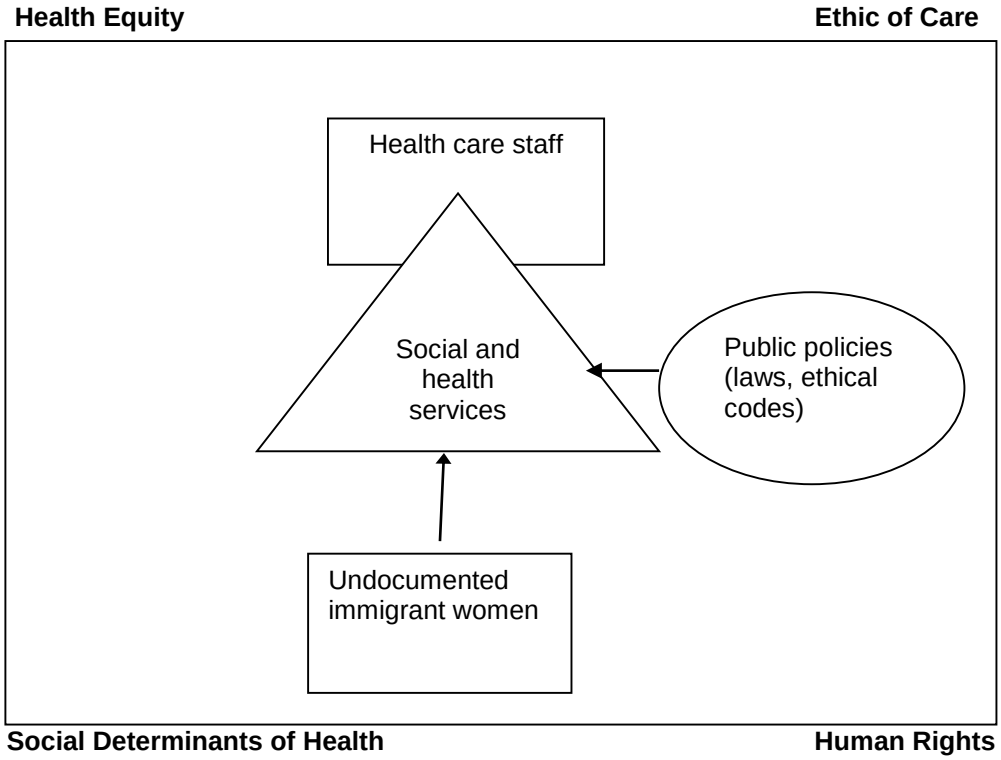
Gender and migration as social determinants of health, the right to health as a human right and for social justice, equality in health and the ethic of care are the axes that constitute the theoretical framework of this Doctoral Thesis, which contextualises access to social and health care of undocumented immigrants. Figure 2 shows the connection of these perspectives, which are the theoretical and conceptual frameworks where the results are located and discussed.

Access to health care services for female immigrants is conditioned by public policies in each country or region, such as health care law or the ethical codes of the professional colleges. These policies are in turn socially determining for health since they cause health inequalities between, in this case, the indigenous population or immigrants with residence permits and those that do not possess them. In turn, formulating health care policies is based on international public policies such as the Declaration of Human Rights (United Nations, 1948) and international health care policies aimed at reaching equality in health care (Marmot, Friel, Bell, Houweling, & Taylor, 2008).

Health care staff form part of the health services and its practice is influenced by health care regulation and ethical codes. Nurses' professional practices are covered in the philosophy of ethic of care governed by the aim of improving the health of people without distinction.

The fact that undocumented female immigrants, the subject of the study in this Thesis, attend social and health services without barriers or obstacles (such as the current health care regulations) is a question of equity.

Figure 2. Perspectives configuring the theoretical-conceptual framework applied in the Thesis



2.1. Social Critical Paradigm

The social critical paradigm arose in Germany in the 1920's, on the one hand as a response to positivist reductionism reigning in European intellectual thinking and, on the other, concerned about the growing trend of the fascist movements following the First World War. Under such circumstances, social-critical theory was formed in the so-called Institute for Social Investigation, by an interdisciplinary group of scholars, among whom stood out Horkheimer, Pollock, Adorno and Marcuse and whose legacy would continue in the 1960's with Jürgen Habermas (Adorno et al., 1969; Dunphy & Longo, 2007; McLaughlin, 1999), in what would subsequently be called the Frankfurt School and which would give rise to different critical paradigms.

According to Laso (2004) the First Generation of the so-called Frankfurt School had the following common characteristics:

- •Theoretical-practical interest in Marxism (connection of critical theory with a liberation praxis)
- •Opposition to the concept of illustrated reason and the idea of progress that arose in the XVIII century.
- •Rejection of neopositivism.
- •Concept of philosophy as critical theory of society.
- •Rejection of purely philosophical speculation, their being dedicated to the knowledge of what they called “the word of life”.

In this scenario, critical tradition rejects the aseptic analyses that positivism tries to introduce into social sciences and, Horkheimer and Marcuse (Adorno et al., 1969) even go further, expressing the ideological character hidden behind this supposed neutrality:

“In studying, for example, society, it must not be forgotten that the background social trends, for example, certain political developments, do not act uniformly according to the statistical model of the whole population, but according to the most powerful interests and the actions of those creating public opinion. The relays, therefore, must follow as far as possible the specific differentiation and not be invariably linked to the statistical average.” (Adorno, Horkheimer, Mazía, & Institut für Sozialforschung, 1969, p. 19).

In the same way as Interpretativism, the critical current is based on social constructivism, i.e. its epistemology that maintains knowledge as truth is socially constructed and for this reason facts are relevant only within people’s experience, of life (Duchscher, 2000), although as a differentiating element it maintains that said constructions are created and moulded according to the relationships of power and the conflicts of interests in all societies, resulting in inequalities among the population.

The critical paradigm introduces ideology and reflection specifically in the processes of knowledge, attempting to avoid intellectual neutrality by means of two key elements: criticism and praxis (or action). Consequently, the need to denounce situations of margination and oppression are emphasised, to propose subsequently measures to favour change or emancipation (Prasad, 2005).

The representative of the Second Generation, Jürgen Habermas (1988) goes further, directly accusing the State of being the main tool of technical control of the social dimension; in this way, the absence of any critical and emancipating reflection on the ends that the State must pursue determines that it is one of the main guarantors of ecological problems and social inequality being accentuated. This is especially true in developed countries that impose with various forms of coercion their procedures on States of other countries, which within a framework of globalised capitalism produces an increase in the gap between “first” and “third” world countries, benefiting transnational capital. In this framework, State and economy constitute the instrumental reasons that threaten to colonise the “life of the world” (social interactions) and endanger the production of social significance (Darder & Torres, 2003; Habermas, 1988; Kalyvas, 2004; Toens, 2007).

We can recognise some of these ideas with some modification and in others that are theoretical within critical traditions, which generally possess as a joining nexus of Marxist notes in the discourse. These traditions would also include, as well as the Frankfurt School, others such as Historical Materialism, Feminism or others developed more recently from structuralist theories mainly represented by Giddens or the praxeology of Bourdieu (Florido del Corral, n.d.; Fowler & Zavaleta Lemus, 2013; Prasad, 2005).

Pierre Bourdieu (2005), states, concerning the neoliberal trends adopted by the States, accusing them in this way of directly defending the most radical capitalism, whose results derive from the unceasing creation of wealth, which is concentrated in the hands of a privileged minority at the cost of decadence of the rest. The result is what he called “the

social costs of economic violence" characterised by the gradual loss of social achievements and by the increase of work precariousness, industrial injuries and illnesses among others.

In this way, we can see how capitalism and the uneven distribution of wealth have derived from an increase in social inequalities, which in turn have a tremendous impact on health. In this environment of structural inequality, frustrates the practice and professionals, on seeing how their efforts to cover individuals' health needs are frustrated when they have no resources or strategies to eliminate or correct the underlying social conditions. On the one hand, recognising the social determinants of health, together with the dissatisfaction experienced by nurses on the other, has led to an increase of nursing scientific production that uses critical theories as a reference framework, whether applied to clinical practice (Duchscher, 2000; Lynam, 2005), or applied to the self-perception of the collective as an oppressed group due to reasons of gender, class and occupation (Fulton, 1997; Mooney & Nolan, 2006; Sander, 2008).

In this latter sense, immigrant women, on whom this research is centred, also face other forms of domination and characteristics such as ethnicity or urban or rural location, which will be analysed according to the frameworks stated in figure 2.

2.2. Feminism

Simone de Beauvoir, considered one of the most influential feminist authors of the XX century, set the bases of feminism on equality, seeing woman as a cultural and social construct. From her point of view, the main defining characteristics do not come from genetics but identity is constructed by means of education and socialisation processes, or in her own words, "one is not born a woman, one becomes one" (Beauvoir, 1998).

In the 70's, academics of the second wave of feminism separated the concepts of sex and gender in an attempt to differentiate between what is biology and what is culture and

denounced naturalisation of women as a basic mechanism in their social subordination (Esteban, 2001). According to Stolcke (2006) the term “gender” came about precisely to emphasise that inequity and oppression of women with respect to men, and did not depend on the differences of biological sex in the human species but that they were sociocultural phenomena through which certain groups (among them women) were condemned to social marginalisation.

In this way the term “sex” denotes the physical, anatomic and physiological differences between men and women, which in turn are associated with the capacity to procreate, whereas the concept of gender supposed a different level of abstraction by which we refer both to the ideas and representations and the social practices of men and women, which implies a differentiation of social spaces and functions and a hierarchisation with regards to the access to power (Esteban, 2006, p. 28).

The anthropological and sociological perspective denounces that in separating the concepts of sex and gender and especially in healthcare activities, sex has tended to be seen as an unarguable and unmovable biological fact whose chromosomal, physiological and anatomical expression materialises in the division between two groups: men and women. This ethnocentric view leaves out other societies and even western phenomena such as transsexuality. Gender, however would be modifiable depending on customs, belief and the historical, political, religious and social context (Esteban, 2001).

According to Showalter (1989) the analytical concept of “gender” attempts to question the existentialist and universalist declaration that “biology is destiny”. It transcends biological reductionism by interpreting relations between men and women as cultural constructions born from attributing to them social, cultural and psychological meanings to their biological sexual identities. From this point of view, “gender” is distinguished as a symbolic creation, “sex” as a biological fact and “sexuality” as referring to sexual preferences and conducts.

The theory of gender as a social construction has gained ground progressively and, although there is not a consensus on the concept itself, in recent times feminist theories (specifically postmodernist ones) argue for the fact that gender can only be understood when interacting with race, social class, sexuality and other social identities as axes of oppression (Crenshaw, 1997; Ferber, 1998; Hankivsky & Christoffersen, 2008).

Despite this interaction being certainly interesting, authors such as Young (2007) or Bourdieu (1998) insist on the need to turn to structural analysis of domination relationships in order to analyse how these are assimilated naturally by means of social constructs and history of the bodies from an androgenic point of view in which division is organised by gender. Specifically Bourdieu (2000, p. 24) in one of her last works underlined that:

"The biological difference between the sexes, i.e. between male and female bodies and very especially, the anatomical difference between the sexual organs can appear as the natural justification of the socially established difference between the sexes in this way, and especially the sexual division of work (…). Thanks to the principle of social vision constructing the anatomical difference and that this constructed social difference is converted into the foundation and the guarantor of the natural appearance of the social point of view that supports it, a relationship of circular causality is set up that encloses thought in the evidence of domination relationships, inscribed both in objectivity, in the form of objective divisions, and in subjective divisions in the form of cognitive, schemes that, when organised in accordance with their divisions, organise perception of their objective divisions".

From this it is derived that sexual division is not only inscribed in productive activities but also in representation activities attributed to men (and reinforced through institutions such as the family, school, the State or the church) against the aptitude situation of women as objects of exchange or also in relation to another key dichotomy, according to which men are in charge of public, discontinuous and extraordinary exchanges, while women are

occupied with private, invisible, continuous and daily exchanges (i.e.domestic work, care of children and the elderly).

Moss (2002) considers that the private environment is the darkest and least regulated stronghold where power, authority and control is exercised on the extraction of the energy of work. Artazcoz et al. (2004) noted at an empirical level such as Spain that there still is a low level of remunerated female activity compared with other European countries, accompanied by differences and inequities of gender in the work market, in the conditions of employment and exposure to industrial risks, a fact that causes gender differences in health.

In the same sense, several authors (Colino Sueiras, Riquelme Perea, & Cánovas Pedreño, 2007; Ferrara Garcia, 2002; Ruesga Benito, 1985) note that in several Spanish autonomous regions how domestic and care work are the sectors with the highest rate of unofficial work and work precariousness.

As well as the gender differences in remunerated work, there are also inequalities in domestic work resulting from the persistence of social roles assigned to men and women: domestic work is still mostly undertaken by women, so that if they also join the labour market, they perform a double shift (Borrell, Muntaner, Benach, & Artazcoz, 2004; Larranaga, Arregui, & Arpal, 2004).

2.3. Colonialism

In the mid XX century, following the failures of wars and the colonial regimes, a questioning of the Eurocentric thought was emphasised and which was imposed in the a large part of the world in one way or another. The extension of the capitalist model arrived in a second uniformising wave, subtler and accompanied by its own critiques of the model. However, these critiques came from the so-called West to be universally adopted and

accompanied and imposed within the unitary point of view, which expanded across the world from certain power centres.

The concept of post-colonialism arose in the 60's reactively to this imposition and perpetuation of colonial relationships. The term post-colonial criticism refers to the theoretical and empirical work that focused its attention on the causes and consequences of European colonialism as well as in contemporary neo-colonial practices (Anderson, 2004).

The beginnings of this current were marked by works of intellectuals such as Franz Fanon, Aimé Cesaire or Edward Said. The latter, through his book "Orientalism" (1979), generated a fertile literary production on the perception of "the other" and of the links between human sciences and western imperialism in the scientific knowledge of non-western cultures. The book is considered to mark the beginning of the anti-colonial discourse and introduced a new field of academic research (Racine, 2003) giving rise to other intellectuals developing different theoretical points of views from the post-colonial model (Kirkham & Anderson, 2002).

Although post-colonialism revolved round the problems and after-effects of the colonial era as well as the oppressive dynamics that have been maintained and expanded to the present day, it does not represent a single school of thought, but in its own conception it integrates a multiple perspective. It has a multi-disciplinary character receiving contributions from different disciplines and post-colonial literature has had a great influence from post-modernism and post-structuralism through authors such as Lacan, Derrida, Althusser or Foucault and more recently, from feminism and from post-Marxism (Kirkham & Anderson, 2002).

Post-colonialism is a transnational process that affects both the colonising and colonised country and it does not refer to a set time in history but implies working "against and beyond" colonialism (Anderson, 2004). It is defined in the alternative, in the diversity of

view points and in the opening, beyond what De Sousa Santos calls “indolent reason” which criticises for not thinking from any other place that is not that single and hegemonic thought:

“Then, what I am trying to do here today is a criticism of the indolent, lazy reason that is considered unique, exclusive and that does not exercise enough to be able to contemplate the boundless wealth of the world. I think the world has an inexhaustible epistemological diversity and our categories are very reductionist” (Sousa Santos, 2006).

From this open, integrating and liberating point of view a perspective is provided that not only is considered a critique and alternative but is assumed to be decolonial in its efforts to influence a homogenising process that has already expanded and whose bases and concepts need to be questioned. In this sense, there are key concepts that mean in their broadest sense, beyond a historically simple and limited category. The term race is at the forefront as a socially constructed category and used in the process of colonisation, linked to hierarchy and imposition, and reproduced by post-colonialism. Therefore racism is a key concept within the post-colonial paradigm, since, quoting one of the initiators of this current, “the Fanonian definition of racism allows us to conceive different forms of racism avoiding the reductionisms of many definitions” (Grosfoguel, 2011). This conception allows different types of oppression to be identified and denounced.

In this sense, post-colonialism brings our attention to the structural processes that cause dehumanisation and suffering, being a basic axis in the nursing discipline and in understanding inequalities in health (Anderson, 2004).

2.4. Model of the social determinants of health

According to Sen (2002), health constitutes one of the most important aspects of human life and is intimately related to social justice. Starting from the need for just distribution as well as from efficient training of human capacities, people must have the same

opportunities to achieve health free from avoidable illnesses and premature death. However, the reality shows how too often that the least socially favoured collectives suffer poorer health so that determinants such as social class, gender, territory or ethnicity provoke excessive morbidity and mortality greater than most known factors of illness (Borrell & Benach, 2005). In this section I proposes to clarify the concepts and interactions that are produced among these factors, from the theoretical framework of the Social Determinants of Health (SDH) as well as the impact that they have especially on immigrant females.

The concept of "social determinants of health" (SHD) arose in the 1970's from a series of international publications that highlighted the limitations of health interventions aimed at reducing individual (Diderichsen, Evans, & Whitehead, 2001, p. 13).

The World Health Organisation (WHO) at its constitution in 1948 already recognised the impact social and political conditions had on health and the need for collaboration with sectors such as agriculture, education, housing and social welfare to achieve benefits regarding health (World Health Organization, 2009). Despite this, during the 50's and 60's both the WHO and the other world actors chose to emphasise the benefits resulting from technology and vertical campaigns against specific diseases, hardly mentioning the social context in which these were developed (WHO Commission on Social Determinants of Health, 2007).

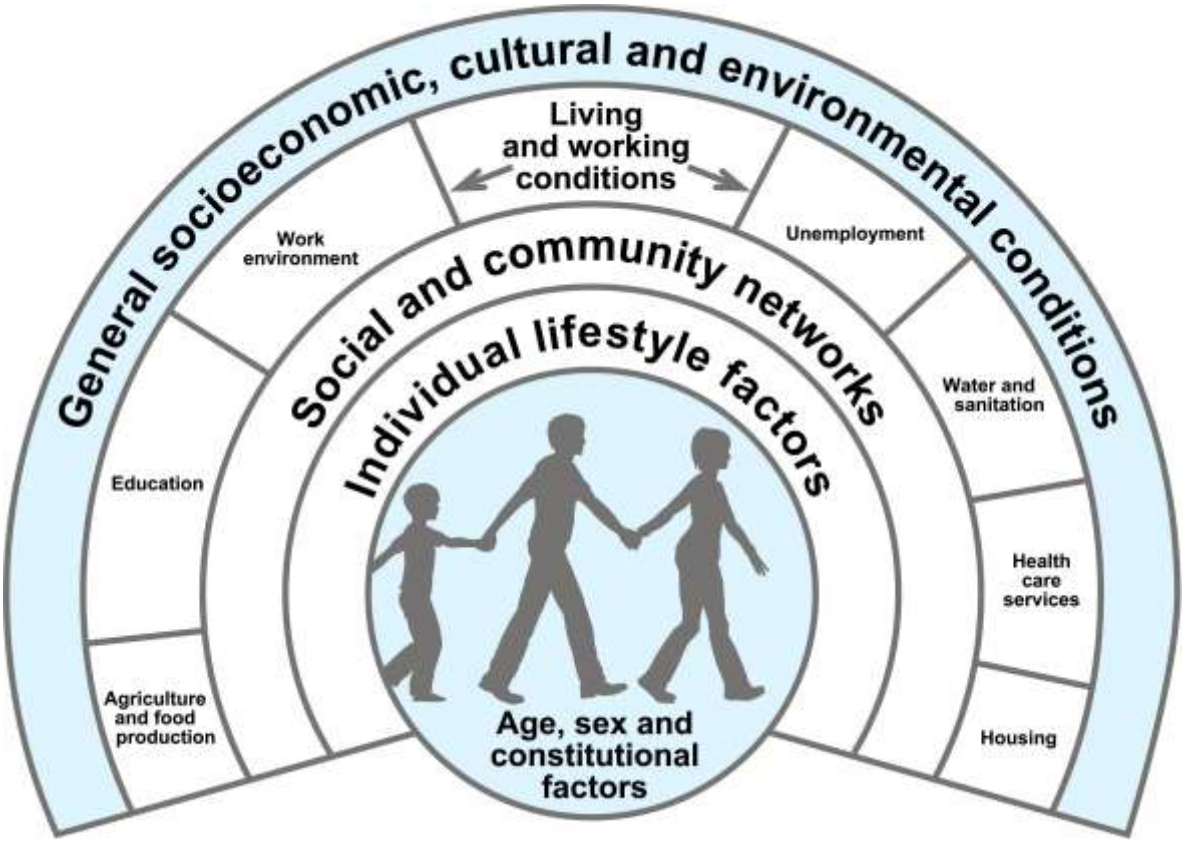
The Alma-Ata Declaration (Organización Mundial de la Salud & UNICEF, 1978),and the movement "health for all by 2000" regained the social model in health, insisting on the need to bear in mind social conditions in the programmes so as to achieve equity in health matters (World Health Organization, 1981). However, neo-liberal policies that characterised the 80's and 90's led to a reduction in public spending and, as a result, there were reductions in social provisions in developed and developing countries (Labonte & Schrecker, 2006).

It is therefore not strange in this sense that the report considered as a point of inflexion to renew the debate on the need for a social focus on health/illness should arise in Great Britain in 1980, known as the “Black Report”. It emphasised the importance of reducing the differences in health between the most privileged classes and the most humble. Moreover, it indicated that, to achieve these ends, not only should the health system and technological advances play a leading role but also the education, housing and social welfare sectors (Black, Morris, Smith, & Townsend, 1980; Naidoo & Wills, 2000).

The WHO defines SDH as the “circumstances in which people are born, grow up live, work and become old and the systems set up to combat illnesses. These circumstances comprise a wider group of forces: economic, social, regulatory and political” (WHO Commission on Social Determinants of Health, 2005).

The SDH model developed by Whitehead and Dahlgren considers life styles and health services important. However, socioeconomic, cultural and environmental conditions encompass much more widely what is understood by “social determinants of health” (see figure 3) (Labonté & Schrecker, 2007; Ritsatakis & World Health Organization. Europe, 2008).

Figure 3: SDH model developed by Whitehead and Dahlgren*

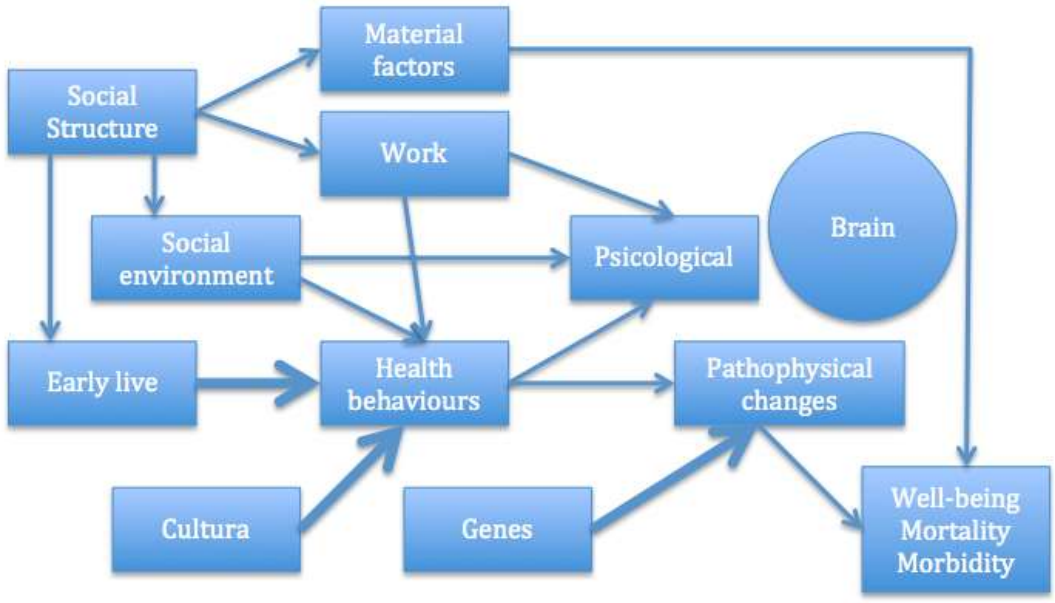


In this way, the determinants of health would include genetic make-up, gender, lifestyles, poverty, unemployment, education, working conditions etc. This multi-factor consideration, beyond the purely biological, would explain why certain interventions such as vaccination barely have an impact on mortality levels of the population (McKeown & Lowe, 1974; Naidoo & Wills, 2000) and why, despite technological advances, millions of people still die or become sick every year (Labonté & Schrecker, 2007).

Acheson (1998), in his influential report on health in Great Britain, showed, as well as the model provided by Whitehead y Dahlgren, another approach towards understanding how social processes affect health (figure 4). This model considers inequalities in health as a product of differential exposures and vulnerabilities that arise from differences in individuals' socioeconomic positions, from the stage of gestation and during the course of

life, causing socio-psycho-biological interactions (Acheson, 1998; Brunner & Marmot, 2006; Marmot, 2000, 2001).

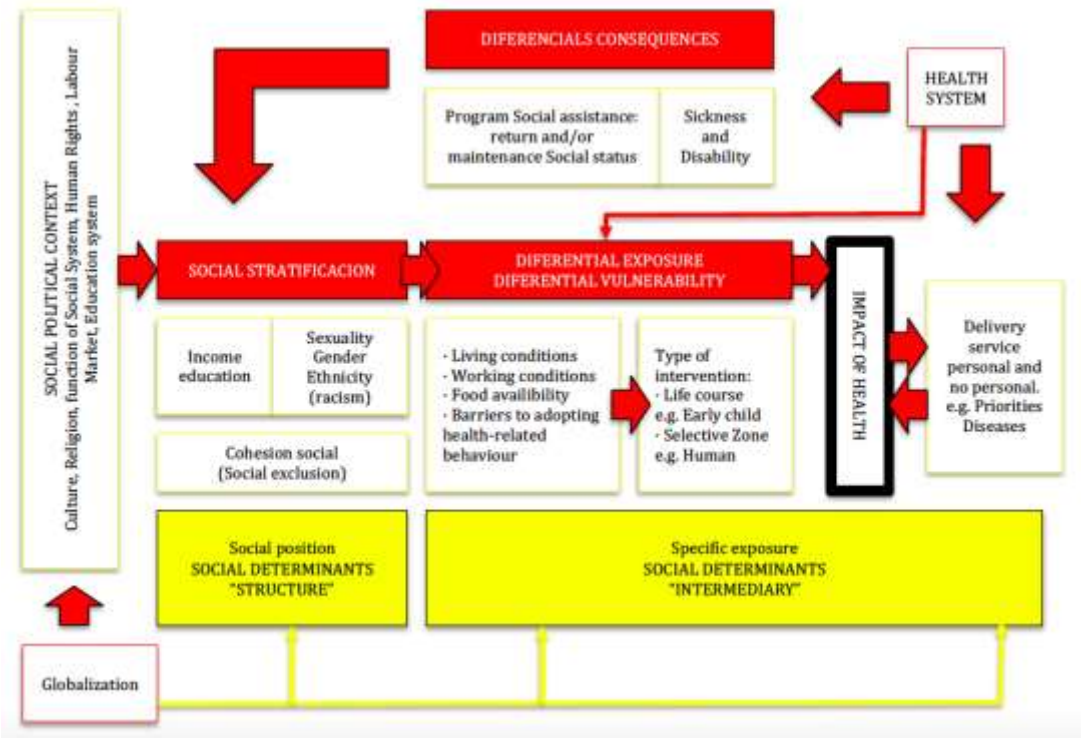
Figure 4: SDH model developed by Acheson



In the XXI Century, there arose a new focus on social determinants of health influenced by the repercussion of economic globalisation and demonstrated by failing to achieve the targets of the millennium, there being a sustained increase in inequalities between countries and within countries themselves (Baum & Harris, 2006; Dunn & Dyck, 2000).

In view of the events, the Commission for Determining Social Factors of Health (WHO) again took up world leadership producing a conceptual framework between the two previous ones in order to generate the mechanisms through which social determinants of health generate inequities and the interrelation that is produced between them (figure 5) (World Health Organization, 2010a).

Figure 5. SDH model developed by WHO Commission

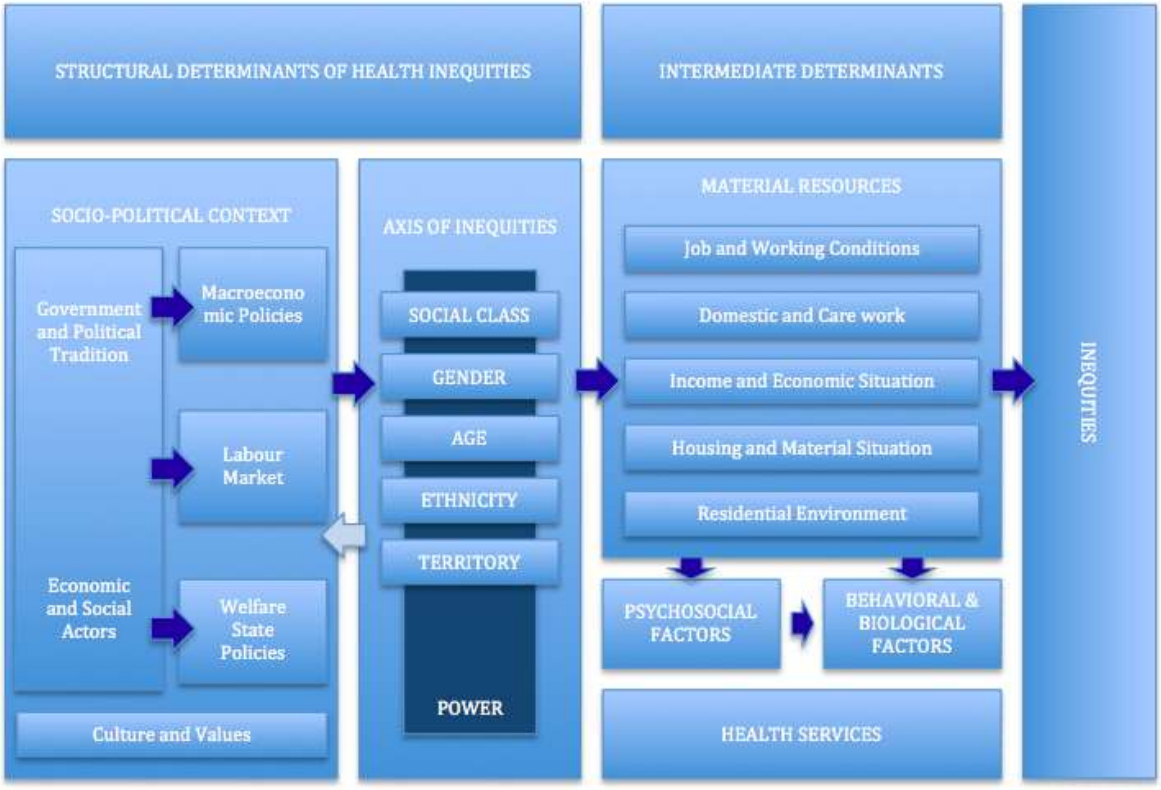


As can be seen in the model, there are structural and intermediate social determinants. Structurally determining factors would be those producing social stratification (income, education, gender or ethnicity would be examples), whereas the intermediate determining factors decide better or worse health opportunities depending on what the vulnerability situation is (working conditions, housing quality, access to food and even the health system).

At a national level, the Spanish Ministry of Health, Social Services and Equality created a commission which in 2010 proposed an adaptation of the models proposed by Orielle Solar and Alec Irwin for the Commission of Social Determinants of Health of the WHO and the model proposed by Vicenç Navarro, where as well as showing the structural and intermediate determining factors, the role was specified that the relations of power had when intensifying the so-called axes of inequality; social class, gender, age, ethnicity and

territory (figure 6) (Ministerio de Sanidad Servicios Sociales e Igualdad. Comisión para reducir las desigualdades sociales en salud en España, 2015).

Figure 6. SDH model developed by Spanish Ministry Commission



Paradoxically and despite the explicit recognition given to the immigration factor, the last legislative changes in Spain have not served to ameliorate their effects on health; rather the contrary, as is described in chapter 1, with the coming into force of the Royal Decree Law 16/2102 (España, 2012), not only is access to the national health system severely restricted to undocumented immigrants, but inequities are also caused by the NHS itself according to whether the autonomous region has applied the legislation or health staff have resisted its being introduced.

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2.4.1 Gender as a social determinant of health

The Commission on Social Determinants of Health of the WHO (2007) stated that inequalities regarding gender damage the physical and mental health of millions of girls and women across the world. One of the structural reasons that pointed out as a principal cause of inequity is the lack of resources and policies promoting change, with the freeing of women from the tasks of care by means of making men co-responsible as well as urging that recognition of domestic work being considered as work itself, with all the industrial risks involved for health (Sen, Östlin, & George, 2007).

In this way, the same report indicates how gender relationships are materialised in hierarchical social structures interacting with economic, racial or ethnic inequities. Only by paying attention to the first ones, we find that women possess less land, wealth and properties in nearly all societies, as women are usually employed and segregated into badly paid, insecure and unofficial work. In this way, gender is related to poverty and this with worse health, both in terms of access to the health system and in results on health.

Despite there being related evidence and the recommendations of the WHO, the literature still insists that both health policies and national and international research, is characterised by being gender blind. For example, In Spain until 1995 the question of gender was not included in health surveys, from which time the analyses began to be desegregated, allowing complex theoretical frameworks to be considered explaining health differences between men and women based on sexual differences and those related to gender, incorporating questions relating to the family environment, reproductive work and the workplace in order to detect differences and inequities (e.g., in domestic work, discrimination, domestic violence etc.) (García-Calvente, del Rio Lozano, & Eguiguren, 2007; Rohlfs, Borrell, Artazcoz, & Escriba-Aguir, 2007).

According to Macintyre (2001), there are two kinds of gender bias in the field of research. The first would be the result of assuming that men and women are equal; this assumption

has derived from the study of certain illnesses by means of clinical trials whose samples comprise exclusively males ("male biased"), while the results have been extrapolated to the entire population. The most commonly used example are cardiac illnesses, more prevalent in men, although with higher fatality rates in (Fleisch, Fleisch, & Thürmann, 2005; Kolk & van Well, 2007; Rochon, Clark, Binns, Patel, & Gurwitz, 1998), although others can be found, such as respiratory illnesses, where women are infradiagnosed despite reporting the same symptoms as men (Ruiz-Cantero, Ronda, & Alvarez-Dardet, 2007).

The second would assume that men and women are fundamentally different in situations where in fact there are similarities (Ruiz & Verbrugge, 1997; Ruiz-Cantero et al., 2007; Verdonk, Benschop, de Haes, & Lagro-Janssen, 2009). Clear examples of these would constitute the studies relating to food disorders or relating to post traumatic stress, where the studies carried out on women are considerably greater than those including men as the study population (Ruiz-Cantero et al., 2007).

2.5. Human Rights and Social Justice

2.5.1. Human rights and right to health

Although United Nations National Assembly proclaimed health care as a Human Right in 1966, and, in consequence, States have the obligation of providing an equal access to health care system for all populations (Schoevers, Loeffen, van den Muijsenbergh, & Lagro-Janssen, 2010), specific legislations, regulations and laws make access to health facilities for immigrants problematic in many countries (Devillanova, 2008; Kullgren, 2003; Kulu Glasgow, Bakker, Weide, & Arts, 2000; Nandi et al., 2008; Okie, 2007).

European policies in this respect are ambiguous, since the growing interest for certain aspects of irregular immigration have been accompanied by, on the one hand, restrictive immigration policies and criminalisation of entry, stay and employment (Lund Thomsen,

2012), while, on the other, the European Parliament adopted a resolution to reduce the health inequities in the European Union calling on member states to tackle inequities in access to healthcare for undocumented migrants (Committee on the Environment Public Health and Food Safety, 2011) pressured by the signing of over 3 million Healthcare Professionals, among which was the European Federation of Nurses Associations (EFN).

The Universal Declaration of Human Rights arose in 1948 when it was adopted by the United Nations Organization. This declaration started with a preamble in which initial considerations were quoted, referring to the equality of rights for all members of humanity and that freedom, justice and peace in the world were based on recognising human dignity, as disrespecting human rights had caused barbaric acts which had outraged humanity. It was considered essential to protect human rights by a legal regime so that people would not have to resort to rebellion to defend themselves from oppression and that they had freedom of speech and religion. It was proposed to promote developing friendly relations between nations and that the member states undertook to ensure the universal respect for human rights and liberties and to promote social progress (United Nations, 1948).

The right to health is very relevant in human rights and therefore various articles were dedicated to health. Regarding medical assistance, in point 1 of article 25, all people were granted the right to enjoy dignified living conditions with the guarantee of access to primary goods and medical attendance was expressly named as an essential good:

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (United Nations, 1948).

Regarding access to social resources article 22 recognises the right of everyone of a same state to benefit from the indispensable social resources for his dignity:

“Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality” (United Nations, 1948).

Regarding non-discrimination, article 2 refers to non-discrimination for any reason, including their economic position that must not restrict their access to primary goods:

“Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty” (United Nations, 1948).

The Human Rights Declaration has, from its proclamation, served as the basis for numerous treaties, agreements and laws, both national and international. Such is the case of the Spanish GHL of 1986, setting up the NHS (España, 1986). It recognises the right to receive treatment from the health system for all citizens and foreigners resident in Spain and it names them as rightfully entitled to health protection and medical attention. Likewise, in article ten point 1 it recognises for all the right to their personality, human dignity and privacy without being able to be discriminated for reasons of race, social type, sex, morality, economy, ideology, politics or trade union (España, 1986).

2.5.2. Right to health and social justice

Social justice is aimed at creating the conditions needed so that a relatively egalitarian society is developed in economic terms. Therefore it is aimed at the common good and equitable wealth distribution. The state acquires the commitment to compensate for inequalities that arise in the market and other society mechanisms by means of decisions, rules and reasonable principles for the whole population.

According to Rawls, health is a primary social good which must protect the basic institutions of society; "All primary social goods (...) must be distributed equally unless inequality of one or all of these goods results to the benefit of the least advantaged". He also considered that "each person possesses an inviolability based on justice that even considering the joint welfare of society can be cancelled (…) It does not allow that sacrifices imposed by a few to be exceeded by the greater sum of benefits which a few enjoy (...) The rights that justice guarantees cannot be the subject of political negotiations or of calculating social interests" (Rawls, 1999).

In focussing on the capacities of M. Nussbaum, the protection of the right to health is considered to be a requirement of social justice and this must be understood as the real possibility of everyone's access at all levels of health attention and it grants the responsibility for reaching this goal to the State and society (Nussbaum, 2007).

For Bottari, the right to health, recognised in the constitution requires public action directed at protecting health (Bottari calls it the "right of tutelage") (1991). Protecting health implicitly involves the right to "have the best means possible to maintain one's "good health" or to recover it should it be lost without it depending on one's socioeconomic position" (Vélez Arango, 2011).

Summarising, a just health system is that which foresees the provision of institutions, infrastructure, human and financial resources and logistics aimed at ensuring satisfaction

of health needs, valuing it as a public good. Therefore, the distribution of health resources must ensure universal and integral access to the population (Herreño Hernández, 2008).

2.6. Equity in health: What is Equity in health and what is considered social inequity and inequality?

Margaret Whitehead (1990) in her famous document produced for the WHO "The concepts and principles of equity and health" distinguishes between health inequities, inequities in the health system and inequalities. The term "health inequity" has an ethical and moral dimension and refers to the "differences in health that are unnecessary, avoidable and unjust". As a result, instead of defining a situation as inequitable, the cause must be examined and judged to consider it unjust from the social context (Rodríguez, Urbanos, & Abásolo, 2008; Whitehead, 2007; Whitehead, 1990).

Differently from the previously quoted concept, traditionally on speaking of "the inequities in the health system", access is considered, i.e. on equal opportunities that different groups of the population have when faced with the same need, independently of what their geographic location, culture, gender or sexual orientation is, to enter the health system (Whitehead, 1990). In this sense, bearing in mind the distribution of resources, vertical equity points to the fact that people with the greatest needs must be treated unequally providing more resources for them. Horizontal equity refers to the fact that people with the same needs must be treated in the same way (Almond, 2002).

Referring to inequalities, in a practical sense, the WHO has decided not to make distinctions and uses as synonyms the terms inequalities in health and inequities "The terms social inequities in health and social inequalities in health are synonymous in the report. Both have the connotation of differences in health that are unjust" (WHO Commission on Social Determinants of Health, 2007, p. 5). The reasons are, on the one hand, the tradition in British literature that does not distinguish between "inequalities" and

"inequities" (Marmot, 2004) and, on the other, the impossibility of translating both terms into languages where only one of them exists (Whitehead & Dahlgren, 2006).

For this reason, both internationally and in Spain, we can note that most authors use the "term inequalities to refer to the socioeconomic inequalities en health in which are included more or less explicitly a negative moral evaluation" (Costa-Font & Rico, 2006; Daponte-Codina et al., 2008; de la Puente Martorell, 2008; Enrique Regidor et al., 2006; Rodríguez et al., 2008).

Graham (2004) proposed that inequalities in health are "the health differences produced systematically between community groups occupying different positions in society". Braveman (2006) indicated that this definition had certain weaknesses: "it is not explicitly directed to the determining factors of health, it needs a broader explanation of who the people are occupying unequal positions in society and it does not show that these inequalities are avoidable". The author suggests (as a brief definition) that inequalities in health are "those differences in health that are potentially avoidable (or modifiable by means of health policies) between the more socially disadvantaged groups in comparison with the most advantaged; these differences make the less advantaged group experience systematically worse health".

Chang (2002), considered that the terms equity and equality in health to have different meanings and, as a result, should be separated. The first difference noted is that equity is a different regulatory concept to equality, which would be an empirical concept whose purpose in practice would be to determine/measure why inequalities or differences in the state of health between various individuals or groups would arise.

Therefore, to treat certain inequities as inequalities, a regulatory evaluation must be made, such as, for example, returning to the question: Are there biological differences that can explain the observed variations in the state of health? If no plausible biological differences are found, then these variations are caused by environmental factors (physical and social)

linked to human intervention, as different studies showing that life expectancy is substantially less in poor countries compared to the richest, or within the same country, among the least advantaged social groups compared with the most advantaged, or women with a greater tendency to experience worse health by occupying less privileged social positions, have less access to and control over the economic resources and are separated in employment whose conditions are characterised by high levels of requirements and poor material and formal rewards, such as domestic work or formal care work (Chang, 2002; Dunn & Dyck, 2000; García-Calvente, Mateo-Rodríguez, & Eguiguren, 2004; Marmot & Friel, 2008; Marmot, 2005; WHO Commission on Social Determinants of Health, 2005).

Given the huge range of researchers coming from different disciplines and variability when attributing meaning to terminology, the debate still seems open. Yet there is still a consensus (more or less explicit) regarding the ethical-moral nature of the term equity and its intimate relationship with the concept of social justice (Braveman & Gruskin, 2003).

Thus Rawls understood it when formulating the Theory of Justice as equity "a fundamental concept for justice is equity ("fairness"), which is related to due treatment of people who are cooperating or competing with each other", understanding that a just society is that which has a just system of cooperation (Rawls, 1999, 2003).

Peter (2001) maintains that Rawl's theory, despite not being directly focussed on the field of health, constitutes a valuable theoretical framework to evaluate social inequalities and develops what is called the "indirect perspective" under the premise that social inequalities are unfair, not only because they produce health results far from what would be ideal, but they are also the expression or product of injustices produced by economic, social and political institutions.

From the operative point of view, I shall consider inequalities in health as: those injustices rooted in social structures that derive in different health results depending on the level of

privilege of some groups with respect to others (Braveman, 1998; Gomez-Redondo, 2002).

2.7. Ethic of Care and Deontological Codes

Nursing practice is based on the philosophy of ethics of care. As its name indicates, this is based on the care of others from a responsible and empathetic point of view, bearing in mind its peculiar and contextual characteristics (Barrio Cantalejo, 1999). It grants importance to ethical, moral and sentimental values such as the commitment with the health care of patients, with the priority of working for the wellbeing and human rights of patients and assisting their needs in an effective and humanized way (Fry, 1989).

Apart from the current legislation, health care staff work on the basis of there being ethical codes produced by the professional colleges and which are agreed rules, approved by consensus of its membership. These documents gather a set of rules based on values that are formulated and assumed by those carrying out a professional activity with the purpose of maintaining a certain level of requirements, competence and quality at work.

Nurses, in their representation of the organisms that regulate them, have produced codes of conduct in order to regulate decision making in professional practice. These codes are based on values that are their foundation and are adapted to the social and cultural context in which they work. Nurses' ethical codes have evolved with the profession; at the beginning of the nursing profession, Florence Nightingale considered that the nurse should act within ethical rules and extended the principles of traditional medical ethics (doing good, not evil) with those of confidentiality and truth (Amaro Cano, 2004).

The International Council of Nurses (ICN) published in 1953 the first deontological code for nurses that has served as a guide for international ethical codes worldwide and is adapted as a national code in countries that have produced no other. It is defined as "a guide for action based on social values and needs". In the preamble section it describes

fundamental duties of nurses, which are: to promote and restore health, prevent illness and alleviate suffering and it declares that nursing is universally needed. It considers inherent to nursing respect for human rights and declares there can be absolutely no discrimination in nursing care. In turn, in element 1 of section 5, it considers the nurse co-responsible together with society to “start and maintain any action aimed at satisfying public health and social needs, in particular those of vulnerable populations” (Consejo Internacional de Enfermeras, 2012).

Later, in 1986, Official College of Technical Health Assistants and Nursing Graduates of Barcelona produced the Nursing Code of Ethics with the framework of the GHL and it was adopted for all Catalonian Colleges by the agreement of the Council of Nursing Colleges of Catalonia. Its section 1, General Principles, considers that “respect for all human and social rights of the individual, family and community must constitute the fundamental ethical attitude of professional conscience” and that it is a person’s fundamental right to have the maximum degree of health that can be attained. In turn, it considers health a public good and that nursing staff must work towards the health system reaching all the population. It also rejects discrimination for any reason and states that “the nurse must not abandon a patient/user who needs vigilance or nursing care without assuring their continuance” (Col·legi Oficial Infermeria de Barcelona, 1986).

The Deontological Code for Spanish Nursing, produced by the Spanish General Nursing Council in 1989, considers that professional ethics must be the framework of the profession and that the ethical must guide reflection both in extreme and routine situations. In its conceptual framework, it defines human, society, health and nursing and it is based on the values of human health, liberty and dignity. It considers duties of nursing to be serious and responsible professional commitment, active participation in society, recognition and application of the principles of professional ethics and respect for human rights (Consejo General de Enfermería, 1988).

The Codes of Ethics and Conduct of European Nursing, produced by the European Federation of Nursing Regulatory Organs in 2007, whose principle purpose is to guarantee the safety of people receiving nursing care in Europe, advising the nursing regulatory organs on the fundamental principles that they must bear in mind in producing their codes of ethics and conduct and to inform patients and nurses on common standards of ethics and conduct, what is expected of all nurses working in Europe. In section 3.4 “Equitable access to quality health care” it considers nurses to be responsible for caring with no discrimination whatsoever and considers nurses as a representative of recognising that health is a right and, as such, they must defend it “preventing illnesses, caring for patients and carrying out duties of rehabilitation” (Federación Europea de Órganos Reguladores de Enfermería, 2007).

The Catalonian Nurses’ Code of Ethics, elaborated by Council of Nursing Colleges of Catalonia in 2013, is a revision of the Nursing Code of Ethics of 1986 whose purpose is to provide the foundations for regulating decision making adapting it to the current social and cultural context. It gives importance to professional values for their relevance to human beings and considers that they must be reflected in all codes of ethics. These values are: nursing responsibility, autonomy of the person, intimacy and confidentiality, social justice and professional commitment. It is based on a scientific study with qualitative and quantitative approaches to be aware of the ethical problems that most concern Catalonian nurses in their various professional fields. Section 4, based on the value of social justice, states that nurses undertake to “treat people equally and to guarantee an equitable access to nursing care, taking into account society’s global nature and favouring the common good”. It considers the nurse responsible for generating social conscience in the face of a breach of human rights, that they must be committed to reducing inequalities that are generated by social determinants of health and that they must safeguard, through the official organisms, “so that legislation affecting the accessibility, the quality and the cost of

health is adapted to people's needs" (Consell de Col·legis d'Infermeres i Infermers de Catalunya, 2013).

OBJETIVES AND METHODOLOGY

3. OBJECTIVES

The general objective of this Doctoral Thesis is to explore the access to and utilization of health care and social services by undocumented immigrant women in Spain from different perspectives.

In this sense, the specific objectives derived from the general objective are the following:

1) To identify, describe, and analyze recent evidence on immigrant undocumented women's access to and utilization of health and social services in Spain (Study I).

2) To know the perceptions of health care professionals (midwives) regarding access and utilization of sexual and reproductive health programs in an area with a widely dispersed population, in this case the rural environment of the province of Segovia (Study II).

3) To describe access and utilization of social and health care services by undocumented Latin American women working and living in rural and urban areas, and the barriers these women may face (Study III).

4) To highlight the ethical dilemmas that may arise from the contradiction between legal and ethical discourse, by exploring the contents of the Royal Decree-Law16/2012 and the codes of ethics (Study IV).

4. METHODOLOGY AND SELECTED RESEARCH TECHNIQUES

Each one of the studies that compose the Doctoral Thesis has been approached from different methodological standpoints and using different sources of information.

These compilation of articles conform a composed approach from a critical perspective focused not only on the situations but also on the context to achieve a complex analysis of the reality (Dunphy & Longo, 2007; Gastaldo et al., 2005). In this analysis were combined methods and variables to understand the access to and use of health care and social services in Spain, specially focused on undocumented immigrant women. To contextualize the study, a scoping review was done searching existent scientific and grey literature about access to and utilization of health and social services by immigrant women in Spain. Besides giving a response to the objective, this study summarizes some of the barriers identified or pointed out by authors, that were later introduced in the design of empirical studies (II and III). Studies II and III use the qualitative descriptive exploratory technique with personal interviews of midwives and undocumented immigrant women in two areas in Spain, which are characterized by being rural and geographically dispersed.

The empirical data are complemented by a critical discourse analysis about the nursing ethics and legal arguments in relation to the RDL 16/2012. This analysis is key to identify the implications for the professional nursing practice and the limitations of access to health care services, ultimately a limitation of rights, for undocumented immigrant women.

Table 1. Methodological outline of the Doctoral Thesis

General objective	To explore access to and utilization of health care and social services by undocumented immigrant women in Spain from different perspectives.			
Analyzed data	Secondary Scientific articles and grey literature	Primary Interviews with midwives dealing with undocumented immigrant women	Primary Interviews with undocumented immigrant women	Secondary Nursing codes of ethics and Royal Decree-Law 16/2012
Sample	16	7	12	6
Context of observation	National	Segovia	Lleida	National
Methodology/ Analysis	Scoping Review	Qualitative Inquiry		Critical Discourse Analysis
Resulting articles	I	II	III	IV

Study I. Scoping Review

There are a wide variety of bibliographic reviews which vary according to their methods and objectives. In the present document the scoping review put forward by Arksey and O'Malley (2005) was followed. Scoping reviews differentiate from systematic reviews in that: “a scoping study tends to address broader topics where many different study designs might be applicable”; “and a scoping study is less likely to seek to address very specific research questions nor, consequently, to assess the quality of included studies”. In conclusion, “there is no single ‘ideal type’ of literature review, but rather that all literature review methods offer a set of tools that researchers need to use appropriately" (Arksey & O’Malley, 2005).

Scoping reviews have only been used relatively recently in publications about nursing and health, but their use is increasing and becoming more notable (Davis, Drey, & Gould, 2009). The enormous quantities of data existing about a subject are synthesized by means of the searches (Colquhoun et al., 2014) through different sources that include relevant literature with the objective of determining the extension, range and nature of the existing research in a specific area (Brien, Lorenzetti, Lewis, Kennedy, & Ghali, 2010). Therefore, scoping reviews are interdisciplinary in nature and, to obtain a better understanding of the texts, it is convenient to bring together the contribution of different experts (Daudt, van Mossel, & Scott, 2013).

Thus, they offer a "panoramic vision that illuminates not only the extension and context, but has also the potential to influence political and practical actions " (Davis et al., 2009)

The decision of including a scoping review for Study I of this Doctoral Thesis responds to the need to open the field and identify general patterns, tendencies, evidence and gaps in the access and utilization of health care and social services by undocumented immigrant women in Spain. Thus, research goes beyond a specific research question and one

methodological design; it is open to a broader range in a reflective and interactive process that is taking shape according to the research requirements (Arksey & O'Malley, 2005)

In order to carry out the scoping review we used the methodological framework suggested by Arksey and O'Malley (2005) and repeatedly referenced (Colquhoun et al., 2014; Levac, Colquhoun, & O'Brien, 2010), which guides the review through six stages: "identifying the research question, searching for relevant studies, selecting studies, charting the data, collating, summarizing, as well as reporting the results, and consulting with stakeholders to inform or validate study findings".

In this way technical and specific knowledge is gained, which enables the mapping of the field opened by publications about the subject to be completed. However, the knowledge about the range of publications regarding the subject, diverse in their methods and designs, does not involve an immersion into the detailed synthesis and analysis processes that guide intervention in a given case (Arksey & O'Malley, 2005) although it constitutes a valuable first step to guide the research process (Daudt et al., 2013).

Therefore, the present scoping review is taken as a description of the published literature between 2004 and 2014, about access to and utilization of health care and social services by undocumented immigrant women in Spain. Within the present study it quantifies the existing studies and its results help locate, guide and complete the research done thereafter.

Search parameters

An extensive search of Pubmed, CinahlPlus, Embase and Scopus databases was carried out to locate peer-reviewed papers and grey literature relevant to the Spanish context. The search in Scopus retrieved Medline and Embase contents since 1996, with particular use of free-text search. It is also worth noting its coverage of the European context, and therefore, the Spanish context. Pubmed, CinahlPlus and Embase permitted us to use

controlled text. Specific sites of grey literature in Europa OpenGrey and DART-Europe were also consulted, and a search was completed in Google Scholar.

The search was limited to papers published during the 10 years comprised between 2004 and 2014. The search was not spoken-language based to ensure that no results were omitted and consultations were performed in English.

Search Terms

First, the parameters of a research question were set for the search of the MeSH Database, obtaining the controlled terms for the search in Pubmed. The search of Pubmed was used as a basis and transferred into other databases with controlled language, adapting the terms to the specific characteristics of Cinahl Plus and Embase, and finally to the free-language resources Scopus, Open Grey and DART-Europe. Having previously used controlled text; we could now reach all the possible variants in free text. The terms identified and used in the MeSH Database were “Health Status Disparities” “Delivery of HealthCare” “Delivery of HealthCare, Integrated” “Healthcare Disparities”, “Culturally Competent Care” “Health Services Accessibility” combined with “Emigrants and Immigrants” and “Transients and Migrants”. Since there was no MeSH term, and to make sure we were not omitting results, combinations were also made with the free-text terms “Social Care” “Healthcare” “Health Care” “Access” “Use” and “Utilization”, and the name of the country “España” as well. Once the search started, the term “homeless” was excluded, as it did not answer our question. The basic search strategy used in Pubmed, which was then exported and adapted to the rest of databases, is shown in table 2.

Table 2. Search strategy used in the Study I

Database: Pubmed
("Health Status Disparities"[Majr:NoExp] OR "Delivery of Health Care"[Majr:NoExp] OR "Delivery of Health Care, Integrated"[Majr:NoExp] OR "Healthcare Disparities"[Majr:NoExp] OR "Culturally Competent Care"[Majr] OR "Health Services Accessibility"[Majr:NoExp] OR "Social Care" OR "Health Care" OR Healthcare) AND ("Emigrants and Immigrants"[Mesh] OR "Transients and Migrants"[Mesh] OR migrant*) AND (Access OR Use OR Utilization) AND Spain AND ("2005/01/01"[PDAT] : "2014/31/01"[PDAT])
Database: CinahlPlus
(((MM "Health Status Disparities") OR (MM "Health Care Delivery, Integrated") OR (MM "Health Care Delivery") OR (MM "Healthcare Disparities") OR (MM "Cultural Competence") OR (MM "Health Services Accessibility") OR ("Social Care" OR "Health Care" OR Healthcare))) AND (((MH "Emigration and Immigration") OR (MH "Transients and Migrants") OR (MH "Relocation")) OR ("EMIGRATION" OR "IMMIGRATION" OR "MIGRANT" OR "TRANSIENTS" OR "RELOCATION")) AND (MH "Spain") NOT (MH "Homeless Persons")
Database: Scopus
(((TITLE-ABS-KEY("Health Status Disparities") OR TITLE-ABS-KEY("Health Care" OR Healthcare OR Delivery OR Disparities) OR TITLE-ABS-KEY("Social Care") OR TITLE-ABS-KEY("Culturally Competent Care") OR TITLE-ABS-KEY("Health Services")) AND (TITLE-ABS-KEY(Emigrant* OR Immigrant* OR Migrant*) AND TITLE-ABS-KEY(Access OR Use OR Utilization))) AND NOT TITLE-ABS-KEY(Homeless)) AND (LIMIT-TO(AFFILCOUNTRY,"Spain")

Database: Embase
((health status disparities.mp. or exp health disparity/) OR (delivery of health care.mp. or exp health care delivery/) OR (exp health care access/ or health care accessibility.mp.) OR (social care.mp. or exp social care/) OR (healthcare.mp. or exp health care/) AND exp migrant/ AND (access.mp. OR utilization.mp.) AND Spain/
Database: OpenGrey
("health status" OR "health care delivery" OR "health care disparities" OR "health care disparity" OR "health services accessibility" OR “cultural competence”) AND (immigration OR migrants OR transients) AND spain
Database: Google Scholar
(Healthcare OR Health (care OR disparities OR services OR status OR delivery) OR “social services” OR servicios (sociales OR sanitarios)) AND (*migrant* OR inmigrante*) AND (use OR utilization OR acces* OR utilización) AND (spain OR españa)

Selection criteria

A total of 289 papers (Figure 7) were retrieved, and 87 duplicate papers were eliminated using the bibliographic management program Mendeley. The review seeks to identify all the published research about immigrant women in Spain, and refer to their legal status and access to the Spanish health care system; therefore, the following inclusion criteria were established when revising the full text:

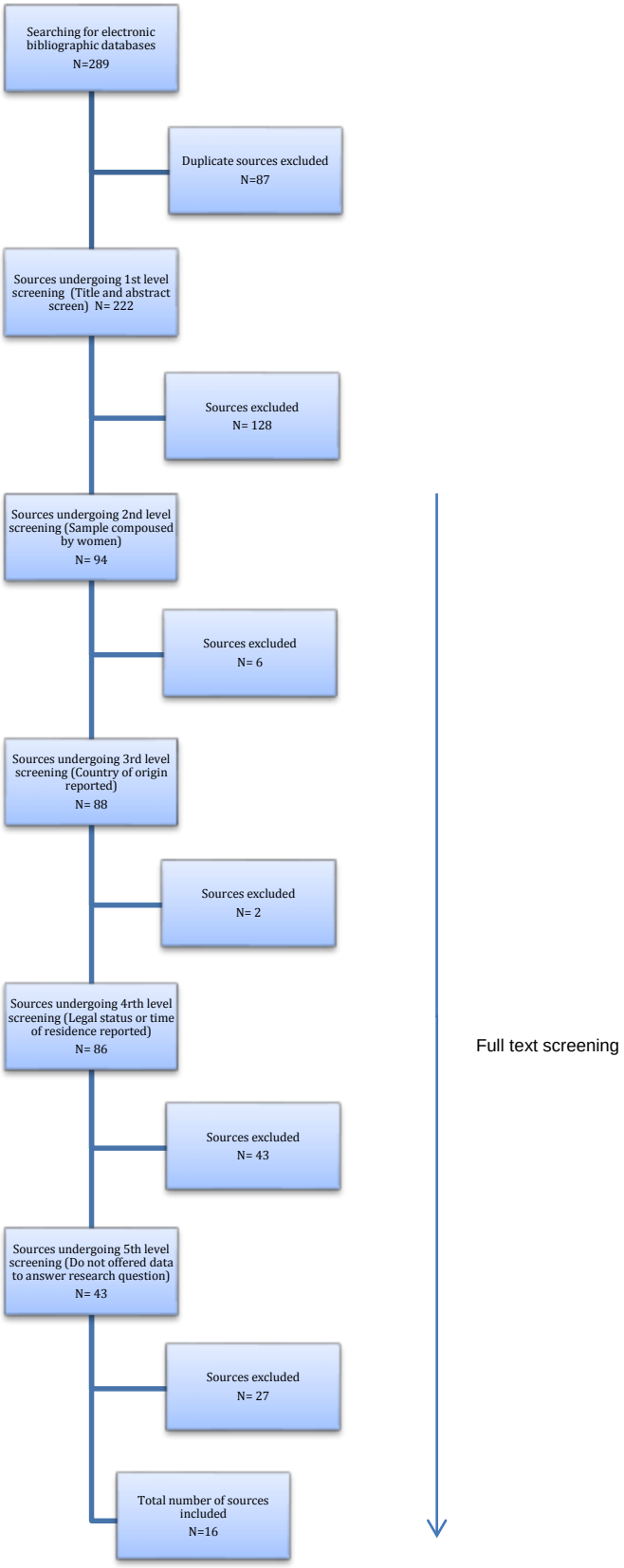
i) Include women or disaggregate data by sex or gender.

ii) Include undocumented women or provide information about legal status or length of residence in Spain.

iii) Include studies that identify immigrants according to their origin and not as a unique same category, since the concepts hygiene and health, and the perception of proper social care are mediated by cultural factors.

Articles that did not comply with the inclusion criteria were discarded. Pertinence and quality was debated to check if the articles offered data to answer the research question. Two independent reviewers were responsible for reviewing the eligible sources (MGS and RP). A third reviewer (AAR) made the decision of inclusion or exclusion when the two-primary reviewers did not agree. There was a general agreement except with an article that needed further examination and debate before achieving unanimity about its exclusion because it did not respond to the criteria (Figure 7).

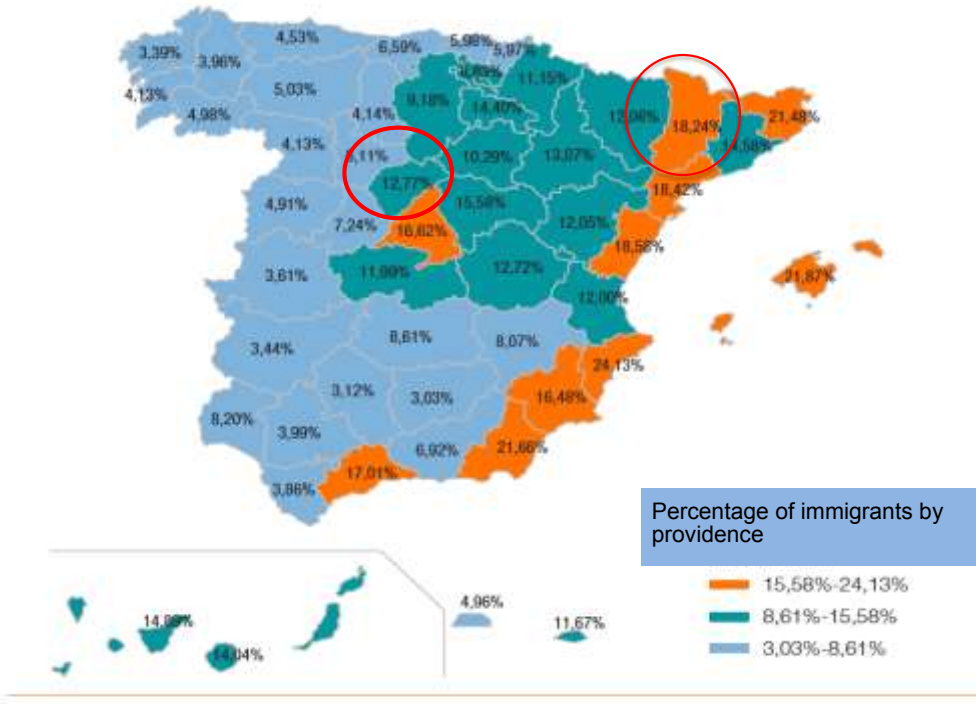
Figure 7. Flow diagram of source data search and selection



Study II and III. Qualitative Inquiry

The next two articles are focused on interviews about two different but complementary contexts. Both of them were carried out in low density and predominantly rural population provinces (Segovia and Lleida) (Figure 8) and describe the access of immigrant women to health services in these circumstances through exploratory qualitative studies (Hesse-Biber 2006) involving personal semi-structured interviews.

Figure 8 - Percentage of Immigrants by Province in Spain



The aim of the interview is to obtain subjective descriptions from the people interviewed, in order to interpret the described phenomenon (Rubin & Rubin, 1995). Through this technique we seek to obtain subjective perceptions about experiences, situations or processes lived, and increase knowledge and understanding of these phenomena and the meanings given by the people interviewed.

Semi-structured interviews or guideline-based interviews have been used in both studies. Interviews had previously defined questions, open answers; sequence and formulation could vary according to each interviewed subject. This technique is coherent with the emerging design of qualitative research, by which changes can be made in the study objective and the development plan, as progress is made in the research. The persons' subjectivity being the object of the research, new research questions and requirements may arise during the research progress.

After preliminary analysis, considerable repetition of data was identified and the research team considered that saturation on the key issues of the study was achieved.

Information collection

In both studies interview guidelines were set up with open questions based on the objectives, with no pre-determined order and without answer options, with the aim of orienting the development of interviews and encourage participants to express their own views and experiences. The interviewer was flexible in exploring emerging subjects to clarify and extend the account.

Interviews were recorded and transcribed with prior consent from participants, who were informed about the study objectives, obtaining oral and written informed consent to record interviews, and with guarantee of anonymity and confidentiality of opinion, based on the principles of the Helsinki Declaration and the Belmont Report (General Assembly of the World Medical Association, 2014).

The participants' names, their cities/villages, and the services they have used were omitted or replaced by pseudonyms in order to preserve confidentiality; this was especially important for participants residing in rural villages.

Interviews were conducted in participants' homes or other places interviewees suggested, and lasted for approximately 90 minutes, and were conducted by the interviewer in a

dialogical manner to make participants feel comfortable. Institutional settings were avoided because they could inhibit an open conversation about social and health care services.

Given the exploratory nature of these studies, different settings (rural and urban) were chosen to examine whether place of residence was also a factor to be considered when studying access and utilization of services for undocumented immigrant women.

Analysis

Analysis was based on the Qualitative Inquiry proposal, parting from the text and not focusing on specific predefined contents. This implies identifying the manifest and latent contents and its meanings. Unlike other qualitative methods such as the grounded theory, qualitative inquiry analyses do not have the aim of generating models or abstraction theories.

The interviews were recorded and transcribed and field notes were incorporated into the verbatim. Transcriptions were imported to software OpenCode3.4 (Study II) and NVivo (Study III) to facilitate the coding process and assist researchers with the analysis. From the repeated reading of transcriptions, sentences and paragraphs with the same meaning were identified. First, an initial open encoding was performed, identifying the principal subjects and assigning labels or emerging codes to the identified units of meaning, followed by an inductive analysis pattern. These codes condense the meaning of the selected sentences, thus showing a higher level of conceptual abstraction. Axial encoding was performed, and relations between codes were identified: codes were sorted and grouped forming categories that capture perceptions of the interviewees (midwives and/or immigrant women) on the aspects that each study focuses. Throughout the process of analysis results were triangulated with notes gathered through observation during fieldwork.

Citations in each article were chosen on the basis of their clarity and representativeness.

Ethical issues

The research protocol of Study II was approved by the Ethics Committee of the Health Institute Carlos III (Spain).

Study II

Geographical Context

The second study is performed in the rural context in the province of Segovia. This province is in the Autonomous Community of Castilla y León (Spain), the largest and least populated region in Europe (27 inh. /Km^2). In Segovia 64% of the population (104,895 inhabitants) reside in rural areas, divided into 208 municipalities and 17 local entities. Segovia's population is characterized by a high level of dispersion (28 % of villages have less than 100 inhabitants) and low population density (23 inh. /Km^2); Segovia suffers from depopulation and an ageing population (21% of the population are over 65), and is a host region of immigrant population (12.5% of the total population) (Instituto Nacional de Estadística, 2008) . Segovia's Health Area is divided up into sixteen Basic Health Areas (BHA), three urban and thirteen rural. Each BHA has a primary health care center, with an office for midwifes. Seven midwives cover all thirteen rural BHAs, with each midwife covering between one and three BHAs.

Participants

Participants in study II were seven midwives who covered all 13 rural BHAs in the province (Table 3). That is to say, all the midwives working in the primary health care centers in Segovia at the time of the fieldwork were interviewed. Six of the seven were over 45 years of age.

Table 3. Sample of midwives participating in Study II (n=7)

Midwives	Age
Virginia	> 45
Beatriz	< 45
Lucía	> 45
Ana Belén	> 45
Silvia	> 45
Isabel	> 45
Amaya	> 45

Information collection

Fieldwork for Study II was carried out between February 2008 and November 2009.

The guidelines for Study II included questions to collect information about midwives' health care activity in general, and about pregnant and puerperal women's care protocols in particular (Lunardi et al., 2007) (Table 4).

Table 4. Interview with primary health care (PHC) midwives (Study II)

• Primary health care organization in rural areas and work developed by primary health care professionals.
o Characteristics of primary health care in rural areas.
o Work organization in local offices (doctors' and nurses' offices) and health care centers (midwives' offices)
o Work organization in continuous care points (medical and nursing staff.)
o Coordination with other care services and referrals to specialist care.
• Access to/demand for services provided in primary health care (studied).
o Access to (medical/nursing/midwife) office.
o Demand for (medical/nursing/midwife) office.
o Access to continuous care points.
o Demand for continuous care points.
• Characterization of local office users / Continuous Care Points.
o Characterization of local office users (sex/gender, age, occupation, pathologies/associated conditions)
o Characterization of local office users(sex/gender, age, occupation, pathologies/associated conditions)
• Perceived needs by primary health care professionals to develop their work in a rural area.

Study III

Geographical Context

The third study was conducted in the province of Lleida, which is part of the Catalan Autonomous Community (Spain) and the second largest province in Spain. It has the lowest population density in Catalonia (36.4 inh. /km^2). In Lleida, 54.68% of the population live in rural areas (municipalities with less than 10,000 inhabitants). Of those, 23.64% of the population live in municipalities with less than 2,000 inhabitants, and 31.04% in

municipalities with between 2,001 and 10,000 inhabitants (IDESCAT, 2013). Lleida is one of the top 10 Spanish provinces with the highest immigrant population per total population (18.24%, higher than Madrid and Barcelona), largely because of the jobs created by agricultural and farming industries (Figure 8).

Participants

Participants in Study III were 12 undocumented Latin American immigrant women living and working in three different settings: an urban city (more than 100,000 inhabitants), a rural city (9,000 to 11,000 inhabitants) and rural villages of the Pyrenees (less than 1,000 inhabitants) (Table 5).

Table 5. Sample of undocumented Latin American women participants at study III (n=16)

Pseudonym	Age	Nationality	Education	Residence	Years in Spain	Jobs	Dependents
Denise	19	Dominican	High School	Urban city	4	Domestic and Bar Cleaning (on demand)	Yes
Maribel	20	Brazilian	Primary	Rural Village	2	Domestic cleaning (on demand)	No
Laura	22	Brazilian	Primary	Rural Village	5	Domestic and Hotel Cleaning (on demand)	No
Santiaga	28	Bolivian	University (unfinished)	Urban city	6.5	Domestic cleaning (on demand)	Yes
Andrea	29	Brazilian	University (unfinished)	Rural Village	3.5	Domestic cleaning (on demand)	Yes
Fidela	29	Brazilian	Primary	Rural Village	2	Domestic and Hotel Cleaning (on demand)	Yes
Carmen	32	Bolivian	Primary	Urban city	6	Domestic cleaning (on demand)	Yes
Ana	33	Bolivian	High School	Urban city	7	Caregiver and domestic cleaning (on demand)	Yes
María	36	Colombian	Primary	Urban city	13	Caregiver and domestic cleaning (on demand)	Yes
Miguela	46	Brazilian	Technical Diploma	Rural City	1.5	Domestic and Hotel Cleaning (on demand)	Yes
Josefa	50	Chilean	Technical Diploma	Rural City	8	Caregiver and domestic cleaning (on demand)	No
Juana	52	Chilean	Technical Diploma	Rural City	5	Caregiver at hospital and domestic cleaning	Yes

The ages of participants in this study ranged from 19 to 52 years of age, the average educational level was high school, and they had been living in Spain between 2 and 13 years, some never had legal status, while others lost it (Table 5). Participants were selected through an immigrant woman who was working as a Cultural Mediator (CM), and who had previously been undocumented herself. She recruited one urban and one rural undocumented Latin American woman, and the recruitment that followed proceeded through a snowball technique.

Information collection

Fieldwork for Study III was carried out between September and December 2011.

The interview guide of Study III included topics on migratory process, legal status, working conditions, perception of their own health and access to and use of health and social services (Table 6).

Table 6. Interview guide used in Study III

MIGRATORY PROCESS
Please tell me about your immigration experience
Why did you leave _____ (country of origin)?
• What motivated you to leave your country of origin?
• How were things for you there?
Why did you choose Spain?
• How did things go for you when you arrived?
• How do you find Spain? What has made coming worthwhile?
• How did you get to Lleida?
Issues and challenges
• With what type of issues or challenges were you confronted with when you arrived in Lleida?
• How did you deal with them?

- Who helped you overcome these issues or challenges?
- Where did you find the necessary information and resources to enable you to settle in Lleida?

WORKING CONDITIONS

Finding a job

- How did you find your first job? What was the process? Did you have the intention to work?
- Since then have you had other jobs? Can you tell me all the other jobs you have had?
- What is your current job?

Could you describe your work experience in Spain?

- What is your current job? Is your job or professional experience different from what you did or had in your country of origin?
- Before you arrived in Spain did you have any training or instruction to do this job?
- Can you tell me a little about the conditions or circumstances under which you perform your job?

Physical conditions

- How is the space/physical environment?
- What are the physical conditions (work responsibilities) of your work (position, weights, movements, repetition, speed)? How do you manage these conditions? Do you feel prepared for these conditions?
- What do you find difficult about your work? How do you deal with/adapt to this?
- What are your main responsibilities at work? How do you feel about these responsibilities? Under what criteria or circumstances are these responsibilities distributed?

Safety

- What are the safety conditions like at work?
- How do you feel at work with regard to safety conditions?
- Are there any health and safety issues you can identify? How do you deal with

these?

- What preventative strategies have been implemented or applied?

Working hours and remuneration

- What are your working hours? How do you get days off? How do you co-ordinate your breaks during the day?
- How do you feel about your salary? How does your salary compare to that of your colleagues? Have you ever negotiated your salary?
- Have you ever negotiated other working conditions?

LEGAL STATUS

Can you explain the conditions that allow you to work without documents? Your work doesn't require documents?

- Have employers asked you for your work documents? What have you done in these circumstances?
- Did you get help to find this job?
- Have you used documentation of another person with a Spanish work permit?

PERCEPTION ON THEIR OWN HEALTH

What can you say about health in the context of migration and undocumented work? Take into consideration your body, mind, spirituality and social welfare.

- How has your current job impacted on your health and social wellbeing?
- What has been the impact on your health of being undocumented?
- What worries do you have about your health?
- What strategies do you use to avoid becoming ill? In your day-to-day life, what do you do to protect and care for your health?
- What things make you feel healthier/better? What things do you think are good for your health?
- What do you think about your current job in relation to your health? (Consider your mental, physical health).

ACCESS TO AND USE OF HEALTH AND SOCIAL SERVICES

Now can we talk about your use of social/health or other services in Spain?

- What kind of service do you use most often? For what reasons?
- How did you find out about these services? How did you get access to them?
- How is your access to these services? At the time you used these services did you encounter any difficulties?
- What services would you use that you are not using now?
- What is your opinion of the services that you use?

Study IV. Critical Discourse Analysis

Critical discourse analysis (CDA), a means to study the language in social processes (Íñiguez Rueda, 2006, p. 83), has been the methodology chosen to carry out this study, This technique consists in analyzing the discourse "with an approach to the political and social context of the language and the discourse of society. It focuses on social problems, in particular on the role of discourse in the production and reproduction of abuse of power and domination, and whenever possible, this will be done from a perspective in coherence with the dominated groups' best interest" (Stecher, 2010; Wodak & Meyer, 2003)

The CDA applied to public policy documents is useful to analyze what interests policies pursue, for example in health matters, and to explore subjacent ideologies, words and official government discourses. As a consequence, it delves into the structures and discourse strategies used by policy makers to naturalize actions and ideologies with the aim of avoiding the population's rejection or criticism (Soler Castillo, 2011).

CDA is considered a tridimensional practice, in the sense that analysis operates in three dimensions simultaneously: i) Discourse as text (the oral or written result of a discursive production); ii) Discourse as a practice within the framework of a specific social situation; and iii) Discourse as example of social practice, that does not only express or reflect identities, practices, relations, namely, social representations, but constitutes and molds them (Martín Rojo & Whittaker, 1998)

CDA's core objective is to know how discourse contributes to the reproduction of inequalities and social injustice, since access to discourse structures, and law making in particular is limited to the elite, who possess access to the discourse structures, accepted and legitimized by society. Power is discursive, since through communication we obtain what Van Dijk came to name the "manufacture of consensus" which is "discursive control of linguistic actions through persuasion, the most modern way of exerting power" (Van Dijk & Atenea Digital, 2001; van Dijk, 1994).

Discourse influences society through social cognitions, at the origin of ideologies, social attitudes, and knowledge about the world and also prejudice. Domination appears from the unequal relation among social groups where some groups have control over others. In the case of health care, when access to heath care resources is decided according to people's economic wealth, that is classism. When classism is dictated by an institution, then that is structural or institutional classism, the form in which the state and other institutions manage to socially stratify the population of a country. In official texts (laws) prejudice is not openly expressed, therefore not all the message is recorded (van Dijk, 1994).

CDA seeks to critically investigate social inequality as expressed, highlighted, constituted, legitimized, etc. though language use (that is, discourse). CDA has been used in other studies carried out in the same context as ours (Otero García, 2011) .

Thus, Study IV presents the CDA of five nursing codes of ethics (in the autonomic, national and international contexts) and the health care law in force in Spain (Table 7).

Sample

The codes of ethics selected are: ICN Code of Ethics for nurses, drawn up in 1953, revised version of 2012; Nursing Code of Ethics drawn up in 1986 by the Barcelona College of Nursing and Nursing Aids; the Spanish Nursing Code of Ethics drawn up by the Spanish Nurses Association in 1989, revised version of 1998; the Code of ethics and conduct for European Nursing drawn up by the European Nurse Directors Association in 2007 and the Catalan Nursing Code of Ethics drawn up by the Catalan Association of Nursing Colleges in 2013. The health care law selected is Royal Decree-Law 16/2012 (Table 7).

Table 7. Analyzed documents in study IV

	Document name
Codes of Ethics	ICN Code of Ethics for nurses, drawn up in 1953, revised version of 2012
	Nursing Code of Ethics drawn up in 1986 by the Barcelona College of Nursing and Nursing Aids
	Spanish Nursing Code of Ethics drawn up by de Spanish Nurses Association in 1989, revised version of 1998
	Code of ethics and conduct for European Nursing drawn up by the European Nurse Directors Association in 2007
	Catalan Nursing Code of Ethics drawn up by the Catalan Association of Nursing Colleges in 2013
Law	Royal Decree-Law 16/2012, of urgent measures to ensure the Sustainability of the National Health System and to improve the Quality and Security of its Provisions.

Units of analysis

The CDA of the selected documents was search guided, through identification of related words and/or expressions, based on 5 key concepts on which they are supported, and shared by the model of social determinants of health and health care ethics (Turale, 2014; Wilkinson & Marmot, 2003): “Equity”, “Human Rights”, “Rights of health”, “Access” and “Continued care” (table 8).

Table 8. Key concepts applied in the analysis of Study IV

Concepts	Definition	Keywords
Equity	Resource allocation should be done in accordance to the persons' health needs, including access to the health care system (A. Sen, 2002).	"equity" "equitable" "reduce inequalities"
Human rights	Inherent rights to all human beings, without distinction of any kind, such as place of residence, color, sex, language, religion, or any other condition (United Nations, 1948).	"human rights" "equally" "with the same respect" "non discrimination" "without distinctions based on …"
Right to health	It is one of the human rights. Right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services (United Nations, 1948).	"right to the protection of health" "right to health care" "right to health" "right to health care" "right to health care coverage"
Accessibility	For the health care system to be accessible, institutions should ensure the efficient provision of health care services with regards to organizational, economic, cultural and emotional barriers (Hirmas Adauy et al., 2013).	"accessibility" "coverage for the whole population" "equitable access" "opposition to denial of health care" "access to nursing care" "access" "obtaining health care provision" "access" "equal access"
Continuity of care	A quality element in health care (García-Abad Martínez, 2012).	"continuity of care" "continuity of care" "guarantee of care" "guarantee of care" "continuity of care" "treatment continuity" "treatment continuity"

RESULTS

5. RESULTS

Through the different approaches used in this analysis we got several interlinked results relating to the peculiarities of the different utilization of health and social services according to gender and migration conditions. The following chapters show the results of these approaches exploring scientific literature perspectives (Study I), the role of health professionals as midwives (Study II), the discourse of the immigrant undocumented women (Study III), and the conflict between health law and ethic codes (Study IV).

Table 9. Synthesis of the objectives and results of the studies.

Study	Research Question	Main results
I	What evidence exists on immigrant undocumented women's access to and utilization of health and social services in Spain?	None of the studies focused exclusively on undocumented women. The main topics are socio-cultural differences in the access and utilization of social and health services and barriers faced by immigrant women.
II	Which are the perceptions of midwives who provide these services regarding immigrant women's access and participation in sexual and reproductive health programs offered in a rural area?	Midwives perceive that immigrants in general, and immigrant women in particular, underuse family planning services. This underutilization is associated with cultural differences and gender inequality. They also believe that the number of voluntary pregnancy interruptions among immigrant women is elevated and identify childbearing and childrearing-related tasks and the language barrier as obstacles to immigrant women accessing the available prenatal and postnatal health care services.
III	How is the access and utilization of social and health care services by undocumented Latin American women working and living in rural and urban areas? Which barriers these women face?	While residing and working in different areas of the province impacted the utilization of services, working conditions was the main barrier experienced by the participants.
IV	Which possible ethical nursing dilemmas may arise between the legal and ethical discourses by exploring the content of Royal Decree-law 16/2012 and the codes of ethics?	The analysis has revealed differences in the use of the terms within the ethical and the legal discourses. While codes of ethics define the nursing function according to equity, human rights, right to healthcare, access to and continuity of care, the legal discourse focuses on the concept of beneficiary or being insured to legitimate the discrimination of vulnerable collectives.

STUDY I. UNDOCUMENTED IMMIGRANT WOMEN IN SPAIN: A SCOPING REVIEW ON ACCESS TO AND UTILIZATION OF HEALTH AND SOCIAL SERVICES.

Characteristics of Articles Selected

Table 10 shows the general characteristics of the studies considered in the scoping review. A total of 16 articles were included in the final synthesis. These articles had been published between 2007 and 2014 as follows: 2007 (1), 2008 (5), 2009 (1), 2010 (2), 2011 (2), 2012 (3), and 2014 (2). We have not found articles published before 2007, which complied with the inclusion criteria, and the empirical data were only until 2010.

All the articles included were published in Spanish (n=5) or English (n=11) in international scientific peer-reviewed journals, with the exception of one grey literature publication(Moreno Fuentes & Bruquetas Callejo, 2011). Among the 16 studies reviewed, 11 were cross-sectional studies(Alcaraz Quevedo et al., 2014; Bocanegra et al., 2014; Folch et al., 2008; Pascual et al., 2008; Albares Tendero et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Rodríguez Álvarez, Lanborena Elordui, Pereda Riguera, & Rodríguez Rodríguez, 2008; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011; Saurina, Vall-Llosera, Laura; Saez, & Saez, 2012; Torres-Cantero, Miguel, Gallardo, & Ippolito, 2007), 3 qualitative studies (Barona-Vilar et al., 2013; Saurina, Vall-Llosera, & Saez, 2010; Terraza-Núñez, Toledo, Vargas, & Vázquez, 2010), one was mix-methods (Saura et al., 2008), and one was a documentary review (Moreno Fuentes & Bruquetas Callejo, 2011).

Fourteen of them analyzed access to and utilization of health services (Barona-Vilar et al., 2013; Bocanegra et al., 2014; Folch et al., 2008; Saura et al., 2008; Pascual et al., 2008; Albares Tendero et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín,

Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Rodríguez Álvarez et al., 2008; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011; Saurina et al., 2010; Saurina et al., 2012; Terraza-Núñez et al., 2010; Torres-Cantero et al., 2007) while two analyzed access to and utilization of social services (Alcaraz Quevedo et al., 2014; Moreno Fuentes & Bruquetas Callejo, 2011). With regard to the type of care explored in the articles, they can be classified in three areas: 7 articles dealt with general utilization and access to services (Alcaraz Quevedo et al., 2014; Saura et al., 2008; Moreno Fuentes & Bruquetas Callejo, 2011; Rodríguez Álvarez et al., 2008; Saurina et al., 2010; Terraza-Núñez et al., 2010; Torres-Cantero et al., 2007); 6 dealt with primary health care and community health (Bocanegra et al., 2014; Folch et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011; Carme Saurina et al., 2012); and 3 with specialist care (Barona-Vilar et al., 2013; Pascual et al., 2008; Albares Tendero et al., 2008).

Two thirds of the studies used a quantitative research design (Alcaraz Quevedo et al., 2014; Bocanegra et al., 2014; Folch et al., 2008; Pascual et al., 2008; Albares Tendero et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Rodríguez Álvarez et al., 2008; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011; Saurina et al., 2012; Torres-Cantero et al., 2007) as the chosen method to explore access to services with broader samples. The samples in these studies ranged from 100 (Sanjuan Domingo et al., 2012) to 1866 (Sanz-Barbero et al., 2011) immigrant women. The qualitative publications included samples of immigrant women ranging from 13 (Saurina et al., 2010) to 26 people (Barona-Vilar et al., 2013).

The proportion of undocumented people in the studies is 80.5% (Torres-Cantero et al., 2007), 69.8% (Folch et al., 2008), 50% (Alcaraz Quevedo et al., 2014) and 16.2% (Saura et al., 2008). Although only seven articles included the legal status of

participants, other studies included the length of time resident in Spain – between one and ten years – except for studies focused on utilization of screening programs by women older than fifty years of age (e.g. breast cancer), in which case all the sample had lived for more than ten years in Spain.

Regarding country of origin, in just 8 studies the sample included only immigrants (Alcaraz Quevedo et al., 2014; Bocanegra et al., 2014; Folch et al., 2008; Saura et al., 2008; Rodríguez Álvarez et al., 2008; Sanjuan Domingo et al., 2012; Terraza-Núñez et al., 2010; Torres-Cantero et al., 2007), whist 7studies mixed immigrants with native population in their samples (Barona-Vilar et al., 2013; Pascual et al., 2008; Albares Tendero et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Sanz-Barbero et al., 2011; Saurina et al., 2010; Saurina et al., 2012), and the last one was a documental analysis (Moreno Fuentes & Bruquetas Callejo, 2011). Concerning the differentiation of the compared groups according to the geographic origin of the immigrants, 4 papers were focused on specific groups: 3 had a sample of Latin Americans (Barona-Vilar et al., 2013; Terraza-Núñez et al., 2010; Torres-Cantero et al., 2007) and 1 Maghrebians (Saura et al., 2008); 11 studies included immigrants as a whole (disaggregating data according to geographical origin, but not comparing the groups). In six studies, only women comprised the population selected to be studied (Alcaraz Quevedo et al., 2014; Barona-Vilar et al., 2013; Folch et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011), and the remaining five focused on sexual and reproductive health care.

Frequency of Access to and Utilization of Health and Social Services

A total of 9 studies showed that the utilization pattern differed according to the geographical origin of the immigrants (Alcaraz Quevedo et al., 2014; Bocanegra et al.,

2014; Pascual et al., 2008; Albares Tendero et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Rodríguez Álvarez et al., 2008; Sanz-Barbero et al., 2011; Saurina et al., 2010; Saurina et al., 2012).

In relation to the general utilization of health care services, all the studies found that immigrant population use health care services less than Spanish-born citizens. Immigrants demand less surgery, outpatient services, and dermatology services (Albares Tendero et al., 2008), they use less psychiatric emergency services, despite experiencing more work and family related difficulties (Pascual et al., 2008). Conversely, immigrants use emergency services, for example for prenatal care (Barona-Vilar et al., 2013), more often than another services (Rodríguez Álvarez et al., 2008); likewise, immigrants use emergency services more often than the native population (Albares Tendero et al., 2008).

Regarding immigrant women, Maria-Saura's findings reported that 69.7% of immigrant women studied used health care services (mainly primary health care 42.6% and emergency services 17.7%) (Saura et al., 2008); 62.5% and 36.3% of the women studied attended health care and social services respectively (Folch et al., 2008). They use gynecological cancer screening programs less than Spanish-born women (Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Sanz-Barbero et al., 2011); they use contraceptive methods less in planning pregnancies (Barona-Vilar et al., 2013; Sanjuan Domingo et al., 2012). For instance, 42% of immigrant women did not use any contraception and 3.2% had voluntary abortions compared with 0.6% of the native population (Sanjuan Domingo et al., 2012). Latin American women reported more problems related to anxiety in comparison to natives, despite an under-utilization of psychiatric emergency services (Pascual et al., 2008). It is worrying that cultural mediators identified that 11.2% of Latin

American women who were referred to their services had suffered gender violence (Alcaraz Quevedo et al., 2014).

Fuentes (Moreno Fuentes & Bruquetas Callejo, 2011) underlines that the working conditions of these women limit their access to and utilization of social services because most are employed in the caregiving sector, closely linked to the underground economy, and most women are not entitled to social benefits such as unemployment benefits.

Barriers to access and utilization of health and social services

Apart from nationality, other factors influencing the utilization of services described by the studies are summarized in Table 11. These factors that, in some cases could be identified as barriers, are the following: poor working conditions, which is linked to insecure or illegal employment status and being unable to attend scheduled appointments (Barona-Vilar et al., 2013; Bocanegra et al., 2014; Moreno Fuentes & Bruquetas Callejo, 2011; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Sanz-Barbero et al., 2011; Saurina et al., 2012; Terraza-Núñez et al., 2010; Torres-Cantero et al., 2007); cultural differences, such as different perceptions about health and illness (Alcaraz Quevedo et al., 2014; Barona-Vilar et al., 2013; Saura et al., 2008; Pascual et al., 2008; Rodríguez Álvarez et al., 2008; Saurina et al., 2010; Saurina et al., 2012); language and communication barriers (Alcaraz Quevedo et al., 2014; Saura et al., 2008; Pascual et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011; Saurina et al., 2010); time living in Spain, which could be linked to the knowledge of available resources and access to services (Alcaraz Quevedo et al., 2014; Bocanegra et al., 2014; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Rodríguez Álvarez et al., 2008; Sanz-Barbero et al.,

2011; Torres-Cantero et al., 2007); immigrant women's lack of knowledge of their rights (Barona-Vilar et al., 2013; Saura et al., 2008; Sanz-Barbero et al., 2011; Saurina et al., 2010; Terraza-Núñez et al., 2010); their legal status (Moreno Fuentes & Bruquetas Callejo, 2011; Pascual et al., 2008; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011; Terraza-Núñez et al., 2010); the organization, which is the coordination of services and facilitating strategies, such as staff attitude or availability of cultural mediation services (Alcaraz Quevedo et al., 2014; Barona-Vilar et al., 2013; Saura et al., 2008; Saurina et al., 2010; Terraza-Núñez et al., 2010); living conditions, such as their housing circumstances or living in a rural area (Albares Tendero et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Rodríguez Álvarez et al., 2008; Saurina et al., 2012; Torres-Cantero et al., 2007); and finally, lack of knowledge about the Spanish health care system (Alcaraz Quevedo et al., 2014; Barona-Vilar et al., 2013; Sanz-Barbero et al., 2011; Terraza-Núñez et al., 2010).

Some studies revealed more specific information regarding undocumentedness. Torres Cantero (Torres-Cantero et al., 2007) showed that there was no significant difference in the utilization of health services between documented and undocumented Ecuadorian immigrants in Madrid. In turn, the study of Maria Saura (2008) placed legal status as one of the stress factors most reported by participants (together with distance from family).

Table 10. Summary table with main characteristics of the 16 studies included in Study I

Citation	Topic	Study Design	Main Findings
(Albares Tendero et al., 2008)	Utilization of dermatology services	Cross-sectional	1. Demand was lower in immigrant population. 2. Immigrants use less surgery and outpatient services and more emergency services. 3. Utilization pattern differed according to country.
(Alcaraz Quevedo et al., 2014)	Utilization of Intercultural mediation services	Cross-sectional	1. The main cause for patient referral was contraception. 2. Women from Bolivia presented more vulnerability factors such as unregulated situations (almost 50%), precarious work and no social benefits. 3. Mediators detected 19.7% had social problems and 11.20% of women suffered from gender violence.
(Barona-Vilar et al., 2013)	Utilization of maternity health care	Qualitative inquiry (exploratory)	1. The main barriers identified to health-care services were linked to insecure or illegal employment status, inflexible appointment timetables for prenatal checkups and lack of information about services provided. 2. Women use emergency services because of a lack of knowledge or fear as they are undocumented 3.They could not access public nurseries 3. Women acknowledged a poor use of contraceptive methods in planning pregnancies.
(Bocanegra et al., 2014)	Access and utilization of screening services for Imported diseases	Retrospective observational	1. Patients from Sub-saharian Africa had greater infectious diseases. 2. 53.8% of Latin American patients tested positive in Chagas, so at risk of developing a heart condition or mother to child transmission. 3. Highest percentage of patients with new diagnoses is Sub-Saharian Africa 56.6%. 4. Temporary living situation or working conditions are perceived as a barrier in order to perform adequate Mantoux test.
(Folch et al., 2008)	Sexually Transmitted Infections among Immigrant Female Sex Workers	Cross-sectional	1. Just 30.2% of FSW have legal permits 2. During last 6 months 62.5% and 36.3% of the women had attended health care and social services, respectively. 3. The prevalence of STI is lower than that observed in other European countries. 4. Young age is associated with higher rates of CT and NG

(Moreno Fuentes & Bruquetas Callejo, 2011)	Access to Social Services	Documental analysis	1.There is a subordinate construction of the social rights of immigrants as job opportunities are largely determined by an unprotected sector. 2. The immigrant population who work and are affiliated to social security have temporary contracts that only entitle them to short periods of unemployment benefit 3. Part of the immigrant population work in the informal economy, and only have access to welfare benefits through local councils and social organizations 4. The growing incorporation of Spanish women into the labour market has resulted in a increasing need for caregiving and domestic jobs, where Latin American women are overrepresented and work in precarious conditions.
(Saura et al., 2008)	Utilization of Health Services	Mix methods	1. 69.7 % have used health care services (42.6% mainly primary health care and 17.7% emergency services) 2. 16.2% were undocumented 3. 14.2% didn't have a healthcare card because they were undocumented, so they didn't know that their right to be a cardholder was independent of their legal status. 4. Just 35% used immigrant aid associations 5. The percentage or immigrants that used health care services in the last 12 months was less than the general population
(Pascual et al., 2008)	Utilization of Psychiatric emergency service	Cross-sectional	1. Immigrants use psychiatric emergency services less often than indigenous population. 2. Immigrant subgroup of Latin American is the only one with greater proportion of women and they had more problems related with anxiety in comparison to indigenous. 3. 43% experienced serious social problems presenting more difficulties related to job, family and housing, and in consequence, higher ratios of hospitalization. 4. Immigrants were unlikely to seek medical help for depression.
(Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012)	Breast cancer screening	Cross-sectional	1. Immigrant women had poorer knowledge, less positive attitude, perceived fewer benefits and had more barriers to screening than native women. 2. Maghrebian women perceived the most barriers to screening 3. Social class, urban/rural setting and cultural differences with country of origin are key contributors to these inequalities.

(Rodríguez Álvarez et al., 2008)	Utilization of Health Services	Cross-sectional	1.Immigrant population used less healthcare services except for emergencies. 2. Utilization patterns differed depending on origin of immigrants and length of time in Spain. 3. A higher utilization of emergency services was associated with being a woman and Latin American as a reflexion of cultural patterns and/or gender roles which determine worse health self-perception, higher fecundity and less follow-up in primary health care services.
(Sanjuan Domingo et al., 2012)	Utilization of contraception	Cross-sectional	1. 42% of immigrant women didn't use any contraception. 2. 32% had an abortion and 20% more than one 2. 3.2% had voluntary abortions in comparison with 0.6% of Spanish population.
(Sanz-Barbero et al., 2011)	Utilization of Gynecological cancer screening	Cross-sectional	1.Immigrant women use less screening programs than native women. 2. The association between place of origin and receipt of mamography was significant.
(Saurina et al., 2010)	Access and utilization of Primary Care System	Qualitative inquiry	1. Use of Healthcare system is linked to the perception of not being well, knowledge of the healthcare system and length of time resident in Spain. 2. Divergences between immigrants and healthcare professionals are in healthcare education, use of healthcare services and reproductive healthcare and reticence with regard to being attended by staff of the opposite sex demonstrate a need to work with the immigrant population as a heterogeneous group.
(Saurina et al., 2012)	Access and utilization of Primary Care System	Cross-sectional	1.Contacting Primary Health services is associated with having a chronic illness, taking prescribed medications and being aged between 46 and 55. 2. Utilization and quantity of services consumed varied depending on the origin of the patient, Africans and Central Americans being those with more barriers related with working and living conditions.
(Terraza-Núñez et al., 2010)	Access to Health Services	Phenomenological	1.Access to health care was considered easy for personal health-care card holders 2. Barriers attributable to the immigrant population (poor knowledge of the system and poor working conditions) and to the system (insufficient information available, organization, behavior of healthcare staff)
(Torres-Cantero et al., 2007)	Utilization of Health Services	Cross-sectional	1. There was no significant differences in the utilization of health services between documented and undocumented Ecuadorian migrants (Madrid) 2. Working conditions, education level and length of time living in Spain are associated with the utilization of health services.

Table 11. Barriers identified in the studies included in the Scoping Review

Barriers	N	Studies
Poor working conditions	8	(Barona-Vilar et al., 2013; Bocanegra et al., 2014; Moreno Fuentes & Bruquetas Callejo, 2011; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Sanz-Barbero et al., 2011; Carme Saurina et al., 2012; Terraza-Núñez et al., 2010; Torres-Cantero et al., 2007)
Cultural differences	8	(Alcaraz Quevedo et al., 2014; Barona-Vilar et al., 2013; Saura et al., 2008; Pascual et al., 2008; Albares Tendero et al., 2008; Rodríguez Álvarez et al., 2008; Saurina et al., 2010; Carme Saurina et al., 2012)
Language barriers	7	(Alcaraz Quevedo et al., 2014; Saura et al., 2008; Pascual et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011; Saurina et al., 2010)
Time of residence	6	(Alcaraz Quevedo et al., 2014; Bocanegra et al., 2014; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Rodríguez Álvarez et al., 2008; Sanz-Barbero et al., 2011; Torres-Cantero et al., 2007)
Lack of knowledge on her rights	5	(Barona-Vilar et al., 2013; Saura et al., 2008; Sanz-Barbero et al., 2011; Saurina et al., 2010; Terraza-Núñez et al., 2010)
Legal status	5	(Moreno Fuentes & Bruquetas Callejo, 2011; Pascual et al., 2008; Sanjuan Domingo et al., 2012; Sanz-Barbero et al., 2011; Terraza-Núñez et al., 2010)
Organizations	5	(Alcaraz Quevedo et al., 2014; Barona-Vilar et al., 2013; Saura et al., 2008; Saurina et al., 2010; Terraza-Núñez et al., 2010)
Living conditions	5	(Albares Tendero et al., 2008; Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet, Casamitjana, & Borrell, 2012; Rodríguez Álvarez et al., 2008; Carme Saurina et al., 2012; Torres-Cantero et al., 2007)
Lack of knowledge about Spanish health system	4	(Alcaraz Quevedo et al., 2014; Barona-Vilar et al., 2013; Sanz-Barbero et al., 2011; Terraza-Núñez et al., 2010)

STUDY II. ACCESS TO AND USE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES PROVIDED BY MIDWIVES AMONG RURAL IMMIGRANT WOMEN IN SPAIN: MIDWIVES' PERSPECTIVE.

Results regarding rural midwives' perceptions are organized into two categories: (1) place of origin and socioeconomic situation (being an economic immigrant) and gender (being a woman) affects family planning; (2) there are access barriers to and underutilization of available prenatal and postnatal health care services by immigrant women. The theme that combines both of these categories is: midwives' perceptions of underutilization of sexual and reproductive services by immigrant women.

Culture as the source of difficulties with family planning for immigrant women. According to rural midwives, immigrant populations residing in the rural areas of Segovia hardly engage in any family planning, which midwives interpret as a consequence of 'cultural differences'.

> "In this area, immigrants are mostly Bulgarian and Romanian. They don't use contraception [...] these are people who you explain things to and maybe you get them to agree with the analysis, or something, and then, they don't do it. They won't take the pill, they won't get an IUD, they don't use condoms... and I think it's cultural." (Ana Belén)

> "I think that immigrant women do not have the issue of prevention and family planning incorporated. It is true that until they are sick many do not come to me. It can be cultural." (Lucía)

When asked to elaborate on what they meant by cultural differences, midwives explained that it was the men who decided whether or not to use family planning methods, since they often held negative attitudes regarding taking any action around

contraception and whether it is for the woman or themselves. Thus, the decisions of men prevail over women's decisions.

> "Many are influenced by their husbands, their partners. They tell you that their husbands are in control. Then, you feel very frustrated. I ask them What about an IUD? No, my husband doesn't want me to get an IUD. -What about the pill? -No, my husband doesn't want me to take anything. -Well, then tell your husband to use a condom -But he doesn't want to use a condom either." (Beatriz)

> "Immigrant women know about contraceptive methods because I explain to them when they come to see me, but for them it is easier not to use anything. Their partners don't even want to use a condom." (Silvia)

Less often, midwives perceived that immigrant women used family planning methods but without their partner's knowledge. This shows the decisions of men are above the decisions of women, gender inequality is evident in this case.

> "A few of my patients took the pill without their partners' knowledge, but those are the exceptions." (Amaya)

> "Some women tell me they want to plan their families, but they do not want their partners to know, because they (the partners) do not want to plan." (Isabel)

Midwives asserted that if a few immigrant women and their partners used family planning methods, they would serve as an example within their close social circle.

> "If one started to use it they would encourage others, because here in Spain, 40 years ago no one took the pill and if anyone did, they were told: 'Oh no, that's really bad for you, it causes cancer, you grow hair, you gain weight.' Whatever their friend tells them always works better than anything that I tell them." (Virginia)

> “When an immigrant woman starts to come to the office to plan then her sisters come, then her sisters in-law...” (Silvia)

When faced with an unintended pregnancy VTP is one of the options considered by immigrant women. Midwives reported that VTPs are more common among women from Bulgaria and Romania as a consequence of the family planning policies in these countries, which are based on easy accessibility to VTP. In this way, midwives made references to the social, cultural, educational differences in immigrant women’s notion of VTP, pregnancy, and family planning.

> “I have realized that Bulgarian and Rumanian women use abortion as a method of family planning.” (Beatriz)

> “There are countries like Bulgaria and Romania, where family planning was based on voluntary abortion. Abortion was promoted, and I believe that makes it less important to go for a visit to check there are no problems with the pregnancy, similarly, they don’t have the same take on contraception that we do.” (Lucía)

Some of the midwives pointed out that immigrant women did not always go to specialized centers to carry out these procedures (VTP), among others, but instead, some searched for alternate strategies despite the risks.

> “There is a medication, not sure they all know about it, but I’m convinced they get it. It’s sold on the internet. I visited the site once and they give you addresses and phone numbers. I bet that they are selling it. It’s used in the hospital environment for the stomach, but, of course, you’re in a controlled environment. There’s a risk of hemorrhaging, they may start bleeding and, just imagine, they think they’ve got it all out but a portion stays in, and can cause an infection. I’ve been asked for it, and the ones that ask for it are foreign women. Not Spanish women, which doesn’t mean they don’t know about it.” (Lucía)

Midwives explained that these VTPs were performed either in Spain or in the immigrant women's country of origin, and that they (either themselves or their partners) bore the expenses.

> "There are Bulgarian women who go to Bulgaria for abortions." (Virginia)

> "Sometimes they abort here. Others go to their own countries, because, it's probably cheaper in their own country. Of course, here they might not be eligible for a legal abortion and they have to go to private clinics. That is why I think it's cheaper for them to go to Bulgaria." (Amaya)

Finally, midwives perceive that most of the teenage pregnancies occur among immigrant women.

> "I do not see many teenage pregnancies, but the few I see if there are more percentage in immigrant women." (Virginia)

> "Most of the teenage pregnancies we see are Romanian women from Rumania." (Ana Belén)

Rural midwives perceived difficulties of access and use of prenatal and postpartum services among immigrant women Midwives perceive that immigrant women make use of midwifery services mainly during pregnancies.

> "The only time when you really see a much higher proportion of immigrant women is during pregnancy. You don't see them during menopause, nor for contraception, but you see a few in Pap Smear and cervical cancer prevention programs, however during pregnancy is when you see them most." (Ana Belén)

> "For instance, I see Moroccan women in my office during their pregnancy and for post natal consultations, but I see them a lot less for pap smears." (Amaya)

However, midwives detect an underutilization of prenatal visits, which translates into a delayed first prenatal visit.

> "When Spanish women know they're pregnant they have the habit of going to their doctor or to the nurse, or the midwife, but they go to the health center. Immigrant women sometimes leave it longer." (Silvia)

> "There are women, especially Moroccans, who leave it longer to come. That's my experience. I think that if they come from a place where healthcare is not as accessible, then they are not used to going for medical care, and miss the usual first prenatal visit." (Isabel)

Regarding the program offering maternal education classes, midwives perceive that immigrant women use this program to a lesser extent than native-born women. Some of them compared immigrant women to women of Romany ethnicity.

> "About childbirth preparation group, sometimes I get that some Bulgarian or Moroccan women come. It is difficult to grasp them for activities like that." (Isabel)

> "They hardly come to the childbirth courses I offer, and if they attend one class, then they drop out. I'm not sure whether it is because it's silly, or because they can't follow it. You talk to them and then ask: Do you understand? - and they answer affirmatively, but... It's the same thing with the gypsies, they don't come either. Maybe they think it's useless information, or they have other children to look after, or they have other things that prevent them attending..." (Ana Belén)

Once again, midwives explain away this underutilization of their services based on 'cultural differences' regarding prenatal care. Some report that immigrant women think of pregnancy as a natural process, which requires little supervision. Additionally, some midwives link this idea of immigrant women exhibiting an underdeveloped preventative

culture with the fact that the immigrant population living in rural areas has a low socio-economic level. Other midwives talk about how women, in particular Moroccan women, do not attend these group activities because their husbands do not allow them.

> "Moroccan women relate to their children, with her husband, and very little with the rest of the people. I think we have a hard time doing group activities. I think they have restrictions by such husbands to attend childbirth preparation classes. In their culture the woman is in the private sphere." (Virginia)

> "It could be that for them pregnancy is not such a big deal... I don't mean they don't think it's important, but that they don't see the need for so much vigilance; it's something natural, and nothing will go wrong. In their country of origin they do go to be seen, I mean that they do follow the prenatal care. In Romania and Bulgaria for example, they do go as after all those countries are not so underdeveloped. As many people point out, the issue is that this type of immigrant is not their country's average citizen, but come from a lower social background; therefore culturally, prevention and care are lower". (Silvia)

Midwives explain that immigrant women sometimes skip scheduled appointments with them as well as with obstetricians in specialized care, going without some of the diagnostic tests in the prenatal protocol.

> "Immigrant are less reliable with their appointments, often they don't turn up, then they arrive without an appointment expecting to see you whenever it suits them, and things can get a bit chaotic. Of course there are all sorts of people, but you do see this more often with immigrants." (Ana Belén)

> "They are not as reliable when it comes to appointments; they are less likely to show up. Then they come with no appointment to be seen when it suits them, and this

creates a degree of chaos. Many people do it but it is more common among immigrants, and especially within the Bulgarian population." (Amaya)

Some of the midwives point out that these sets of behaviors distinguish immigrant women from native-born women, except in those cases when native-born women live in socially dysfunctional situations.

"Access to healthcare is relatively easy. If they don't go it's because they don't want to, because as sometimes happens with these women (immigrants) they don't even show up for blood test and miss hospital appointments ... It's not all of them, but you don't see Spaniards doing that, and if you do, it's usually an isolated case with a family with issues. [...] If you have six such cases per year, five are foreigners and one is not." (Beatriz)

Finally, midwives also refer to language limitations as an access barrier for women from non-Spanish-speaking countries. Language limitation also results in these women's partners or their own children assisting with any communication with health professionals.

"We get many from Morocco, the majority. We always give them, books about pregnancy and all that for them to read, although we mostly communicate with the husbands who know more, are more up-to-date, or with the kids, who speak very well." (Virginia)

"Today I started a childbirth preparation group which should have like ten women, some of them immigrants. [...] It is difficult to grasp for group activities for different reasons. One is the difficulty with the language, the language barrier." (Isabel)

STUDY III. ACCESS AND UTILIZATION OF SOCIAL AND HEALTH SERVICES AS A SOCIAL DETERMINANT OF HEALTH: THE CASE OF UNDOCUMENTED LATIN AMERICAN IMMIGRANT WOMEN WORKING IN LLEIDA

Four main themes emerged describing access and utilization of social and health care services and the barriers that Latin American women faced: health is a tool for work which worsens due to precarious working conditions; lack of legal status traps Latin American women in precarious jobs; lack of access to and use of social services; and limited access to and use of health care services.

Health is a tool for work, which worsens due to precarious working conditions

All participants considered that having good health equates to having a stable job. They had certain difficulty talking about health in abstract terms. Having good health was described as a social concept. Health assures the ability to work and to obtain income to cater for the people participants are responsible for (children and/or parents), as explained below:

> “I feel healthier and better when I have a job, when I know I can provide for my daughters (…). I’m concerned about my health, because unless I work I cannot send anything to Bolivia for my daughters”. (Ana, urban city)

> "(…) I came to earn money to pay for our children's studies. I had an accident and my health is now frail (…). I'm worried about what may happen, because I will not be able to work and send money to my children." (Santiaga, urban city)

Participants indicated a decrease in their health status after migration. In the case of immigrants living in villages, this loss is described in terms of physical health while in the case of immigrants living in rural and urban cities, the deterioration affects both physical and mental health.

> “While I was living over there [country of origin] I never fell ill. Never. Now my hips are sore all the time. Always. (…) I never knew what it was to be depressive and here... it happens all the time.” (María, urban city)

This worsening health status is explained by the radicalization of the precarious working conditions experienced by the participants. All of them began their immigration journey in Spain caring for seniors, having a stable wage, even though those who resided with their employers had several experiences of exploitation and did not want to ever go back into bonded labour (working and residing at the employers’ property). Later, due to the effects of the economic recession or the death of their care recipients, participants moved into a combination of part-time jobs, cleaning private houses, restaurants or hotels or looking after children and elderly people. These jobs were characterized by unpredictable schedule, income insecurity, and lack of benefits derived from stable work, such as the right to in-service training or measures for reducing risks in the workplace.

> "I’m looking after a couple of elderly people in the hospital [rural city]. I go every day to feed them and give them their medication (…) on top of this job, I clean houses. This morning I have worked 5 hours, but every day is different. I also did work for the Town Council of [Rural Village]." (Juana, rural city)

> "When something needs to be cleaned more thoroughly… I use “salfuman” [caustic soda] or a fat remover that is very strong […] Products are the difficult bit of cleaning […] Nobody has taught me how to clean: women seem to be born knowing how to clean. (...) I don’t use anything to protect myself." (Andrea, rural village)

The participants revealed that public and private employers alike, and the immigrant workers themselves, assume caring and cleaning work as gendered activities that are intrinsically known by women and undervalued socially and economically.

Lack of legal status traps Latin American women in precarious jobs

As suggested above, to be healthy is to be able to perform a job and participants tie the possibility of finding a stable job to their legal status. Participants described having lost many job opportunities because they were undocumented. They felt that a vicious circle is generated, since being undocumented they cannot get jobs with a legal contract and social benefits, and thus they are trapped in the underground economy, where jobs have no labour rights and workers live in fear of being discovered and penalized.

> “what worries me is my health and my papers [legal permit] (…) because my first application for residency has been rejected (…). I had to turn down many job offers because I didn’t have the papers”. (Juana, rural city)

> "I had problems in my job because I had no papers. I was working in a hotel; I had to hide all the time. Always running away from someone or another: this is slavery". (Miguela, rural city)

Some participants have always lived in an irregular situation, while others lost their legal status as a consequence of the economic recession:

> “When I lost my papers… everything went awry (…) I would like to go back to doing what I was doing when I had my papers: catering. I love being a waitress. But now they only call me for fairs (…)” (María, urban city)

Participants described having lost many opportunities for employment because they are undocumented, and also accepting jobs without negotiating working hours or salary.

> "I’m getting by with what I have. If I had papers I would find better and steadier jobs. (...) Yes, I work on an hourly basis, you know. In the hotel, (...) sometimes I do

houses. It varies, as it's on an hourly basis, the day that there is work." (Laura, rural village)

It should be noted that women with children were particularly vulnerable to situations of oppression, abuse, and racism by their employers or care recipients.

"...because in some jobs..., in one there was some racism (...), they humiliated me, well... I needed money to send to my children. The kids [care recipients] used to beat me (…). In Madrid they called me "fucking immigrant" in one house (...) the elderly for whom I worked." (Santiaga, urban city)

In spite of more work opportunities and wage stability, situations of abuse arose much more often in bonded labour. The main problems were sleep deprivation, lack of food, and no free time to rest:

"(...) the man had dementia (…). I slept in a room next to the man's and he knocked on the wall every two hours for attention. That work was 24 hours a day during 3 years. (…) They told me they would legalize my papers, but they never did." (Josefa, rural city)

As reported above, employers also used the promise of legal permits in order to retain women in precarious jobs.

Lack of access to and use of social services

Latin American women living in rural settings verbalized they had never tried to access social services, while the rest of participants did try, but could not use these services because of their legal status. Participants living in cities reported that the lack of legal status not only shaped government institutional policies, but also NGOs because they too just provided social services for documented immigrants.

"I can't get unemployment benefit, and can't go to the social worker all the time. She won't give me anything."(María, urban city)

"(…) and from social services I went to the Red Cross. I went many times. They said they'd call me, but they never did. I went to Cáritas in [rural city] and the same thing happened. The girls at the Red Cross said if I had papers I would be working already. But I don't have them, and she said she couldn't do anything, that they had their hands tied." (Miguela, rural city)

Additionally, participants who have tried to use social services expressed their frustration and channelled it by blaming social workers for the decisions made, failing to see that social workers were constrained by governmental or institutional policies:

"She could have helped me, at least with the food for the house or something... she helped a lot of people, but not me, she said she couldn't." (Denise, urban city)

Of all participants interviewed only one was able to use social services, in particular to get additional food, but this may have been because of her husband and sons' legal status.

"We had applied for supplementary economic assistance that the social worker had told us about. She said she could present our case because we're a large family and my husband and my children have papers and he's unemployed. (…) They give you 3 packs of milk and something else, but this is not enough (...) I went to the Red Cross because the food they gave us was insufficient; in the food bank they give you more rice and flour. But there's not even the basics, I mean, the kids want yogurt, sugar (...) basic things. I went [to the Red Cross] and she said the social worker had to refer me there, but the social worker well...she can't or she says no (Carmen, urban city)

Participants did not understand the rules that were being applied to different cases and were excluded from any form of social services.

Limited access to and use of health care services

The Latin American women interviewed indicated differences in registering and accessing the health care system according to place of residence. Participants who lived in rural settings described an easy process to obtain their health card, while those who lived in larger cities faced difficulties both to get their health card and in accessing health services. Lack of knowledge about how to register was not a barrier.

The barriers described included employers and landlords who refused to sign a contract to avoid paying taxes (and therefore women could not demonstrate their residence in order to obtain a health card) and administrative staff in hospitals, who "administratively screen" emergency clients.

> "In Barcelona I lived in a room, and the owner of the apartment didn't want to register me, therefore I could never have a card. I only managed to register and get a health card here, in [rural village] (…) sometimes I have been to emergency, but they asked me for my card, on some occasions they didn't assist me. (Laura, rural village, talking about her previous experience when living in Barcelona)

However, being a cardholder and living in a rural village did not guarantee access to health services either. Some participants could not afford the time or cost of travelling between the rural villages of the Pyrenees and the referral hospital (three-hour journey by public transport in good weather conditions).

> "(...) at the beginning I was worried because it was hard to get an appointment and go to [urban city] to get tests done, because we couldn't get them done here." (Andrea, rural village)

In spite of the importance of the geographical area, the main barrier to the utilization of healthcare reported by participants was in relation to precarious working conditions and abusive employers. A single day off work represented losing a day's pay, but also carried the threat of being fired. Labour precariousness was more extreme again in the case of bonded labourers, as their employers sometimes even denied them their right to access primary health care services, and made them work while sick:

> "(...) I was off for a day, one Sunday, every fortnight and if I wanted to go to the doctor, the lady [the boss] said it had to be on that day. My back was very sore..." (Josefa, rural city)

Taking into account access barriers, the use of health care services in the case of participants who lived in rural villages was basically limited to the local primary health care centre. A few cases though were referred to the provincial hospital, when deemed necessary. The reasons for consultations were limited mainly to acute physical problems (e.g. stomach haemorrhage, back pain, etc.) and reproductive services and pre-natal care.

> “Once I went to the health centre because my face became swollen. (…) I was supposed to have some allergy tests done [at referral hospital], but I never went back.” (Maribel, rural village)

Participants who lived in cities used the health system for physical and mental health problems. For the latter, they were not referred from primary health care to specialised centres.

> "(…) well, I have become very nervous. I have depression and anxiety problems. Before the baby, I was taking pills that the family doctor gave me, but when I got pregnant I gave them up." (Carmen, urban city)

Regardless of the geographical area, as Maribel and Carmen reported, once the acute stage of the disease is over, participants had limited follow-up and adherence to treatment. Once they were able to work again, they went back into their labour activities.

STUDY IV. THE ETHICAL CONFLICTS OF NURSES FACED WITH ROYAL DECREE-LAW 16/2012

Results are structured into the five concepts within the conceptual framework that guided CDA.

Equity is understood in the RDL 16/2012 as one of the conditions that the population covered should enjoy, understood as regional cohesion between Autonomous Communities. Codes of ethics acknowledge that health is a fundamental right of the person and give the nurse responsibility to care for all patients equally, defend an equitable allocation of resources, engage in the reduction of social determinants of health and participate in health policies. Nurses also need to make sure that the legislation is adapted to the needs of people with regard to accessibility, quality and cost; they should to be trained in the concept of equity, and should promote the inclusion of this concept in their educational curricula.

While the RDL 16/2012 does not mention human rights or their synonyms, the 5 codes of ethics make an appeal for the nurse to respect them and not to discriminate against anyone. Even the Barcelona Code of Ethics gives nurses responsibility to raise social awareness against any such breaches in human rights; the ICN promotes training in this subject and encourages nursing associations to take a stance and address their actions in favor of human rights.

The right to health in the RDL 16/2012 is a right for people who meet the requirements to be a beneficiary or to be insured. Article 12 of Organic Law 4/2000 regarding rights and freedoms of foreign residents in Spain is modified and the right to health care of foreign residents is subject to the laws in force. The right to the protection of health of Spanish citizens residing abroad, and the right to health care through the NHS of Spanish citizens employed in non-EU countries and temporarily in Spain, are now

governed by the law 40/2006. Codes of ethics attribute to nurses the responsibility of defending the right to health and health care of patients as the fundamental right of people to obtain the maximum degree of health, even in cases of conscientious objection and denial of care. Even the ICN encourages nurses to undertake and strive to meet the social and health needs of all persons and of vulnerable persons in particular.

While accessibility, according to RDL 16/2012, depends on the acknowledgement of the condition of insured or beneficiary, codes of ethics put the nurse in a position to defend access to health for everyone on the principles of equity and social justice and quality. Even the Code of Ethics in Catalonia makes special mention of vulnerable persons, and encourages nurses to participate in health policies that affect accessibility.

According to the RDL 16/2012, continuity of care is one of the conditions that population with health cover enjoys. Codes of ethics consider that nurses should guarantee continued care, as their fundamental duty is the person's integral care within pursuance of nursing procedures, educate patients on care and look for strategies for the continuance of care when resources are scarce and protect the right to assistance in exceptional situations such as conscientious objection or during strikes. The ICN ensures four levels of health care: to promote health, to prevent illness, to restore health and to alleviate suffering.

Table 12. Ethical and legal discourse comparison

Concept	Codes of ethics	Law
Equity	*The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services.*	*Provision of health services will be done in a manner to guarantee continuity of care provision, using a patient-centered multidisciplinary approach, guaranteeing maximum quality and safety in provision, as well as the conditions of accessibility and equity for all the population covered.*
Human Rights	*Health protection and promotion and respect for all human and social rights of individuals, families and communities need to be the fundamental ethical attitude of professional awareness. Professional nurses shall never use their knowledge or engage, directly or indirectly in any activity envisaging manipulating consciences or physically or psychically constraining people.*	*No mention of human rights.*
Right to health	*Nurses engage to acknowledge health as a fundamental right of the person and to defend such right preventing illness, caring for patients and undertaking rehabilitation tasks.*	*Once the condition of policyholder or beneficiary is acknowledged, the right to health care will be effective by the incumbent health care administration, which will grant citizens access to health care by the issuance of individual health cards.*
Accessibility	*Nurses work towards their participation in health, academic and social policy planning, personally and via professional colleges and associations, and ensure that legislation affecting health care access, quality and cost is adapted to the need of people.*	*Accessibility of people with disabilities will be taken into account in all information.*
Continuity of care	*Professional nurses shall not abandon a patient who needs surveillance or nursing care without ensuring continuity of care.*	*Service provision will be done to guarantee continuity of care, using a patient-centered multidisciplinary approach, guaranteeing maximum quality and safety in provision, as well as the conditions of accessibility and equity for all the population covered.*

Table 13. Treatment of key concepts in the different documents analyzed

Concept Document	Equity	Human rights	Right to health	Accessibility	Continuity of care
ICN Code	Defend equity in resource allocation and access to health care; be trained in equity and include training on equity in academic curricula.	Shall respect; No discrimination of any type; Promote a respectful environment for human rights; Offer training on human rights; Nursing associations should advocate for them.	Undertake and maintain actions to meet the health and social needs of all people, especially vulnerable people.	Defend access to health care on the basis of equity and social justice	Promote health; Prevent illness; preserve health and alleviate suffering, these being the four levels of health care.
Spanish Code of Ethics		Safeguard human rights, respect and no discrimination of any person, as human beings have the right to life, security and the protection of health.	Defend the rights of patients, even when care is denied, since nurses defend the right of humans to the protection of their health.		
Catalan Council Code	Defend equity in resource allocation; engage in the reduction of social determinants of health; Participate in health care policies, ensuring legislation adapts to people's needs regarding accessibility, quality and cost.	Respect human rights and no discrimination; Nurses responsible for raising social awareness in any breach of human rights.	Protect people in their right to health care in cases of conscientious objection.	Ensure that all people can access health care according to their health situation, especially vulnerable people, and undertake to participate in health policies ensuring their adaptation to people's needs.	Guarantee continuity of care; Instruct patients in care and the search for strategies for continued care in cases of resource scarcity Protect the right to health care in exceptional situations, such as conscientious objection and strike situations;
Barcelona Code		Respect all human and social rights of the individual, families and community, and no discrimination.	Contribute to the person's fundamental right to obtain the maximum possible degree of health.	Ensure a high quality health care system accessible for all the population.	Fundamental duty of the person's comprehensive care; Ensure continuity of care.

European Code	Equal care for all patients; Acknowledge that health is a fundamental right of the person.	Equal care for all patients with no discrimination, as patients have to right to human dignity	Defend the right to health.		
RDL 16/2012	One of the conditions for the covered population.	No mention is made of human rights or any synonyms.	Right of persons acknowledged as policyholders or beneficiaries, establishing the mechanisms to acknowledge such right.	Depends on acknowledgement of the condition of policyholder or beneficiary.	One of the conditions that policyholders enjoy.

DISCUSSION

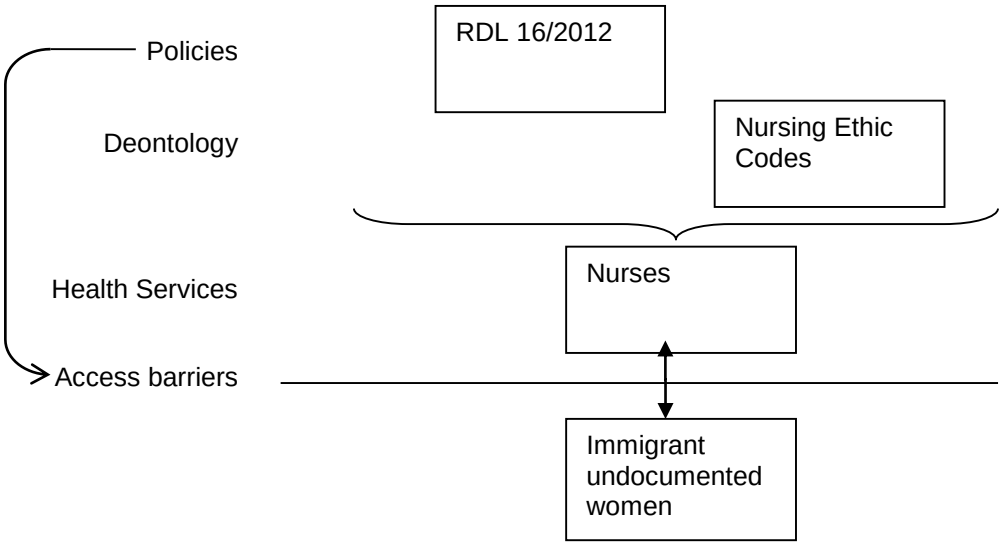
6. DISCUSSION

This compilation of studies about access to and utilization of health and social services by immigrant women in Spain reveals the lack of scientific evidence about the topic. In spite of that, the scarce scientific literature found conclusive evidence that these women make little use of services as a consequence of the barriers they face (Study I); this evidence was confirmed in two qualitative studies (Studies II and III). After the legal reform in Spain in which RDL 16/2012 was approved, the situation can become even worse as barriers and inequities between different NHS regions increase. For these reasons, nurses should position themselves against the application of this law and fight for the defence and compliance of our professional codes of ethics (Study IV).

The conclusions of studies I, II and III highlight that immigrant undocumented women show little access to social services and lower utilization of health care services. The myth existing in many countries that access to health care implies a massive utilization of services by immigrants or the perception supported by some studies that immigrants "abuse or misuse the health care system" is not supported by our findings (Moreno Fuentes & Bruquetas Callejo, 2011; Solé-Auró, Mompart-Penina, Brugulat-Guiterras, & y Guillén-Estany, 2010).

Figure 9 shows the relations between the different actors and fields in which the objectives, results and discussion of this thesis are based.

Figure 9. Relation between areas and social agents studied



The present thesis brings together the relations between all these factors and circumstances to identify the main determinants in the access to and use of health and social services by undocumented immigrant women in Spain.

Public policies have effects on the access of immigrant people to public services in host countries. Therefore, health policies such as RDL 16/2012 determine the access of undocumented immigrant women to health services in Spain. Between official health policies and clinical practice, the codes of ethics published by health care professional colleges have the objective of communicating, internally and externally, the principles and values that inform the behavior of nursing professionals. Among all the different professionals attending undocumented immigrant women, this thesis focuses on the role of nurses:

First, fieldwork in qualitative studies was carried out by two nurses, one of them is the author of this thesis. Second, midwifes were interviewed. Among nursing specialists, midwives have a remarkable contact with the collective of immigrant women because of how they use the health care system, mainly accessing reproductive care, which will continue to be the most demanded service even after the application of the RDL 16/2012. Finally, nurses' codes of ethics were analyzed at local level as well as at

national, European and international levels.

In spite of this focus on nurses' role and their ethical and professional dilemmas, undocumented immigrant women have had the leading role. Giving voice to these women in Study III is not only a complement for the other perspectives explored, but it also agrees with the importance they deserve. Without their contribution the global study would remain incomplete.

The group of undocumented immigrant women was chosen according to their classification as especially vulnerable group, because several socio-cultural conditions coincide in them, which are at the same time health determinants and risk factors for social exclusion. These are gender, ethnic group and socio-cultural status. There is no doubt that these characteristics aggravate the vulnerability derived from the migration process that took them far away from their support networks.

There is a vast amount of literature showing that for immigrant women language is a barrier to access and utilize health and social services in the host country. The women studied in this thesis include Latin immigrant women, who share the same language as their host country, Spain. As a result, these women do not face a language barrier but they do face other barriers such as poor working conditions related to their non-status.

In this way, it is important to mention that undocumented immigrant women from countries other than different Latin America may be even in an even worse situation, something that should be addressed in future studies.

Nurses are in a privileged position to assist undocumented immigrant women. First because traditionally being a female collective, they share the gender perspective; second, they are the first contact in primary health care, reproductive services and emergency departments, all of them the most used by undocumented immigrant women.

This Thesis focuses first on health services and second on social services. The encounters of immigrant women as patients with providers take place in a Primary Health Care context. In Study II, midwives give their view on the care of undocumented immigrant women to sexual and reproductive health programs. In turn, study III constitutes another micro-approach by interviewing undocumented immigrant women. Studies I and IV make macro approaches by describing how literature describes undocumented immigrant women's access and utilization of health and social services and how health policies and codes of ethics influence it.

The formulation of National health policies inspires local health policies and the two coexist along with professional nursing codes of ethics. All of these together influence, condition and even determine professional nursing practice. At the local level, the Catalan code of ethics has been chosen since Catalonia is the region in which part of the fieldwork took place. Furthermore, it is one of the Spanish regions that most actively positioned itself against the RDL 16/2012.

The results of this Thesis imply that immigrants nowadays face increased accessibility barriers related to health policies. Since the application of Royal/Decree in 2012 further restrictions among vulnerable collectives will take place, with the resulting effect on people's health and public health. Since the RDL 16/2012 was approved, residence permits are required to access primary and specialized health care services.

Restrictions on health care access for undocumented migrants in Spain is sometimes justified by financial reasons, but services were always accessible for people regardless of their citizenship status up until 2012, when the human-rights approach of the national health care system in Spain turned into a more restrictive policy. Thus, coverage in Spain is no longer universal at the present time, similarly to other European countries which only allow immigrants to access emergency services and certain primary care services (such as Austria, Belgium, or Denmark) (Dauvrin et al., 2012). A previous study showed that there is European consensus on ensuring the right to equal access to health care for immigrants, without barriers, as a priority, which

is supported by several policy documents (Devillé et al., 2011; World Health Organization, 2010b). In fact, a central challenge for Europe, with its increased proportion of migrants, is the provision of accessible, equitable, and good quality health services for everyone (Lindert, Schouler-Ocak, Heinz, & Priebe, 2008; Norredam, Nielsen, & Krasnik, 2010; Watters, 2002).

In this section, discussions on the studies are shown following the same order as they were conceived as different and complementary approaches to explore a single but complex reality from different perspectives: scientific literature (study I), midwifes (study II), immigrant undocumented women (study III), health law and the codes of ethics (study IV). Finally, a subsection follows describing implications for policymaking, practice and future research.

Study I. Existing scientific evidence on undocumented immigrant women's access and utilization of health and social services in Spain.

The findings of the scoping review (Study I) suggest that the number of immigrant women receiving public-funded primary health care is low, which may explain a higher demand for emergency services.

The limited utilization of preventative, curative and rehabilitation health and social services is related to structural/political, organizational, and individual factors connected to immigrant women's living conditions and socioeconomic and cultural characteristics.

Some access barriers identified are poor working conditions, job insecurity and unemployment, which combined with gender role responsibilities (e.g. multiple precarious employment and family commitments) result in limited time and opportunities for utilization of services. These circumstances may prevent them from affording travel expenses to the location of the required services. Regarding geographical barriers living in a rural or urban setting also influences access and utilization (Pons-Vigués, Puigpinós-Riera, Serral, Pasarín, Rodríguez, Pérez, Benet,

Casamitjana, Borrell, et al., 2012). There are barriers related to characteristics of the population at risk, such as the acceptability of the services as a result of aspects such as cultural differences, fear of being financially punished or deported, and consumer satisfaction features that may suit other cultural practices, such as acupuncture or herbal medicine (Pascual et al., 2008). Other barriers are related to the characteristics of the health care system, such as: i) the effectiveness of resource organization and the coordination of administrative services, and inappropriate attitudes of staff assisting immigrant populations due to lack of cultural and religious knowledge, and ii) lack of available information (Terraza-Núñez et al., 2010) and lack of cultural mediators (Saurina et al., 2010).

Other studies show that plausible reasons for undocumented migrants not availing of health services may be reactive conditions related to the stress of migration, fear to being picked up by the police and deported or paying for health care bills (Briones-Vozmediano, La Parra, et al., 2014; Hargreaves et al., 2008; Perez-Rodriguez et al., 2006).

Barriers can overlap and interact. For example, according to our results an unregulated situation must be added to other vulnerability factors such as precarious work and no social benefits (Alcaraz Quevedo et al., 2014); migrants may not know that their right to be a holder of a health care card is independent from their legal status (Saura et al., 2008). This all depends also on the host context, as the autonomic competences on health care and social welfare may make a difference in the access of immigrants to health care resources (Godenau, 2014).

The review covers ten years of literature during which the social and health reality in the country have changed due to political decisions allegedly made in response to the economic situation. Relating to these changing situations and the discourses of different perspectives, the articles can be divided between the humanitarian approach and the utilitarian approach in which the provision of health services to undocumented immigrants is limited to those that protect the health of the host population (Goldade,

2009).

According with their methodology there are articles differentiating groups of immigrants and others considering immigrants as one group only, as opposed to native people. We consider this last approach not to be adequate, since the papers included in this review reveal the country of origin as one of the main differential determinant in having better or worse access to health care and in identifying the most vulnerable groups.

The information gathered in this study is useful to i) understand the barriers faced when attempting to access services, and ii) develop future health policies for immigrants in host countries, and consequently improve specific programs that could address undocumented migrant women's needs. According to Deville, inequities in the use and accessibility of health care services for immigrants in EU countries is a matter of concern for both health care providers and policy makers (Devillé et al., 2011).

Study II. Midwives´ views on immigrant undocumented women access to and use of sexual and reproductive health services

In turn, the reproductive patterns described by the rural midwives in the study II reflect official figures (Instituto Nacional de Estadística, 2012; Luque Fernández & Bueno-Cavanillas, 2009). Data published by INE (Spanish acronym for the Spanish National Institute of Statistics) support the perceived high rates of VTPs that midwives believe their patients endure. These data show that in 2010, 41.7% of all VTP were performed on immigrant women (Ministerio de Sanidad política social e igualdad, 2013), which is a very high percentage considering that in 2010 only 13.4% of women residing in Spain were immigrants (Instituto Nacional de Estadística, 2013). In addition, the number of VTPs recorded among these women may be underestimated since, as the midwives indicated, some of these procedures are performed in the immigrant's country of origin, or in Spain but outside the public healthcare system. Finally, midwives argued that women from Eastern Europe choose VTP because this was a common practice in their countries of origin, encouraged by the legislation originated in those popular

democracies (Berthin, 2012). Considering that 31.9% of adolescent pregnancies occur among immigrant women (Instituto Nacional de Estadística, 2012); that immigrant women have higher rates of VTP and higher fertility rates than autochthonous women (1.61 births per immigrant woman vs. 1.33 children per Spanish-born woman); that birth rates are also higher among immigrant women (17 immigrant mothers per 1,000 inhabitants vs. 9.5 Spanish-born mothers), we can say that there are family planning deficiencies among immigrant women. According to the midwives the underutilization of family planning services, also described in relation to the cervical cancer prevention program elsewhere (Otero et al., 2011; Regidor et al., 2009; Sanz-Barbero et al., 2011) is, again, likely related to cultural differences, the main barrier being the male partner's opposition, due to gender inequality (Scott-Samuel, 2009), and to certain family planning practices. It is worth noting that rural midwives do not think that the distance from the immigrants' municipality of residence to the rural health center is a barrier when seeking midwifery services. The fact that this potential barrier, observed and documented in previous studies (Borda et al., 2011; Sanz-Barbero et al., 2012), fails to be perceived as an obstacle may reflect the existence of the communication difficulties between midwives and immigrant women. It is also possible that the women who do go to the midwife's office are those with no access barriers or those who managed to overcome them. However, the fact that midwives fail to perceive certain barriers to access and use of healthcare services already identified by different studies carried out in the same geographic environment (Borda et al., 2011; Otero et al., 2011) may indicate a 'blaming the victim' attitude toward immigrant women. This viewpoint could prevent the launching of strategies aimed at improving access as well as utilization. In summary, the midwives in our study equated the pattern of delayed access and underutilization of care often found in immigrant women with that of women of Romany ethnicity. That is, they identified immigrant populations with other groups at risk for social exclusion, as reported in a recent study (Otero et al., 2011). Furthermore, the association that these professionals made between low socio-economic level

characteristic of the immigrant population and an underdeveloped preventative culture (these last one originated by the fact that they proceeded from low-income countries with limited preventative programs) has also been reported in quantitative studies as an association between lower socio-economic level and a lower utilization of preventative services (Luque Fernández & Bueno-Cavanillas, 2009; Regidor, de Mateo, Gutiérrez-Fisac, Fernández de la Hoz, & Rodríguez, 1996). Regarding the underuse of maternal education programs, midwives emphasized the communication difficulties, specifically the language barrier, as an obstacle to access and use of such programs, as previously described by other authors (Seguí Díaz, 2005; Woltman & Newbold). They also identified the burden of childcare and childrearing, mostly the woman's responsibility in these immigrant populations, as a potential access barrier to prenatal care and services. This finding may be an indicator of how immigrant women's health is negatively impacted by the absence of the support received from traditional family and social network (Bernosky de Flores, 2010; García-Calvente et al., 2004).

Study III. Undocumented immigrant women´s perspectives on their access and use of health and social services

In study III, we have identified that for undocumented Latin American women living and working in the province of Lleida, irrespective of region, the main barrier to accessing social and health services is precarious working conditions in caregiving and cleaning occupations. The intersection of several social determinants of health places them in a vulnerable situation that is detrimental to their physical, mental and social health.

Over the last decade, scientific literature exposed immigrants' poor quality of life as well as physical and mental suffering as consequences of their precarious work in Spain (Ahonen et al., 2009; C. Borrell et al., 2008; García Mainar & Montuenga Gómez, 2009; Sanchon-Macias, Prieto-Salceda, Bover-Bover, & Gastaldo, 2013). However, since the economic recession started, poor employment conditions and fear of unemployment have increased presenteeism (working while sick) and discouraged

health-seeking behaviors (Galon et al., 2014; Ronda-Pérez et al., 2015).

In the informal labour market of cleaning and caregiving, occupational precariousness is socially reproduced because these jobs traditionally do not allow immigrant women to acquire legal status (Briones-Vozmediano, Agudelo-Suarez, Goicolea, & Vives-Cases, 2014; Hondagneu-Sotelo, 2001). In the context of the Spanish recession, study participants lost full-time jobs and were left with multiple part-time jobs, which according to Thomsen's model (2012), moved them from a position of "compliance" or "semi-compliance" to "non-compliance", and therefore, "trapped in illegality" and vulnerable to exploitation (Miklavcic, 2011).

The fact that they were women and "Latinas" legitimized labour segmentation and naturalized domestic activities as their occupation (Fernández & Ortega, 2008; Porthé et al., 2010). Even though study participants seldom referred directly to racism, but rather spoke in generic terms about humiliation and discrimination, conceptually, they were talking about the colonial logic of servilism, which is supported by racism and sexism (Agudelo-Suárez et al., 2011; Bianchi Pernasilici, 2014; Federici, 2010). It is paradoxical that Spanish women's liberation from caregiving and cleaning duties have been achieved in part at the expense of migrant women's rights and health, most of them their former colonial subjects (Ahonen et al., 2009; Briones-Vozmediano, Agudelo-Suarez, et al., 2014; Domínguez Mujica & Guerra Talavera, 2006)

In this context of neo-colonialism and non-compliance, trapped in illegality, access and utilization of social and health services was very limited. However, at the time data was collected, Spain (together with other European countries, such as Italy and Portugal) was held as an exemplar of good practice, with a legal framework that acknowledged full rights for undocumented immigrants to access social and health care services (Dias, Gama, Cortes, & de Sousa, 2011; Rechel et al., 2011). Our participants' reveal that access did not happen in the intended manner, that is: "providing the right services at the right time in the right place" (Rogers, Flowers, & Pencheon, 1999). Considering this definition, from resource allocation to actual service utilization, there was a clear

service failure for undocumented Latin American women (Tanahashi, 1978).

In the case of social services, the principles of social protection were breached when undocumented workers were denied access and coverage at a time of especial vulnerability. Data provided by the Colectivo IOÉ (2012) revealed that half of all foreign workers fired in the last few years had no right to welfare protection, and consequently poverty and exclusion rates have dramatically increased for this group (Otazu Urra, 2012).

The current policies of both the national and the autonomous communities transfer social assistance responsibility to NGOs which have been overwhelmed in recent years by requests for assistance with an increase of 170%, going back to the levels of the 1980s in the form of soup kitchens (Cáritas Española, 2012). In the particular case of this study, NGOs did not provide any assistance to participants.

Regarding health care services, geographic location plays a role in access to services. In rural villages, for instance, there seem to be fewer administrative barriers to get a healthcard, and better information is provided in comparison to cities. In scientific literature, rural and remote locations have been habitually considered as generators of inequity for health care access and utilization (Bourke, Humphreys, Wakerman, & Taylor, 2012; Canadian Population Health Initiative, DesMeules, & Pong, 2006). Conversely, in the case of the undocumented women studied, it became a facilitator, as participants were able to bypass some formal barriers, such as census registration. However, geographic location remained a generator of inequity when travel to a hospital was needed, given the cost of travel and lost wages.

Social and health care needs also differed in some aspects according to the geographic location. For instance, undocumented women who lived and worked in cities had more needs related to mental health, such as anxiety disorders and depression. Yet, all participants limited their consultations to acute problems with the aim of keeping active, or to reproductive health issues. Prevention services, such as

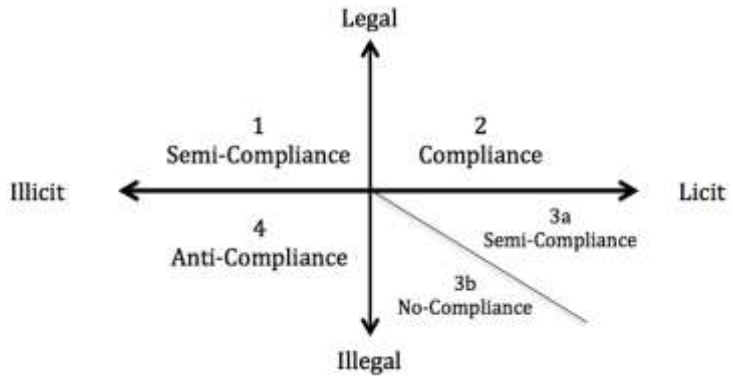
early detection of breast or cervical cancer, were not used, although many participants met inclusion criteria (Generalitat de Catalunya, 2006a, 2006b)

First break the trap

The results of this Thesis reveal that undocumented women have fallen into the “traps of illegality" (Miklavcic, 2011) As shown in Study III, due to the economic recession, they lost the jobs which led them into their migration process and were left without an opportunity to acquire legal status. Their undocumented situation is perpetuated in the informal labour market; mostly working on cleaning and caregiving which main feature is increased occupational precariousness. In this context, working conditions have four negative roles: (1) as illness producer, (2) as a barrier to access social and health services, (3) as an element that shapes the utilization of social and health services, and (4) by perpetuating labour segmentation by gender and naturalization of domestic activities as intrinsically female. In the case of the first three, the intensities or characteristics can vary according to the geographic area within a region and legal framework, as we will explain next.

For the reasons aforementioned, the conclusion of this study is that the promotion of decent working conditions and real right to access and use social and health services encompass a change in legal status. It is what Thomsen (2012) would call moving from the fourth space to the second space but, within the context of our study, the Scandinavian model needs a series of modifications based on social values and practices, as we cannot consider that the characteristics of the participants migratory process are illicit. On this basis, the results of this study suggested the inclusion of a new concept called "anti-compliance" in the fourth space in which those in illegal situations conduct morally unacceptable practices (e.g. human trafficking) and the creation of a sub-space 3b where the concept of non-compliance is resituated (See figure 10).

Figure 10: Types of compliance connected to the different spaces in Lleida Province*



*Gea-Sánchez and collaborators adapted from Thomsen

As a result of this study, Figure 10 proposed a revised version of Thomsen's model. Health as a human right and the right to health care can only be enacted in the context of undocumented immigrant women's lives in our context if we adopt a movement for health promotion for all which includes people's status as a social determinant of health. To move those in non-compliance (3b, e.g. risk of deportation) to semi-compliance (3a, e.g. documents to reside but not to work) to compliance (Schoevers et al., 2010), that is to live and work in a legal and licit space, means to promote health equity. However, as our results reveal, such movement towards legal status through public policy is insufficient: social values also determine what is licit in each society. If employers care recipients, social and health care professionals or the population as a whole do not believe immigrants should access health care, even in a province where the right is legal, it may not be enacted. Addressing care and dependent people needs should not be solve at the expense of an immigrant woman's right to access and utilize health care and social services.

Not having a residence permit does not automatically imply a socially unacceptable act, as it is demonstrated by the fact that participants were invited to move to Spain to work as caregivers and that in rural areas institutions (e.g. town councils, social and health centers) legitimate informal work and become undercover employers of undocumented workers by paying them to assist elderly people and perform other related activities. In

addition, state policymakers that are responsible for formulating migration policies utilize criteria based on the social imaginary of Spanish people towards immigrants (Colectivo Ioé, Walter, de Prada Junquera, & Pereda, 1995; Moreno Fuentes & Bruquetas Callejo, 2011).

The current economic crisis is related to the radicalization of precarious status and working conditions for immigrant women as well as denial of social assistance and health care. By performing work naturalized as women's roles, that is caregiving and cleaning, these women experience barriers to access and utilization of services, so they cannot take care of their own health.

The transformation of the model adopted by Thomsen (2012) is put forward, noting that to transform this situation it is not sufficient to apply measures aimed at a greater control of the work environment, as some authors have suggested (Agudelo-Suárez et al., 2009), but a more radical response is needed, acknowledging these female workers as citizens with full rights.

Study IV. Health policies and ethics codes view on immigrant undocumented women access to health services

Finally, the analysis of Study IV has demonstrated that there are substantial differences between the concepts of equity, human rights, right to health, accessibility and continuity of care between the codes of ethics and the RDL 16/2012. While codes of ethics define the nursing role on the basis of these concepts, in the RDL 16/2012 these are subject to the concept of being insured/beneficiary, which legitimates the coverage for the entitled population, and the regularization of the NHS. The administrative changes that have taken place in the NHS in recent decades have shifted from the premise of the contribution in 1963 to a tendency to universalization in 1986 through the concept of citizen or resident, until the last regularization in 2012, when the new concept of insured or beneficiary was introduced. This key concept opposes the terms person or human being, which are present in the codes of ethics analyzed.

The discourse of the RDL 16/2012 hinges on the term insured or beneficiary, which entails a change of paradigm in the exercising of professional nursing and is used to legitimate discrimination and exclusion of vulnerable collectives from the health system: it justifies approving restrictive measures of access to the NHS with the socioeconomic circumstances and established the requisites to obtain the condition of insured or beneficiary to access the public health system.

This limitation in the access and use of the NHS promotes a frame of action where nurses cannot give care to uninsured collectives, and puts them in situations of making decisions that can cause them a great emotional strain (Barrio et al., 2006; Lunardi et al., 2007). For example, ethical conflicts may appear when nurses who make health care decisions find it impossible to choose actions that comply with their ethical criteria while complying to the regulations of the country they are working in. Codes of ethics are developed from a universal standpoint, but are applied to specific situations, and the conditions imposed by the legal framework in which the practice takes place cannot be modified.

The situation produces discrimination and exclusion of some collectives under the legitimacy of the RDL 16/2012. These criteria are in conflict with the codes of ethics that consider that access to health care should be universal. The legal discrimination and exclusion of people such as unregulated immigrants may have implications on these people's health. Blocking access to medication and primary health care services causes aggravation or chronification of concealed illnesses or illnesses treated too late; this is the case for illnesses such as human immunodeficiency virus (HIV), tuberculosis, cancer, kidney failure, leukemia or schizophrenia (España, 2012; O'Donnell, Burns, Dowrick, Lionis, & MacFarlane, 2013). This can in turn generate important public health problems, as has happened in other countries in our vicinity, also immersed in an economic crisis, such as Greece (Kentikelenis et al., 2012).

In codes of ethics, equity refers to resource allocation according to people's health needs; in the RDL 16/2012, equity refers to equality of rights of access to health and provision of health services of people who meet administrative requirements, whose distinction is that they live in a certain region. The aim of the law is to skip differences and to offer homogeneous service and care to all users of the health care system. However, the administrations of Autonomous Communities have responded in very varied ways: the law enforcement has been postponed in some Communities after bringing an action of unconstitutionality; in others it has been applied, with the resulting increase in inequities between Autonomous Communities (España, 2013).

The difference between the concept of equity in the nursing codes of ethics (understood as equality or justice in resource allocation) and the legal text (equality among people with a given status -insured or beneficiary-) may trigger ethical dilemmas for nurses. Equity means that access to the health care system should equate to the need for care; therefore, in limiting health equity to regional factors and subjecting access to health care to meeting a series of requirements, the law is promoting health inequities (Asociación para las Naciones Unidas en España & Asociación Salud y Família, 2012).

Respect for Human Rights is at the core of the five codes of ethics studied, while the RDL 16/2012 discriminates against people according to their administrative situation when setting conditions of access to health care services, such as labour or economic situations. This fact may trigger an ethical dilemma, as suppressing the right to health for people not meeting these requirements may entail breaching the Spanish Constitution and the International Covenant on Economic, Social and Cultural Rights signed by all EU countries (Asamblea General de las Naciones Unidas, 1966; España, 1978).

It is worth highlighting that the RDL 16/2012 foresees the possibility of ethical conflicts for nurses, as the services need to be open to all the people who are covered. If nurses need to ensure the continuity of care, they are dependent on the coordination of different health professionals and different services in the process (García-Abad Martínez, 2012) in addition to self-care. Since access of uninsured people or non-beneficiaries is limited to the emergencies service (except for maternity care and people under 18 years of age), once the urgent care is given these people cannot access medicines, primary health care or specialized health care (United Nations, 1948) . Therefore, with this legislation, nurses can't ensure the continuity of care to all patients.

The instrument used to carry out the health care reform is a Royal Decree Law, a law of urgent measures in the current socioeconomic situation. Applying the law infringes human rights and will increase health inequalities (Díez & Peirò, 2004; World Health Organization & Pan American Health Organization, 2003) and, at the same time, it is contrary to care ethics as it clashes with the codes of ethics.

6.1 Implications for policymaking, practice and future research

This Doctoral Thesis offers valuable data for policy makers in order to provide health and social services on a real equity basis and designing specific programs for immigrant women. As demonstrated, just a health approach is not enough to provide services for undocumented. Immigration and health care laws should be considered and designed in a most flexible way ensuring that different social and cultural situations are covered. The right to health, and in consequence the right to access and use social and health services by undocumented immigrant women is well recognized by nurses, codes of ethics and undocumented immigrants themselves. In consequence, a restrictive law, as RDL16/2012 should not be applied.

First, we commend that in the case of immigrant undocumented people, it is important to re-institute their access to primary health care and increase the availability of

information about access to social and health care services. It is known that restrictive regulations, such as excluding immigrants from routine primary health care, has adverse public health implications, as their exclusion has negative outcomes both to vulnerable groups as well as to the host society (Fortuny, Capps, & Passel, 2007; Kuile, Rousseau, Munoz, Nadeau, & Ouimet, 2007; Platform for International Cooperation on Undocumented Migrants, 2007). Second, to meet the needs of immigrant undocumented women, health professionals must coordinate themselves to provide adequate care interventions.

In turn, this Thesis provides a starting point to continue exploring access to and utilization of social and health services by undocumented immigrant women. Given the gap existing in Spanish scientific literature on this issue, and the difficulties in reaching this collective from a positivist point of view, factors that influence accessibility should be assessed. As highlighted before, the sample of undocumented women is composed of Latin Americans. This group of immigrants is considered to be culturally closer to the Spanish population, so it could be assumed that they find fewer barriers comparing with other collectives of women. This fact argues the need for broader and deeper studies on this topic in undocumented women from different origins and ethnicities. Additionally, and taking into account that empiric data were collected before the new regulation, a comprehensive study is required on the specific health and social care needs of the immigrant undocumented population as one of most vulnerable groups considered in a recession context (Llop-Gironés et al., 2014).

Due to the evidenced contradiction between the legal discourse and the code of ethics discourse may lead to ethical conflicts in professional nursing practice, it would be interesting if further studies explored how these changes take place and how nurses resist or shape daily nursing practice.

7. Limitations and strengthens

The scoping review (Study I) has some limits in systematizing information about undocumented immigrant women's experiences in accessing health and social care in Spain. There is no Spanish study with a sample composed specifically by undocumented immigrant women. Some of the studies selected did not deal entirely with immigrant women, but also included immigrant men and/or native people in their samples. Full sample representation is not possible due to lack of official data or surveys about undocumented persons. The lack of official databases and the difficulty in reaching this population, who frequently fear registering in community health centers, make the review an important contribution. The literature search was not restricted to studies indexed in databases only, which might have excluded publications outside of these; however, the search in grey literature databases did not yield any results.

Qualitative studies II and III focus on the interviewees' individual opinion and experience. Although results are not statistically applicable to all situations, this is not a limitation of qualitative methodology; rather, results are useful for theorizing about an unexplored topic (Lincoln & Guba, 1985). This gap could be explained because the unregistered population is not easy to reach or to collect data about. Since there are no official databases or statistics, a qualitative approach becomes especially appropriate. Furthermore, results are applicable to other similar contexts, such as immigrant women living in other Spanish regions, and the study itself is replicable.

Fieldwork has been performed in two different Spanish regions. Nevertheless, both regions share similar demographic characteristics, such as low-density dispersed populations, rurality and a considerably high percentage of registered immigrant population in relation to the autochthonous population. Qualitative analyses offered extremely valuable data. First, because findings increase the knowledge on undocumented immigrant women's access to and utilization of health and social services from two different point of views: the insider's view of the women involved, and the outsiders' view of midwifes assisting them in their daily working routines.

Midwives are the nurses who probably come into most contact with immigrant women compared with other professional profiles since, as this Thesis highlighted, immigrant women underuse health services (Rodríguez Álvarez et al., 2008; Sanz-Barbero et al., 2011), and reproductive services, they may be their only contact within health services (Rodríguez Álvarez et al., 2008). Besides, from the RDL 16/2012 on, the midwives are among the only health professionals who remain in contact with undocumented immigrant women. This fact increases the need for being aware of their view on the problem and its evolution, by continuing this research line with further studies. Increasingly, since the implementation of RDL 16/2012, the restrictions did not affect reproductive services and they are still available for immigrant undocumented women, so midwifes keep on working with this population. This fact increase the necessity of being aware of their view on the problem and its evolution, by continuing this research line with further studies.

Second, and the most important, this is the first study in Spain specifically oriented to explore access and utilization of social and health services from a specific undocumented immigrant women group in both rural and urban areas and from the undocumented women's perspectives, a collective which is very difficult to study and recruit.

Studies I and IV were useful to contextualize qualitative studies (II and III) and help the reader reach a holistic idea of the topic being researched: the problems undocumented immigrant women face to effectively use health and social services in the host country. The sample of codes of ethics chosen for the analysis range from the local to the international context; in the future, it would be interesting to broaden the sample of codes for comparison. Nevertheless, results are likely to be similar, since nursing codes of ethics are based on a caring philosophy and the respect for human rights, as seen in Chapter II.

The methodological design of this Thesis combining different qualitative methodologies and personal interviews (Studies II and III) and documental review (Studies I and IV)

has been useful in approaching the studied topic despite the complexity of the design of the Thesis, thus providing an answer to the proposed aims. The approaches implemented complemented each other, and together contributed to increase the knowledge on how undocumented immigrant women accessed and utilized health and social services in Spain before the RDL 16/2012, and in consequence, how they do it nowadays, and also the professional and human role nurses play in attending them. Combining methodological approaches and perspectives increases the quality criteria of this qualitative study through triangulation (Lincoln & Guba, 1985).

CONCLUSIONS

8. CONCLUSIONS

This thesis explores the access and use of social and health services by undocumented immigrant women in Spain, from different perspectives. The main conclusions of the studies presented are:

1- There is a knowledge gap in scientific literature in Spain regarding access and utilization of social and health services specifically oriented to undocumented immigrant women.

2- A significant gap was identified between the general population's perception and that of policy makers of the use of services by undocumented immigrants, and the real use they make. The underutilization of the service of midwifery is also extended to the general utilization of services by immigrants. At the same time, the existence of specific barriers in being woman and/or immigrant was clear in our results, both in the literature and in the discourse of nurses and immigrants. These determinants interact and lead to situations that increase the vulnerability of immigrant women.

3- When immigrants access health and social services they use primary and specialized health services less than accident and emergency departments. Undocumented immigrant women follow this pattern and the reasons for accessing health care services are linked to production and reproduction. Health is perceived as a tool to work, as a consequence they search for quick solutions to acute physical problems; they also attend services for natal and postnatal care.

4- In this moment (and depending on the regional application of RDL 16/2012) the situation for undocumented immigrants in Spain changed from having a

universal health care access focused on human beings regardless of legal status, to a health care system focused on beneficiaries. Immigrant women are particularly vulnerable in this situation as they usually work in irregular cleaning and care-giving jobs where they fall into a precarious circle, which includes an undocumented legal status that is in itself a social determinant of health.

5- The qualitative fieldwork and the literature reviewed included in this thesis were carried out prior to RDL 16/2012, when health care coverage was available to everyone. From the implantation of the aforementioned law we could have only expected deterioration in the access to services by immigrants, as the existing underutilization is probably increased by the subsequent limitations in the access to health and social services.

6- The RDL 16/2012 has consequences for the health of immigrants and probably also natives but it also affects health care professionals. Nurses suffer an ethic and professional dilemma as this general law clashes with their deontological and ethical compromise.

7- From these conclusions a call for action is required to counter RDL 16/2012. Not only is global access to health care and social services recommended, but also the solving of the former sustained underutilization of services by undocumented immigrant women. As has been demonstrated, this action should be accompanied by the reform of other laws, such as the law on migration. A real path to health promotion encompasses ensuring decent working conditions that place immigrant women in a fully legal space. The welfare of Spanish women cannot be built at the expense of other women's rights.

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APPENDIX

Journal of Immigrant and Minority Health

Undocumented Immigrant Women in Spain: A Scoping Review on Access to and Utilization of Health and Social Services.

--Manuscript Draft--

Manuscript Number:	
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Abstract:	This scoping review summarizes and analyzes relevant studies related to the evidence published on undocumented immigrant women's access to and utilization of health and social services in Spain. Scientific literature was identified by entering search terms in seven electronic databases which combined retrieved health sciences peer-reviewed articles (Pubmed, Embase, CINAHL Plus and Scopus) and grey literature databases (Europa OpenGrey, DART-Europe and Google Scholar) published between 2004 and 2014 and written in Spanish or in English presenting data about Spain. Those that fulfill the inclusion criteria were selected after a blind peer reviewed process when pertinence and quality was debated. A total of 16 publications were included, the main topics being socio-cultural differences in the access and utilization of social and health services and barriers faced by immigrant women. None of the studies focused exclusively on undocumented women, hence further research is needed in this area.
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Undocumented Immigrant Women in Spain: A Scoping Review on Access to and Utilization of Health and Social Services.

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Running head: Scoping Review on Immigrants Access to Services in Spain

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ABSTRACT

This scoping review summarizes and analyzes relevant studies related to the evidence published on undocumented immigrant women's access to and utilization of health and social services in Spain. Scientific literature was identified by entering search terms in seven electronic databases which combined retrieved health sciences peer-reviewed articles (Pubmed, Embase, CINAHL Plus and Scopus) and grey literature databases (Europa OpenGrey, DART-Europe and Google Scholar) published between 2004 and 2014 and written in Spanish or in English presenting data about Spain. Those that fulfill the inclusion criteria were selected after a blind peer reviewed process when pertinence and quality was debated. A total of 16 publications were included, the main topics being socio-cultural differences in the access and utilization of social and health services and barriers faced by immigrant women. None of the studies focused exclusively on undocumented women, hence further research is needed in this area.

Keywords: immigrants, legal status, women, access, Spain

INTRODUCTION

In Spain, the sociodemographic reality has changed dramatically since the early 2000s, when a large number of immigrants coming from Latin America, Africa, Asia and Eastern Europe became part of the Spanish population[1]. Their reasons for emigrating were mainly economic, given that Spain was at the time an attractive destination for those looking for job opportunities.

Foreign residents with residence permits showed a steady increase until 2008. With the start of the economic recession this tendency started to reverse slowly until Spain reached a negative migration balance of -256.846 people, of which 82% were foreigners. Thus, the number of foreigners living in Spain in 2014 decreased by 4,90% reaching 4.447.852 registered people[2].

Women accounted for at least half of all foreigners who arrived in Spain during the last decade[3].The majority of immigrant women currently living in Spain come from Latin

America, but they have also emigrated from other countries such Romania, China, and North Africa. Knowledge of Spanish can be considered a facilitator, but for most immigrant women the main reason for their journey has been the search for domestic and caregiving work.

Immigrants usually belong to population groups with lower socioeconomic conditions who are known to suffer more from health problems. Being an immigrant is usually related to poor living and working conditions and poor access to health services[4]. In particular, immigrant women all over the world are at higher risk of suffering poor health conditions due to the overlapping of social determinants of health, such as gender, social class, nationality, ethnicity, and legal status that influence the position of the immigrant in the social structure and their access to resources. In addition, immigrant women are more vulnerable to sexual exploitation and violence[5,6], a situation that becomes more radical when they are undocumented.

Estimations of the number of undocumented people in Spain are betweenfourhundred thousand[7] and 1.3 million[8], although for obvious reasons, it is hard to establish the validity of these data because some foreigners first register in Spain but then move into other European countries and some immigrants do not register at all for fear of being located and deported to their country of origin. In this context,the condition of "illegality" negatively influences immigrants' health and access to medical care, especially for undocumented women who are usually employed in precarious jobs in unregulated sectors[9].

Access to health and social services

According to the inverse care law, vulnerable population groups need more health care, but are those receiving the least; while groups with more social advantage enjoy more health care with less need for it. This situation violates the so-called horizontal equity, that is, an equitable use of health services for an equivalent need[10,11].

Despite international laws, policies and institutions which state that health is a fundamental human right[12,13], in practice there are several barriers that limit health care access to undocumented migrants, mainly resulting from the context of migration associated with situations of greater social vulnerability, such as the lack of a residence permit, existence of language barriers and the lack of support networks[14,15,16].

Some countries have developed supportive policies for immigrants or have adopted legislation that facilitates their access to services. In Spain, the right to health used to be supported by universal health care coverage. Spain was cited as an example of a country with policies that promoted access to social and health services for immigrants[17,18].

The recession and subsequent increase in poverty and unemployment was accompanied by a discourse of concern about the sustainability of social, health and educational services[19] that triggered the stigmatization of immigrants with accusations they overused the Spanish national health care system. However, Spanish studies reveal that immigrants have different health care utilization pathways than natives and that they under-utilize health care services because they face substantial access barriers[20,21].

In this context, in 2012, the Royal Decree Law 16/2012[22] which set out urgent measures to guarantee the sustainability of the National Health Care System and to improve the quality and provision of care was unilaterally approved. According to it, access of immigrants to health services is limited to emergencies, prenatal, labor and postnatal care, and general care for under 18s.

Presently, access to Spanish health services is determined by insurance status which is granted by employers who provide work permits. These measures were controversial at the time, and they continue to be denounced by health care professionals and organizations defending universal health care and human rights to this day[23]. According to the World Health Organization (WHO), the Right to Health implies equal and timely access to health care services, the provision of health-related education and

information, and the participation of the population in health-related decisions at national and community levels[24].

Objective

Access and utilization of services is an important research field about immigrants' health, with most of the literature coming from the US, Canada, and some European countries[25,26]. These studies suggest that migrants experience unequal access to care, resulting in low health care utilization[27,28]

In Spain, researchers working in this area face some challenges. There is a lack of information regarding the nationality of women accessing health and social services, which reduces the possibility of analyzing differences/inequities on access between immigrant and non-immigrant women. In addition, despite the significant increase in publications, information on undocumented immigrants' access to health and social services is seldom discussed.

For this reason, we believe that it is important to explore published information about the experiences of undocumented immigrant women accessing health and social services in Spain. The aim of this scoping review is to identify, describe, and analyze recent evidence on immigrant undocumented women's access to and utilization of health and social services in Spain.

METHODS

A review of the scientific literature published between 2004 and 2014 has been carried out to explore how undocumented immigrant women in Spain access and use health care and social services. The review was conducted according to Arksey and O'Malley's[29] methodological framework for conducting scoping studies.

Search parameters

An extensive search of Pubmed, CinahlPlus, Embase and Scopus databases was carried out to locate peer-reviewed papers and grey literature relevant to the Spanish context. The search in Scopus retrieved Medline and Embase contents since 1996, with particular use of free-text search. It is also worth noting its coverage of the European context, and therefore, the Spanish context. Pubmed, CinahlPlus and Embase permitted us to use controlled text. Specific sites of grey literature in Europa OpenGrey and DART-Europe were also consulted, and a search was completed in Google Scholar.

The search was limited to papers published during the 10 years comprised between 2004 and 2014. The search was not spoken-language based to ensure that no results were omitted and consultations were performed in English.

Search Terms

First, the parameters of a research question were set for the search of the MeSH Database, obtaining the controlled terms for the search in Pubmed. The search of Pubmed was used as a basis and transferred into other databases with controlled language, adapting the terms to the specific characteristics of Cinahl Plus and Embase, and finally to the free-language resources Scopus, Open Grey and DART-Europe. Having previously used controlled text, we could now reach all the possible variants in free text. The terms identified and used in the MeSH Database were “Health Status Disparities” “Delivery of HealthCare” “Delivery of HealthCare, Integrated” “Healthcare Disparities”, “Culturally Competent Care” “Health Services Accessibility” combined with “Emmigrants and Immigrants” and “Transients and Migrants”. Since there was no MeSH term, and to make sure we were not omitting results, combinations were also made with the free-text terms “Social Care” “Healthcare” “Health Care” “Access” “Use” and “Utilization”, and the name of the country “España” as well. Once the search started, the term “homeless” was excluded, as it did not answer our

question. The basic search strategy used in Pubmed, which was then exported and adapted to the rest of databases is shown in table 1.

Selection criteria

A total of 289 papers (Figure 1) were retrieved, and 87 duplicate papers were eliminated using the bibliographic management program Mendeley. The review seeks to identify all the published research about immigrant women in Spain, and refer to their legal status and access to the Spanish health care system; therefore, the following inclusion criteria were established when revising the full text:

i) Include women or disaggregate data by sex or gender.

ii) Include undocumented women or provide information about legal status or length of residence in Spain.

iii) Include studies that identify immigrants according to their origin and not as a unique same category, since the concepts hygiene and health, and the perception of proper social care are mediated by cultural factors.

Articles that did not comply with the inclusion criteria were discarded. Pertinence and quality was debated to check if the articles offered data to answer the research question. Two independent reviewers were responsible for reviewing the eligible sources (MGS and RP). A third reviewer (AAR) made the decision of inclusion or exclusion when the two-primary reviewers did not agree. There was a general agreement except with an article that needed further examination and debate before achieving unanimity about its exclusion because it did not respond to the criteria. (Figure 1)

RESULTS

Characteristics of Articles Selected

Table 2 shows the general characteristics of the studies considered in the scoping review. A total of 16 articles were included in the final synthesis. These articles had been published between 2007 and 2014 as follows: 2007 (1), 2008 (5), 2009 (1), 2010 (2), 2011 (2), 2012 (3), and 2014 (2). We have not found articles published before 2007 which complied with the inclusion criteria and the empirical data were only until 2010.

All the articles included were published in Spanish (n=5) or English (n=11) in international scientific peer-reviewed journals, with the exception of one grey literature publication[8]. Among the 16 studies reviewed, 11 were cross-sectional studies[11,30–39], 3 qualitative studies[40–42], one was mix-methods[43], and one was a documentary review[8].

Fourteen of them analyzed access to and utilization of health services[11,30,32–43] while two analyzed access to and utilization of social services[8,31]. With regard to the type of care explored in the articles, they can be classified in three areas: 7 articles dealt with general utilization and access to services[8,31,36,39,41–43]; 6 dealt with primary health care and community health[11,32,33,35,37,38]; and 3 with specialist care[30,34,40].

Two thirds of the studies used a quantitative research design[11,30–39] as the chosen method to explore access to services with broader samples. The samples in these studies ranged from 100[37] to 1866[11] immigrant women. The qualitative publications included samples of immigrant women ranging from 13[41] to 26 people[40].

The proportion of undocumented people in the studies is 80.5%[39], 69.8%[33], 50%[31] and 16.2%[43]. Although only seven articles included the legal status of participants, other studies included the length of time resident in Spain – between one and ten years – except for studies focused on utilization of screening programs by women older than fifty years of age (e.g. breast cancer), in which case all the sample had lived for more than ten years in Spain.

Regarding country of origin, in just 8 studies the sample included only immigrants[31–33,36,37,39,42,43], whilst 7studies mixed immigrants with native population in their samples[11,30,34,35,38,40,41], and the last one was a documental analysis[8]. Concerning the differentiation of the compared groups according to the geographic origin of the immigrants, 4 papers were focused on specific groups: 3 had a sample of Latin Americans[39,40,42] and 1 Maghrebians[43]; 11 studies included immigrants as a whole (disaggregating data according to geographical origin, but not comparing the groups). In six studies, only women comprised the population selected to be studied[11,31,33,35,37,40], and the remaining five focused on sexual and reproductive health care.

Frequency of Access to and Utilization of Health and Social Services

A total of 9 studies showed that the utilization pattern differed according to the geographical origin of the immigrants[11,30–32,34–36,38,41].

In relation to the general utilization of health care services, all the studies found that immigrant population use health care services less than Spanish-born citizens. Immigrants demand less surgery, outpatient services, and dermatology services[30], they use less psychiatric emergency services, despite experiencing more work and family related difficulties[34]. Conversely, immigrants use emergency services, for example for prenatal care[40], more often than other services[36]; likewise, immigrants use emergency services more often than the native population[30].

Regarding immigrant women, Maria-Saura's findings reported that 69.7% of immigrant women studied used health care services (mainly primary health care 42.6% and emergency services 17.7%)[43]; 62.5% and 36.3% of the women studied attended health care and social services respectively[33]. They use gynecological cancer screening programs less than Spanish-born women[11,35]; they use contraceptive methods less in planning pregnancies[37,40]. For instance, 42% of immigrant women did not use any contraception and 3.2% had voluntary abortions compared with 0.6%

of the native population[37]. Latin American women reported more problems related to anxiety in comparison to natives, despite an under-utilization of psychiatric emergency services[34]. It is worrying that cultural mediators identified that 11.2% of Latin American women who were referred to their services had suffered gender violence[31]. Fuentes[8] underlines that the working conditions of these women limit their access to and utilization of social services because most are employed in the caregiving sector, closely linked to the underground economy, and most women are not entitled to social benefits such as unemployment benefits.

Barriers to access and utilization of health and social services

Apart from nationality, other factors influencing the utilization of services described by the studies are summarized in Table 3. These factors that, in some cases could be identified as barriers, are the following: poor working conditions, which is linked to insecure or illegal employment status and being unable to attend scheduled appointments[8,11,32,35,38–40,42]; cultural differences, such as different perceptions about health and illness[31,34,36,38,40,41,43]; language and communication barriers[11,31,34,35,37,41,43]; time living in Spain, which could be linked to the knowledge of available resources and access to services[11,31,32,35,36,39]; immigrant women's lack of knowledge of their rights[11,40–43]; their legal status[8,11,34,37,42]; the organization, which is the coordination of services and facilitating strategies, such as staff attitude or availability of cultural mediation services[31,40–43]; living conditions, such as their housing circumstances or living in a rural area[30,35,36,38,39]; and finally, lack of knowledge about the Spanish health care system[11,31,40,42].

Some studies revealed more specific information regarding undocumentedness. Torres Cantero[39] showed that there was no significant difference in the utilization of health services between documented and undocumented Ecuadorian immigrants in Madrid.

In turn, the study of Maria-Saura[43] placed legal status as one of the stress factors most reported by participants (together with distance from family).

DISCUSSION

Our findings suggest that the number of immigrant women receiving publically-funded primary health care is low, which may explain a higher demand for emergency services. Results from previous studies comparing immigrant with Spanish native population, also show that immigrants seem to use less specialist inpatient and outpatient services[21,44,45].

The limited utilization of preventative, curative and rehabilitation health and social services is related to structural/political, organizational, and individual factors connected to immigrant women's living conditions and socioeconomic and cultural characteristics. Two frameworks on access to health services[46,47] can help us understand the barriers faced by immigrant undocumented women when accessing services in Spain. Above all, these women face accessibility barriers related to health policies because, since the Royal/Decree 2012 was approved[22], residence permits are required to access primary and specialized health care services.

Other accessibility barriers identified are poor working conditions, job insecurity and unemployment, which combined with gender role responsibilities (e.g. multiple precarious employment and family commitments) result in limited time and opportunities for utilization of services. These circumstances may prevent them from affording travel expenses to the location of the required services. Regarding geographical barriers living in a rural or urban setting also influences access and utilization[35].

There are barriers related to characteristics of the population at risk, like the acceptability of the services as a result of aspects such as cultural differences, fear of being financially punished or deported, and consumer satisfaction features that may suit other cultural practices, such as acupuncture or herbal medicine[34]. Other barriers

are related to the characteristics of the health care system, such as: i) the effectiveness of resource organization and the coordination of administrative services, and inappropriate attitudes of staff assisting immigrant populations due to lack of cultural and religious knowledge, and ii) lack of available information[42] and lack of cultural mediators[41]. Other studies show that plausible reasons for undocumented migrants not availing of health services may be reactive conditions related to the stress of migration, fear to being picked up by the police and deported or paying for health care bills[16,48,49].

Barriers can overlap and interact. For example, according to our results an unregulated situation must be added to other vulnerability factors such as precarious work and no social benefits[31]; migrants may not know that their right to be a holder of a health care card is independent from their legal status[43]. Unregulated housing and work prevent accessing regular jobs; being a recent arrival increases the chances of work vulnerability; weak social networks, among others, reduce the possibilities of compensating for adverse situations. This all depends also on the host context, as the autonomic competences on health care and social welfare may make a difference in the access of immigrants to health care resources[50].

The review covers ten years of literature during which the social and health reality in the country have changed due to political decisions allegedly made in response to the economic situation. The articles included in the review can be divided between the humanitarian approach and the utilitarian approach in which the provision of health services to undocumented immigrants is limited to those that protect the health of the host population[51].Research on undocumented migrants is sometimes justified by financial reasons in Spain, but services were always accessible for people regardless of their citizenship status up until 2012, when the human-rights approach of the national health care system in Spain turned to a more restrictive policy. Thus, coverage in Spain is no longer universal at the present time, similarly to other European countries which only allow immigrants to access emergency services and certain

primary care services (like Austria, Belgium, or Denmark)[52]. A previous study showed that there is European consensus on ensuring the right to equal access to health care for immigrants, without barriers, as a priority, which is supported by several policy documents[53,54]. In fact, a central challenge for Europe, with its increased proportion of migrants, is the provision of accessible, equitable, and good quality health services for everyone[55–57].

Implications for practice and future research

This review provides a starting point for assessing possible factors of accessibility problems for undocumented immigrant women to health and social services, and argues the need for broader and deeper studies on this topic. The articles can be divided between those differentiating groups of immigrants and those considering immigrants as one group only, as opposed to native people. We consider this last approach not to be adequate, since the papers included in this review reveal the country of origin as one of the main differential determinant in having better or worse access to health care and in identifying the most vulnerable groups. A comprehensive study is required on the specific health and social care needs of the immigrant undocumented population, as well as exploring the changes derived from the new regulation in a context of economic crisis[21].

The information gathered in this study is useful to i) understand the barriers faced when attempting to access services, and ii) develop future health policies for immigrants in host countries, and consequently improve specific programs that could address undocumented migrant women's needs. Underlining the immigrant women's experiences through this scoping review provides information for health and social care teams about the need to be flexible and consider the different social and cultural situations their clients face.

We recommend that in the case of immigrant undocumented people, it is important to re-institute their access to primary health care and increase the availability of

information about access to social and health care services. It is known that restrictive regulations, such as excluding immigrants from routine primary health care, has adverse public health implications, as their exclusion has negative outcomes both to vulnerable groups as well as to the host society[58–60]. According to Deville, inequities in the use and accessibility of health care services for immigrants in EU countries is a matter of concern for both health care providers and policy makers[53].

Previous authors like Hargreaves concluded that we need to explore models of appropriate health-care delivery to new immigrants, drawing on models of best practice from established health services in other migrant-receiving countries[31,49].

Limitations

This review has some limits in systematizing information about undocumented immigrant women's experiences in accessing health and social care in Spain. There is no Spanish study with a sample composed specifically by undocumented immigrant women. Some of the studies selected did not deal entirely with immigrant women, but also included immigrant men and/or native people in their samples. Full sample representation is not possible due to lack of official data or surveys about undocumented persons.

This scoping review explores a sensitive and relevant topic. The lack of official databases and the difficulty in reaching this population, who frequently fear registering in community health centres, make this review an important contribution. We have not restricted the literature search to studies indexed in databases only, which might have excluded publications outside of these; however, the search in grey literature databases did not yield any results.

CONCLUSIONS

By focusing this study on previous studies of undocumented immigrant women's access to and utilization of health and social services, we have identified different

barriers in the access to social and health care resources that immigrant women encounter. Such access has been further limited since 2012 by native population-centered policies with no humanitarian or utilitarian justification. The breach existing between the general population's perceived uses of services by immigrants, which justified the health care reform in Spain, and the scientific evidence in previous research is made evident in this review. Although only a few studies explore the access of undocumented immigrant women to services, they demonstrate that these women use primary and specialized health care services less often than the native population. If we take into consideration that the data used in the studies were gathered before the 2012 reform, we can only expect this situation to deteriorate. Consequently, not only should the health surveillance of this collective be increased, their reintroduction into social and health care policies should also be demanded.

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Figure

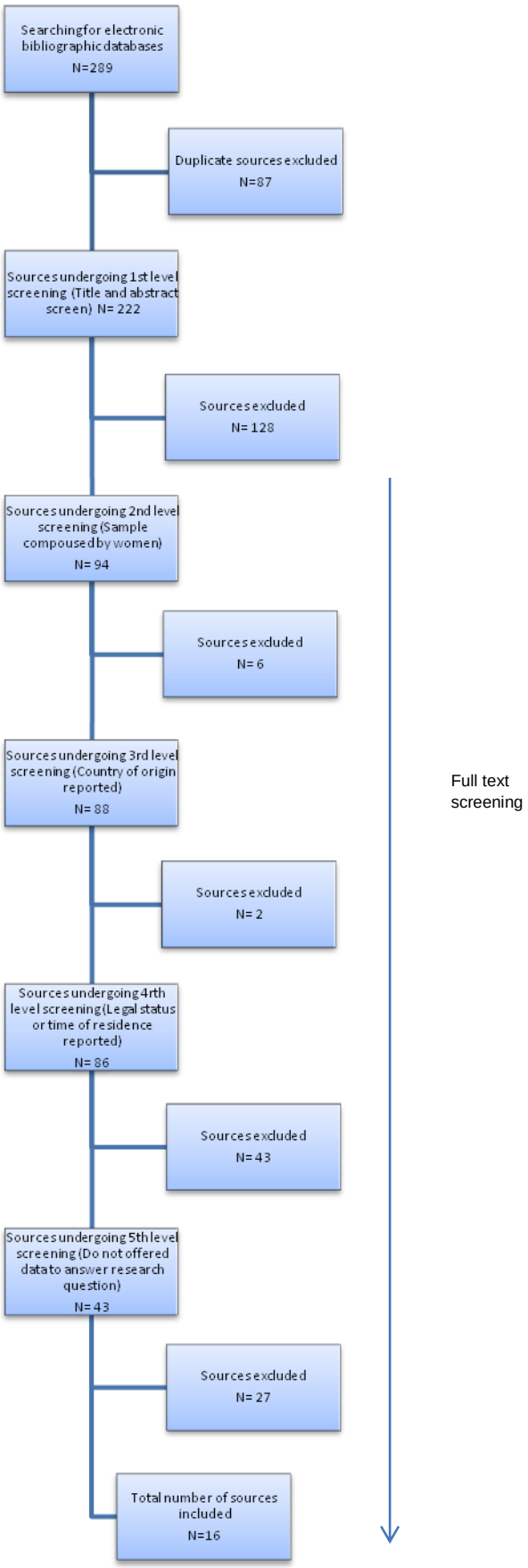

Fig.1 Flow diagram of source data search and selection

Table

Table 1. Search strategy used

Database: Pubmed
("Health Status Disparities"[Majr:NoExp] OR "Delivery of Health Care"[Majr:NoExp] OR "Delivery of Health Care, Integrated"[Majr:NoExp] OR "Healthcare Disparities"[Majr:NoExp] OR "Culturally Competent Care"[Majr] OR "Health Services Accessibility"[Majr:NoExp] OR "Social Care" OR “Health Care” OR Healthcare) AND ("Emigrants and Immigrants"[Mesh] OR "Transients and Migrants"[Mesh] OR migrant*) AND (Access OR Use OR Utilization) AND Spain AND ("2005/01/01"[PDAT] : "2014/31/01"[PDAT])
Database: CinahlPlus
(((MM "Health Status Disparities") OR (MM "Health Care Delivery, Integrated") OR (MM "Health Care Delivery") OR (MM "Healthcare Disparities") OR (MM "Cultural Competence") OR (MM "Health Services Accessibility") OR (“Social Care” OR “Health Care” OR Healthcare))) AND (((MH "Emigration and Immigration") OR (MH "Transients and Migrants") OR (MH "Relocation")) OR (“EMIGRATION” OR “IMMIGRATION” OR “MIGRANT” OR “TRANSIENTS” OR “RELOCATION”)) AND (MH "Spain") NOT (MH “Homeless Persons”)
Database: Scopus
(((TITLE-ABS-KEY("Health Status Disparities") OR TITLE-ABS-KEY("Health Care" OR Healthcare OR Delivery OR Disparities) OR TITLE-ABS-KEY("Social Care") OR TITLE-ABS-KEY("Culturally Competent Care") OR TITLE-ABS-KEY("Health Services")) AND (TITLE-ABS-KEY(Emigrant* OR Immingrant* OR Migrant*) AND TITLE-ABS-KEY(Access OR Use OR Utilization))) AND NOT TITLE-ABS-KEY(Homeless)) AND (LIMIT-TO(AFFILCOUNTRY,"Spain")
Database: Embase
((health status disparities.mp. or exp health disparity/) OR (delivery of health care.mp. or exp health care delivery/) OR (exp health care access/ or health care accessibility.mp.) OR (social care.mp. or exp social care/) OR (healthcare.mp. or exp health care/) AND exp migrant/ AND (access.mp. OR utilization.mp.) AND Spain/
Database: OpenGrey
("health status" OR "health care delivery" OR "health care disparities" OR "health care disparity" OR "health services accessibility" OR “cultural competence”) AND (immigration OR migrants OR transients) AND spain
Google Scholar
(Healthcare OR Health (care OR disparities OR services OR status OR delivery) OR “social services” OR servicios (sociales OR sanitarios)) AND (*migrant* OR inmigrante*) AND (use OR utilization OR acces* OR utilización) AND (spain OR españa)

Table

Table 2. Summary table with main characteristics of the 16 studies included

Citation	Topic	Study Design	Main Findings
[30]	Utilization of dermatology services	Cross-sectional	1. Demand was lower in immigrant population. 2. Immigrants use less surgery and outpatient services and more emergency services. 3. Utilization pattern differed according to country.
[31]	Utilization of Intercultural mediation services	Cross-sectional	1. The main cause for patient referal was contraception. 2. Women from Bolivia presented more vulnerability factors such as unregulated situations (almost 50%), precarious work and no social benefits. 3. Mediators detected 19.7% had social problems and 11.20% of women suffered from gender violence.
[40]	Utilization of maternity health care	Qualitative inquiry (exploratory)	1. The main barriers identified to health-care services were linked to insecure or illegal employment status, inflexible appointment timetables for prenatal checkups and lack of information about services provided. 2. Women use emergency services because of a lack of knowledge or fear as they are undocumented 3.They could not access public nurseries 3. Women acknowledged a poor use of contraceptive methods in planning pregnancies.
[32]	Access and utilization of screening services for Imported diseases	Retrospective observational	1. patients from Sub-saharian Africa had greater infectious diseases. 2. 53.8% of Latin American patients tested positive in Chagas, so at risk of developing a heart condition or mother to child transmission. 3. Highest percentage of patients with new diagnoses is Sub-Saharian Africa 56.6%. 4. Temporary living situation or working conditions are perceived as a barrier in order to perform adequate Mantoux test.

[33]	Sexually Transmitted Infections among Immigrant Female Sex Workers	Cross-sectional	1. Just 30.2% of FSW have legal permits 2. During last 6 months 62.5% and 36.3% of the women had attended health care and social services, respectively. 3. The prevalence of STI is lower than that observed in other European countries. 4. Young age is associated with higher rates of CT and NG
[8]	Access to Social Services	Documental analisys	1.There is a subordinate construction of the social rights of immigrants as job opportunities are largely determined by an unprotected sector. 2. The immigrant population who work and are affiliated to social security have temporary contracts that only entitle them to short periods of unemployment benefit 3. part of the immigrant population work in the informal economy, and only have access to welfare benefits through local councils and social organizations 4. The growing incorporation of Spanish women into the labour market has resulted in a increasing need for caregiving and domestic jobs, where Latin American women are overrepresented and work in precarious conditions.

[43]	Utilization of Health Services	Mix methods	1. 69.7 % have used health care services (42.6% mainly primary health care and 17.7% emergency services) 2. 16.2% were undocumented 3. 14.2% didn't have a healthcare card because they were undocumented, so they didn't know that their right to be a card holder was independent of their legal status. 4. Just 35% used immigrant aid associations 5. The percentage or immigrants that used health care services in the last 12 months was less than the general population
[34]	Utilization of Psychiatric emergency service	Cross-sectional	1. Immigrants use psychiatric emergency services less often than indigenous population. 2. Immigrant subgroup of Latin American is the only one with greater proportion of women and they had more problems related with anxiety in comparison to indigenous. 3. 43% experienced serious social problems presenting more difficulties related to job, family and housing, and in consequence, higher ratios of hospitalization. 4. Immigrants were unlikely to seek medical help for depression.
[35]	Breast cancer screening	Cross-sectional	1. Immigrant women had poorer knowledge, less positive attitude, perceived fewer benefits and had more barriers to screening than native women. 2. Maghrebi women perceived the most barriers to screening 3. Social class, urban/rural setting and cultural differences with country of origin are key contributors to these inequalities.

[36]	Utilization of Health Services	Cross-sectional	1.Immigrant population used less healthcare services except for emergencies. 2. Utilization patterns diferred depending on origin of immigrants and legnth of time in Spain. 3. A higher utilization of emergency services was associated with being a woman and Latin American as a reflexion of cultural patterns and/or gender roles which determine worse health self-perception, higher fecundity and less follow-up in primary health care services.
[37]	Utilization of contraception	Cross-sectional	1. 42% of immigrant women didn't use any contraception. 2. 32% had an abortion and 20% more than one 2. 3.2% had voluntary abortions in comparison with 0.6% of Spanish population.
[11]	Utilization of Gynecological cancer screening	Cross-sectional	1.Immigrant women use less screening programs than native women. 2. The association between place of origin and receipt of mamography was significant.
[41]	Acces and utilization of Primary Care System	Qualitative inquiry	1. Use of Healthcare system is linked to the perception of not being well, knowledge of the healthcare system and length of time resident in Spain. 2. Divergences between immigrants and healthcare professionals are in healthcare education, use of healthcare services and reproductive healthcare and reticence with regard to being attended by staff of the opposite sex demonstrate a need to work with the immigrant population as a heterogeneus group.
[38]	Acces and utilization of Primary Care System	Cross-sectional	1.Contacting Primary Health services is associated with having a chronic illness, taking prescribed medications and being aged between 46 and 55. 2. Utilization and quantity of services consumed varied depending on the origin of the patient, Africans and Central Americans being those with more barriers related with working and living conditions.

[42]	Access to Health Services	Phenomenological	1.Access to health care was considered easy for personal health-care card holders 2. Barriers attributable to the immigrant population (poor knowledge of the system and poor working conditions) and to the system (insufficient information available, organisation, behaviour of healthcare staff)
[39]	Utilization of Health Services	Cross-sectional	1. There was no significant differences in the utilization of health services between documented and undocumented Ecuadorian migrants (Madrid) 2. Working conditions, education level and length of time living in Spain are associated with the utilization of health services.

Table

Table 3. Barriers identified in the studies

Barriers	N	Studies
Poor Working conditions	8	[8,11,32,35,38–40,42]
Cultural differences	8	[30,31,34,36,38,40,41,43]
Language barriers	7	[11,31,34,35,37,41,43]
Time of residence	6	[11,31,32,35,36,39]
Lack of knowledge on her rights	5	[11,40–43]
Legal status	5	[8,11,34,37,42]
Organizations	5	[31,40–43]
Living conditions	5	[30,35,36,38,39]
Lack of knowledge about Spanish health system	4	[11,31,40,42]

COACTION PUBLISHING

Access to and use of sexual and reproductive health services provided by midwives among rural immigrant women in Spain: midwives' perspectives

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Background: There is insufficient information regarding access and participation of immigrant women in Spain in sexual and reproductive health programs. Recent studies show their lower participation rate in gynecological cancer screening programs; however, little is known about the participation in other sexual and reproductive health programs by immigrant women living in rural areas with high population dispersion.
Objectives: The objective of this study is to explore the perceptions of midwives who provide these services regarding immigrant women's access and participation in sexual and reproductive health programs offered in a rural area.
Design: A qualitative study was performed, within a larger ethnographic study about rural primary care, with data collection based on in-depth interviews and field notes. Participants were the midwives in primary care serving 13 rural basic health zones (BHZ) of Segovia, a region of Spain with high population dispersion. An interview script was designed to collect information about midwives' perceptions on immigrant women's access to and use of the healthcare services that they provide. Interviews were recorded and transcribed with participant informed consent. Data were analyzed based on the qualitative content analysis approach and triangulation of results with fieldwork notes.
Results: Midwives perceive that immigrants in general, and immigrant women in particular, underuse family planning services. This underutilization is associated with cultural differences and gender inequality. They also believe that the number of voluntary pregnancy interruptions among immigrant women is elevated and identify childbearing and childrearing-related tasks and the language barrier as obstacles to immigrant women accessing the available prenatal and postnatal healthcare services.
Conclusions: Immigrant women's underutilization of midwifery services may be linked to the greater number of unintended pregnancies, pregnancy terminations, and the delay in the first prenatal visit, as discerned by midwives. Future research should involve samples of immigrant women themselves, to provide a deeper understanding of the current knowledge, attitudes, and practices of the immigrant population regarding reproductive and sexual health to provide better health services.

Keywords: *gender*; *health services accessibility*; *immigrants*; *midwives*; *primary health care*; *qualitative research*; *rural population*; *sexual and reproductive health*; *utilization*; *women's health*

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Research on migrant access and utilization of health services has proliferated in the last decades due to the growth of immigrant population settling into Europe (1). Results point to a lower utilization rate of services by immigrants compared to native-born, although figures display great heterogeneity due to the diversity in host country, place of origin of the immigrants, and the specific healthcare services examined (2–4).

Several authors have associated this lower utilization rate to the commonly healthier status of the immigrant

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population, compared to the native-born, as well as to the existence of barriers to access and use of health services (5, 6). These barriers gain more relevance in rural areas with high population dispersion where the distance to reach health facilities alone limits access and use of services (4).

The fertility rate rebound observed in Spain from 2006 until today (1.38 children/woman) is a reflection of the recent substantial increase in immigration rates (7–11) Immigrant women residing in Spain exhibit different sexual and reproductive health patterns from native-born Spaniards: greater fertility, lower age at first birth, greater rates of premature births and more births to infants with low birth weight (7, 8, 12, 13), as well as a higher proportion of voluntary terminations of pregnancies (VTP) (7, 13).

Despite having quantitative data on these differences, information on access to and participation in sexual and reproductive health programs by immigrant women in Spain is very scarce. Recent studies show a lower rate of participation in gynecological cancer screening programs among these women (14), but little is known about participation in sexual and reproductive health programs, especially among immigrant women living in rural areas. Given this gap in the literature, the objective of our study is to examine the perceptions of the professionals providing these services, the midwives, on the topic. The actual implementation of public health programs is strongly dependent on service providers, who may observe, adapt or completely ignore the programs (15). Their attitudes and practices can enhance or hinder women's access to and use of services. With this purpose, midwives were interviewed regarding access and participation in sexual and reproductive health programs offered in an area with high population dispersion.

Methods

The geographical context of this study is the rural area of Segovia, a province in one of Spain's Autonomous Regions, known as Castile and Leon. This is the largest region in the country and the one with the lowest population density (27 inhabitants/km^2).

About 64% of the population of Segovia (104,895 inhabitants) (16) lives in rural areas composed of 208 municipalities and 17 local authorities. The area has a high population dispersion (28% of the municipalities report fewer than 100 inhabitants) and a low population density (23 inhabitants/km^2) (16). Segovia is experiencing population loss and population aging: 21% of the population is over 65 years of age (16), though this figure is only 12.5% in the receiving immigrant population (16).

Segovia's health area is divided into 16 basic health zones (BHZ), of which three are urban and 13 are rural. Each BHZ has a primary care center where the midwife's office is located. Seven midwives cover the 13 rural BHZ, where one midwife may cover between one and three BHZs.

Based on an ethnographic design, this study focused on primary care and healthcare processes in the rural environment (17). The main author between February 2008 and November 2009 performed fieldwork, including interviews. The qualitative study design included in-depth interviews with seven midwives serving in rural areas. The interview script was designed to collect information about midwives' views about access to and use of midwifery services (18).

After informing the participants about the goals of the study and guaranteeing confidentiality, their consent was secured for participating and recording the interviews. An external expert transcribed all the interviews. The transcriptions of these recordings were analyzed by two of the authors based on the qualitative content analysis approach (19).

The data analysis was developed by two of the authors who first read the transcripts. Then, they imported the text into Open Code software to manage the coding process (20). First, parts of the text relating to the research question were identified (meaning units) and short summarized versions of them were developed (condensed meaning units). From the condensed meaning units, codes were then produced. The codes were grouped together into two emerging categories, which relate to the manifest content of the text. Finally, a theme emerged that cut across both categories and refers to the latent content. During the analysis, consensus about the results was reached among three of the authors. To support this analysis, they also used notes collected during the fieldwork.

In this article, the word *midwife* includes both male and female midwives. The term *immigrant women* indicates women of foreign origin, whom midwives sometimes refer to according to their country of origin as *Moroccan*, *Bulgarian*, or *Rumanian*.

Ethics approval

The research protocol was approved by the Ethics Committee of the Health Institute Carlos III (Spain). This study was funded by National Health Funding Research-project PI 080306.

Results

Results regarding rural midwives' perceptions are organized into two categories: (1) place of origin and socioeconomic situation (being an economic immigrant) and gender (being a woman) affects family planning; (2) there are access barriers to and underutilization of available prenatal and postnatal healthcare services by immigrant women. The theme that combines both of these categories is: midwives' perceptions of underutilization of sexual and reproductive services by immigrant women.

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Culture as the source of difficulties with family planning for immigrant women

According to rural midwives, immigrant populations residing in the rural areas of Segovia hardly engage in any family planning, which midwives interpret as a consequence of 'cultural differences'.

> In this area, immigrants are mostly Bulgarian and Romanian. They don't use contraception [. . .] these are people who you explain things to and maybe you get them to agree with the analysis, or something, and then, they don't do it. They won't take the pill, they won't get an IUD, they don't use condoms . . . and I think it's cultural. (Midwife 4)

> I think that immigrant women do not have the issue of prevention and family planning incorporated. It is true that until they are sick many do not come to me. It can be cultural. (Midwife 3)

When asked to elaborate on what they meant by *cultural differences,* midwives explained that it was the men who decided whether or not to use family planning methods, since they often held negative attitudes regarding taking any action around contraception and whether it is for the woman or themselves. Thus, the decisions of men prevail over women's decisions.

> Many are influenced by their husbands, their partners. They tell you that their husbands are in control. Then, you feel very frustrated. I ask them- What about an IUD? No, my husband doesn't want me to get an IUD. –What about the pill?- No, my husband doesn't want me to take anything. –Well, then tell your husband to use a condom- But he doesn't want to use a condom either. (Midwife 2)

> Immigrant women know about contraceptive methods because I explain to them when they come to see me, but for them it is easier not to use anything. Their partners don't even want to use a condom. (Midwife 5)

Less often, midwives perceived that immigrant women used family planning methods but without their partner's knowledge. This shows the decisions of men are above the decisions of women, gender inequality is evident in this case.

> A few of my patients took the pill without their partners' knowledge, but those are the exceptions. (Midwife 7)

> Some women tell me they want to plan their families, but they do not want their partners to know, because they (the partners) do not want to plan. (Midwife 6)

Midwives asserted that if a few immigrant women and their partners used family planning methods, they would serve as an example within their close social circle.

> If one started to use it they would encourage others, because here in Spain, 40 years ago no one took the pill and if anyone did, they were told: 'Oh no, that's really bad for you, it causes cancer, you grow hair, you gain weight.' Whatever their friend tells them always works better than anything that I tell them. (Midwife 1)

> When an immigrant woman starts to come to the office to plan then her sisters come, then her sisters-in-law . . .. (Midwife 5)

When faced with an unintended pregnancy VTP is one of the options considered by immigrant women. Midwives reported that VTPs are more common among women from Bulgaria and Romania as a consequence of the family planning policies in these countries, which are based on easy accessibility to VTP. In this way, midwives made references to the social, cultural, educational differences in immigrant women's notion of VTP, pregnancy, and family planning.

> I have realized that Bulgarian and Rumanian women use abortion as a method of family planning. (Midwife 2)

> There are countries like Bulgaria and Romania, where family planning was based on voluntary abortion. Abortion was promoted, and I believe that makes it less important to go for a visit to check there are no problems with the pregnancy, similarly, they don't have the same take on contraception that we do. (Midwife 3)

Some of the midwives pointed out that immigrant women did not always go to specialized centers to carry out these procedures (VTP), among others, but instead, some searched for alternate strategies despite the risks.

> There is a medication, not sure they all know about it, but I'm convinced they get it. It's sold on the internet. I visited the site once and they give you addresses and phone numbers. I bet that they are selling it. It's used in the hospital environment for the stomach, but, of course, you're in a controlled environment. There's a risk of hemorrhaging, they may start bleeding and, just imagine, they think they've got it all out but a portion stays in, and can cause an infection. I've been asked for it, and the ones that ask for it are foreign women. Not Spanish women, which doesn't mean they don't know about it. (Midwife 3)

Midwives explained that these VTPs were performed either in Spain or in the immigrant women's country of origin, and that they (either themselves or their partners) bore the expenses.

> There are Bulgarian women who go to Bulgaria for abortions. (Midwife 1)

> Sometimes they abort here. Others go to their own countries, because, it's probably cheaper in their own country. Of course, here they might not be eligible for a legal abortion and they have to go to private clinics. That is why I think it's cheaper for them to go to Bulgaria. (Midwife 7)

Finally, midwives perceive that most of the teenage pregnancies occur among immigrant women.

> I do not see many teenage pregnancies, but the few I see if there are more percentage in immigrant women. (Midwife 1)

> Most of the teenage pregnancies we see are Romanian women from Rumania. (Midwife 4)

Rural midwives perceived difficulties of access and use of prenatal and postpartum services among immigrant women

Midwives perceive that immigrant women make use of midwifery services mainly during pregnancies.

> The only time when you really see a much higher proportion of immigrant women is during pregnancy. You don't see them during menopause, nor for contraception, but you see a few in Pap Smear and cervical cancer prevention programs, however during pregnancy is when you see them most. (Midwife 4)

> For instance, I see Moroccan women in my office during their pregnancy and for post natal consultations, but I see them a lot less for pap smears. (Midwife 7)

However, midwives detect an underutilization of prenatal visits, which translates into a delayed first prenatal visit.

> When Spanish women know they're pregnant they have the habit of going to their doctor or to the nurse, or the midwife, but they go to the health center. Immigrant women sometimes leave it longer. (Midwife 5)

> There are women, especially Moroccans, who leave it longer to come. That's my experience. I think that if they come from a place where healthcare is not as accessible, then they are not used to going for medical care, and miss the usual first prenatal visit. (Midwife 6)

Regarding the program offering maternal education classes, midwives perceive that immigrant women use this program to a lesser extent than native-born women. Some of them compared immigrant women to women of Romany ethnicity.

> About childbirth preparation group, sometimes I get that some Bulgarian or Moroccan women come. It is difficult to grasp them for activities like that. (Midwife 6)

> They hardly come to the childbirth courses I offer, and if they attend one class, then they drop out. I'm not sure whether it is because it's silly, or because they can't follow it. You talk to them and then ask: - Do you understand? - and they answer affirmatively, but … It's the same thing with the gypsies, they don't come either. Maybe they think it's useless information, or they have other children to look after, or they have other things that prevent them attending …. (Midwife 4)

Once again, midwives explain away this underutilization of their services based on 'cultural differences' regarding prenatal care. Some report that immigrant women think of pregnancy as a natural process which requires little supervision. Additionally, some midwives link this idea of immigrant women exhibiting an underdeveloped preventative culture with the fact that the immigrant population living in rural areas has a low socio-economic level. Other midwives talk about how women, in particular Moroccan women, do not attend these group activities because their husbands do not allow them.

> Moroccan women relate to their children, with her husband, and very little with the rest of the people. I think we have a hard time doing group activities. I think they have restrictions by such husbands to attend childbirth preparation classes. In their culture the woman is in the private sphere. (Midwife 1)

> It could be that for them pregnancy is not such a big deal … I don't mean they don't think it's important, but that they don't see the need for so much vigilance; it's something natural, and nothing will go wrong. In their country of origin they do go to be seen, I mean that they do follow the prenatal care. In Romania and Bulgaria for example, they do go as after all those countries are not so underdeveloped. As many people point out, the issue is that this type of immigrant is not their country's average citizen, but come from a lower social background; therefore culturally, prevention and care are lower. (Midwife 5)

Midwives explain that immigrant women sometimes skip scheduled appointments with them as well as with obstetricians in specialized care, going without some of the diagnostic tests in the prenatal protocol.

> Immigrant are less reliable with their appointments, often they don't turn up, then they arrive without an appointment expecting to see you whenever it suits them, and things can get a bit chaotic. Of course there are all sorts of people, but you do see this more often with immigrants. (Midwife 4)

> They are not as reliable when it comes to appointments; they are less likely to show up. Then they come with no appointment to be seen when it suits them, and this creates a degree of chaos. Many people do it but it is more common among immigrants, and especially within the Bulgarian population. (Midwife 7)

Some of the midwives point out that these sets of behaviors distinguish immigrant women from native-born women, except in those cases when native-born women live in socially dysfunctional situations.

> Access to healthcare is relatively easy. If they don't go it's because they don't want to, because as

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> sometimes happens with these women (immigrants) they don't even show up for blood test and miss hospital appointments … It's not all of them, but you don't see Spaniards doing that, and if you do, it's usually an isolated case with a family with issues. […] If you have six such cases per year, five are foreigners and one is not. (Midwife 2)

Finally, midwives also refer to language limitations as an access barrier for women from non-Spanish-speaking countries. Language limitation also results in these women's partners or their own children assisting with any communication with health professionals.

> We get many from Morocco, the majority. We always give them, books about pregnancy and all that for them to read, although we mostly communicate with the husbands who know more, are more up-to-date, or with the kids, who speak very well. (Midwife 1)

> Today I started a childbirth preparation group which should have like ten women, some of them immigrants. […] It is difficult to grasp for group activities for different reasons. One is the difficulty with the language, the language barrier. (Midwife 6)

Discussion

The reproductive patterns described by the rural midwives in our study reflect official figures (7, 8). Data published by INE (Spanish acronym for the Spanish National Institute of Statistics) support the perceived high rates of VTPs that midwives believe their patients endure. These data show that in 2010, 41.7% of all VTP were performed on immigrant women (21), which is a very high percentage considering that in 2010 only 13.4% of women residing in Spain were immigrants (16).

In addition, the number of VTPs recorded among these women may be underestimated since, as the midwives indicated, some of these procedures are performed in the immigrant's country of origin, or in Spain but outside the public healthcare system. Finally, midwives argued that women from Eastern Europe choose VTP because this was a common practice in their countries of origin, encouraged by the legislation originated in those popular democracies (22).

Considering that 31.9% of adolescent pregnancies occur among immigrant women (23); that immigrant women have higher rates of VTP and higher fertility rates than autochthonous women (1.61 births per immigrant woman vs. 1.33 children per Spanish-born woman); that birth rates are also higher among immigrant women (17 immigrant mothers per 1,000 inhabitants vs. 9.5 Spanish-born mothers), we can say that there are family planning deficiencies among immigrant women.

According to the midwives the underutilization of family planning services, also described in relation to the cervical cancer prevention program elsewhere (2, 3, 14) is, again, likely related to cultural differences, the main barrier being the male partner's opposition, due to gender inequality (24), and to certain family planning practices.

It is worth noting that rural midwives do not think that the distance from the immigrants' municipality of residence to the rural health center is a barrier when seeking midwifery services. The fact that this potential barrier, observed and documented in previous studies (4, 25), fails to be perceived as an obstacle may reflect the existence of the communication difficulties between midwives and immigrant women. It is also possible that the women who do go to the midwife's office are those with no access barriers or those who managed to overcome them. However, the fact that midwives fail to perceive certain barriers to access and use of healthcare services already identified by different studies carried out in the same geographic environment (14, 25) may indicate a 'blaming the victim' attitude toward immigrant women. This viewpoint could prevent the launching of strategies aimed at improving access as well as utilization.

In summary, the midwives in our study equated the pattern of delayed access and underutilization of care often found in immigrant women with that of women of Romany ethnicity. That is, they identified immigrant populations with other groups at risk for social exclusion, as reported in a recent study (14). Furthermore, the association that these professionals made between low socio-economic level characteristic of the immigrant population and an underdeveloped preventative culture (these last one originated by the fact that they proceeded from low-income countries with limited preventative programs) has also been reported in quantitative studies as an association between lower socio-economic level and a lower utilization of preventative services (8, 26).

Regarding the underuse of maternal education programs, midwives emphasized the communication difficulties, specifically the language barrier, as an obstacle to access and use of such programs, as previously described by other authors (27, 28). They also identified the burden of childcare and childrearing, mostly the woman's responsibility in these immigrant populations, as a potential access barrier to prenatal care and services. This finding may be an indicator of how immigrant women's health is negatively impacted by the absence of the support received from traditional family and social network (29, 30).

Finally, it is important to comment that while this study provides evidence about midwifes' perceptions on access to and use of midwifery services, it does not include the perceptions of the immigrant women users of these services. It is important to underline that research about immigrant women's perceptions would provide key insights into areas glossed over under culture by the midwives, and it could be an interesting area for further research.

Conclusions

This study revealed perceptions of an underutilization of midwifery care among immigrant populations residing in the rural area of Segovia. According to the midwives working in rural primary care, this underuse results in unintended pregnancies, possible VTPs, and in delayed prenatal care. Further research is needed to gain a deeper understanding of the current knowledge, attitudes, and practices of the immigrant population, both men and women, regarding family planning, voluntary pregnancy interruption, and prenatal care to better match the supply and demand. Therefore, it is also necessary as appropriate delivery of reproductive and sexual health services for the immigrant population residing in rural areas of Segovia.

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Conflict of interest and funding

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Health & Social Care in the community

"Access and utilization of social and health services as a social determinant of health: The case of undocumented Latin American immigrant women working in Lleida (Catalonia, Spain).

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Abstract

Although Spain has social and health care systems based on universal coverage, little is known about how undocumented immigrant women access and utilize them. This is particularly true in the case of Latin Americans who are overrepresented in the informal labour market, taking on traditionally female roles of caregivers and cleaners in private homes.

This study describes access and utilization of social and health care services by undocumented Latin American women working and living in rural and urban areas, and the barriers these women may face.

An exploratory qualitative study was designed with 12 in-depth interviews with Latin American women living and working in three different settings: an urban city, a rural city and rural villages in the Pyrenees. Interviews were recorded, transcribed, and analysed, yielding four key themes: health is a tool for work which worsens due to precarious working conditions; lack of legal status traps Latin American women in precarious jobs; lack of access to and use of social services; and limited access to and use of health care services. While residing and working in different areas of the province impacted the utilization of services, working conditions was the main barrier experienced by the participants.

In conclusion, decent working conditions are the key to ensuring undocumented immigrant women's right to social and health care. To create a pathway to immigrant women's health promotion, the "trap of illegality" should be challenged and the impact of being considered "illegal" should be considered as a social determinant of health, even where the right to access services is legal.

Keywords: *access to health care; utilization; gender and inequality; inequalities in health and health care; migrants; employment*

What is known about this topic:

- Although Spain offered national social and health care systems based on universal access, immigrants underused them.
- Migrant workers are disproportionally affected by and exposed to risks in the work place.
- Research has shown that language, fear of deportation, and being a "newcomer" constitute barriers to access and utilization of social and health care systems.

What this paper adds:

- The main barrier to access and use of social and health care systems in the case of undocumented Latin American women are their working conditions, which are linked to their lack of legal status.
- Living in a rural area facilitates registering for a health card with local authorities and accessing the health care system.
- Gender stereotypes and lack of legal status legitimize, naturalize and perpetuate precarious employment among undocumented Latin American women.

Introduction

The International Organization for Migration (2011) estimates that there are 214 million international migrant workers around the world. Since the United Nations National Assembly proclaimed health care as a human right in 1966, all countries are supposed to provide equal access to health care services for their population (Schoevers *et al.* 2010). However, specific legislation and regulations make access to health care for immigrants problematic in many countries (Rousseau *et al.* 2008, Devillanova 2008, Ravinetto *et*

*al.*2009, Gastaldo & Magalhaes 2010, Ruiz-Casares *et al.* 2010, Galarneau 2011, Sebo *et al.* 2011).

European policies are ambiguous in this regard. While restrictive immigration policies are enforced, criminalizing the arrival, stay and employment of undocumented workers (Thomsen 2012), in 2011 the European Parliament adopted a resolution to reduce health inequalities in the European Union, calling on member states to tackle inequalities in access to healthcare for undocumented migrants (European Parliament resolution 2010/2089(INI)) following pressure from a petition of over 3 million healthcare professionals.

Evidence has shown that migrant workers are disproportionally affected by and exposed to risks in the work place, and this is particularly true in the case of undocumented migrants who are usually employed in "3-D" jobs ("dangerous, dirty and degrading") in under-regulated sectors, such as domestic and agricultural work (Magalhaes *et al.* 2010, Vives *et al.* 2011, Benach *et al.* 2011, Gastaldo *et al.* 2012). The European Parliament's Committee on Employment and Social Affairs (2011) pointed out that the situation of domestic workers, many of whom are immigrant women, is particularly difficult. Many of them are impacted by physical and psychosocial problems, but data about their situation is minimal.

Although Spain has a national healthcare system model based on universal access, restrictive migratory policies have been adopted in response to European Union pressure and as governmental reaction to the post-2008 economic crisis. Until 2012, the Organic Law 4/2000 on rights and freedom of foreigners in Spain (Ley Orgánica 4/2000) acknowledged the right for immigrants who were registered in the municipal census to obtain a health service card and assistance regardless of their status. However, some studies have shown that fear of deportation, being a "newcomer", language

barriers, and other problems could be obstacles for non-status migrants to access health care (Rousseau *et al.* 2008, Cohen 2009). In order to make visible this phenomenon, the aim of this study was to describe how undocumented Latin American women working and living in the various regions of the province of Lleida access and utilize social and health care services, and describe the barriers they faced.

Characteristics of immigration to Spain

In the 21st century, immigration to Spain has been characterized by rapid growth in and concentration of immigrants. In one decade, Spain acquired the second highest number of foreign residents in Europe, only surpassed by Germany. In addition, immigrants are concentrated in particular regions of the country. For instance, Catalonia is the autonomous community with the largest immigrant population (21% of the total) with over a million people (Càtedra Repsol de Competitivitat i Desenvolupament Regional 2013).

This concentration responds mainly to opportunities in the labour market, which clearly becomes a labour stratification mechanism according to nationality, gender and area of activity, resulting in an over-representation of immigrants in agricultural and domestic employment (Moreno Fuentes & Bruquetas Callejo 2011). Regarding the latter sector, Latin American women now take on the role of caregivers and home cleaners, which coincide with the increased incorporation of Spanish women into the labour market (Bover *et al.* 2011).

Access and utilization of health and social services by the immigrant population in Spain

Unlike most European countries, Spain granted undocumented workers access to social and health services between the years 2000 and 2012; access to a health card was conditional to registration in the municipal census, a fairly simple process in many

cities. However, Non-Governmental Organizations (NGOs) reported that there were informal barriers that prevented access to services (WHO 2010, Doctors of the World 2013).

Most studies in scientific literature that focus on access and utilization of health services by the immigrant population in Spain, show a lesser utilization of services such as hospital emergency services, primary health care, and pharmaceutical expenses, compared to the local population (Soler-González *et al.* 2008, Hernando Arizaleta *et al.* 2009, Regidor *et al.* 2009, Ben Cheikh *et al.* 2011). However, these studies do not offer disaggregated data according to immigration status.

Although it is true that the immigrant population is young and, as a consequence is expected to enjoy better health, there is evidence showing that their (physical and mental) health status worsens once in the host country, mainly due to the characteristics and demands of their labour activities (Borrell *et al.* 2008, García Mainar & Montuenga Gómez 2009, Aerny Perreten *et al.* 2010, Benach *et al.* 2011, Casado-Mejía *et al.* 2012). With regard to social services, the situation is worse. Given immigrants' low and unstable income and their limited social and family networks, it would be expected they would utilize many social services. However, the data provided by Moreno & Bruquetas (2011) show that from the total number of social services interventions in Spain in 2008, only 6.85% occurred in the immigrant population. The latest data by the Ministry (MSPSI (España) 2012), corresponding to 2009, reveals that 86.31% of social services users are Spanish citizens.

Conceptual framework

Globalization has intensified migratory movements which have been accompanied by a feminization of labour, including more women getting better paid jobs who in turn need other women to perform caregiving and domestic work, given men's limited

participation in unpaid domestic work in most societies (Bacon 2008, Standing 2011). These jobs are performed by the new precariat – a class of mobile, cheap migrant workers who have minimal rights and social protection (Standing 2011, Gastaldo *et al.* 2013).

In the current nation-state political spectrum, status may vary from full citizen to illegal alien. These socio-political actors establish different economic arrangements in the public and private arenas, but those who lack legal status or those who have their status changed over time are the ones whose social determinants of health are heavily impacted by these circumstances (Gastaldo *et al.* 2013). Van Schendel & Abraham (2005) and later Thomsen (2012) developed a model that illustrates not only the dynamic nature of legal status, but also reveals how ethical values shared by the citizens of host nations, socially accepted practices, and government policymaking all play a role in creating inclusion or exclusion of immigrant workers.

According to this model, the concept of compliance can help us to understand how immigrant workers are situated in different social locations depending on whether they fully, partially or do not comply with host nations laws regarding residence and work. While those who are legal immigrants have their status approved by state laws, those who lack legal status may be socially legitimized and, as a consequence, can have variable social positions, depending on the values of the community and society in which they reside. For instance, some citizens consider any form of work as noble and licit, despite not being legal (Schendel & Abraham 2005, Thomsen 2012).

These shared values on work and migration are then intersected by ideas about gender, race, and nationality, creating a complex post-colonial set of relations that legitimizes or naturalizes precarious working conditions or access to health care as acceptable for some groups, but not for others.

This variability results in a field of tension when what is considered legal comes into confrontation with what is accepted as licit, giving place to situations of civil disobedience, such as those experienced in Catalonia during 2012, when the Spanish state passed the Royal Decree Law 16/2012 establishing urgent measures to improve the quality and safety and ensure the sustainability of the national health care system (Real Decreto-ley 16/2012, de 20 de abril), which explicitly excluded undocumented immigrants from accessing health care. However, in Catalonia, undocumented migrants were allowed to retain their rights preceding the introduction of the aforementioned law (Llei orgànica 6/2006, de 19 de juliol, CatSalut 2012, Recurso de inconstitucionalidad n.º 414-2013).

Methodology

This study was conducted in the province of Lleida, which is part of the Catalan Autonomous Community (Spain) and the second largest province in Spain. It has the lowest population density in Catalonia (36.4 inh/Km^2). In Lleida, 54.68% of the population lives in rural areas (municipalities with less than 10,000 inhabitants). Of those, 23.64% of the population live in municipalities with less than 2,000 inhabitants, and 31.04% in municipalities with between 2,001 and 10,000 inhabitants (IDESCAT 2013). Lleida is one of the top 10 Spanish provinces with the highest immigrant population per total population (18.24%, higher than Madrid and Barcelona), largely because of the jobs created by agricultural and farming industries (Map1).

An exploratory qualitative study (Hesse-Biber 2006) using in-depth interviews with 12 undocumented Latin American immigrant women living and working in three different settings was conducted: an urban city (more than 100,000 inhabitants), a rural city (9,000 to 11,000 inhabitants) and rural villages of the Pyrenees (less than 1,000 inhabitants). Given the exploratory nature of this study, different settings were chosen

to examine whether place of residence was also a factor to be considered when studying access and utilization of services for undocumented immigrant women.

An immigrant woman working as a Cultural Mediator (CM), who was previously undocumented herself, recruited one urban and one rural undocumented Latin American woman. The recruitment proceeded through a snowball technique. Interviews were conducted in participants' homes for approximately 90 minutes by the interviewer and the CM in a dialogical manner to make participants feel comfortable. Institutional settings were avoided because they could inhibit an open conversation about social and health care services. The participants' age ranged from 19 to 52 years old, the average educational level was high school, and they had been living in Spain between 2 and 13 years, some never had legal status, while others lost it (see table 1). The fieldwork was carried out by the first author (MG) between September and December 2011. The interview guide included topics on migratory process, legal status, working conditions, perception of their own health and access to and use of health and social services. The interviews were recorded and transcribed and field notes were incorporated into the verbatim. After preliminary analysis, the first author (MG) identified considerable repetition of data and considered that saturation on the key issues of the study was achieved. Data analysis consisted of several procedures (Silverman 2013) including: first, line by line coding of all data; second, grouping of ideas emerging from this inductive analysis under subcategories; third, refinement of the coding system and subcategories; fourth, identification of central themes presented in our findings; and fifth, verification of the analysis by a researcher (LO) who did not participate in data collection.

Prior to the interview, participants were asked for oral informed consent and were given written information about study objectives, confidentiality, and recording of interviews.

The participants' names, their cities/villages, and the services they have used were omitted or replaced by pseudonyms in order to preserve confidentiality; this was especially important for participants residing in rural villages.

Findings

Four main themes emerged describing access and utilization of social and health care services and the barriers that Latin American women faced: health is a tool for work which worsens due to precarious working conditions; lack of legal status traps Latin American women in precarious jobs; lack of access to and use of social services; and limited access to and use of health care services.

Health is a tool for work which worsens due to precarious working conditions

All participants considered that having good health equates to having a stable job. They had certain difficulty talking about health in abstract terms. Having good health was described as a social concept. Health assures the ability to work and to obtain income to cater for the people participants are responsible for (children and/or parents), as explained below:

"I feel healthier and better when I have a job, when I know I can provide for my daughters (...). I'm concerned about my health, because unless I work I cannot send anything to Bolivia for my daughters". (Ana, urban city)

"(...) I came to earn money to pay for our children's studies. I had an accident and my health is now frail (...). I'm worried about what may happen, because I will not be able to work and send money to my children." (Santiaga, urban city)

Participants indicated a decrease in their health status after migration. In the case of immigrants living in villages, this loss is described in terms of physical health while in

the case of immigrants living in rural and urban cities, the deterioration affects both physical and mental health.

"While I was living over there [country of origin] I never fell ill. Never. Now my hips are sore all the time. Always. (...) I never knew what it was to be depressive and here... it happens all the time." (María, urban city)

This worsening health status is explained by the radicalization of the precarious working conditions experienced by the participants. All of them began their immigration journey in Spain caring for seniors, having a stable wage, even though those who resided with their employers had several experiences of exploitation and did not want to ever go back into *bonded labour* (working and residing at the employers' property). Later, due to the effects of the economic recession or the death of their care recipients, participants moved into a combination of part-time jobs, cleaning private houses, restaurants or hotels or looking after children and elderly people. These jobs were characterized by unpredictable schedule, income insecurity, and lack of benefits derived from stable work, such as the right to in-service training or measures for reducing risks in the workplace.

"I'm looking after a couple of elderly people in the hospital [rural city]. I go every day to feed them and give them their medication (...) on top of this job, I clean houses. This morning I have worked 5 hours, but every day is different. I also did work for the Town Council of [Rural Village]." (Juana, rural city)

"When something needs to be cleaned more thoroughly… I use "salfuman" [caustic soda] or a fat remover that is very strong […] Products are the difficult bit of cleaning […] Nobody has taught me how to clean: women seem to be born knowing how to clean. (...) I don't use anything to protect myself." (Andrea, rural village)

The participants revealed that public and private employers alike, and the immigrant workers themselves, assume caring and cleaning work as gendered activities that are intrinsically known by women and undervalued socially and economically.

Lack of legal status traps Latin American women in precarious jobs

As suggested above, to be healthy is to be able to perform a job and participants tie the possibility of finding a stable job to their legal status. Participants described having lost many job opportunities because they were undocumented. They felt that a vicious circle is generated, since being undocumented they cannot get jobs with a legal contract and social benefits, and thus they are trapped in the underground economy, where jobs have no labour rights and workers live in fear of being discovered and penalized.

"what worries me is my health and my papers [legal permit] (...) because my first application for residency has been rejected (...). I had to turn down many job offers because I didn't have the papers". (Juana, rural city)

"I had problems in my job because I had no papers. I was working in a hotel; I had to hide all the time. Always running away from someone or another: this is slavery." (Miguela, rural city)

Some participants have always lived in an irregular situation, while others lost their legal status as a consequence of the economic recession:

"When I lost my papers… everything went awry (…) I would like to go back to doing what I was doing when I had my papers: catering. I love being a waitress. But now they only call me for fairs (…)" (María, urban city)

Participants described having lost many opportunities for employment because they are undocumented, and also accepting jobs without negotiating working hours or salary.

"I'm getting by with what I have. If I had papers I would find better and steadier jobs. (...) Yes, I work on an hourly basis, you know. In the hotel,(...) sometimes I do houses. It varies, as it's on an hourly basis, the day that there is work." (Laura, rural village)

It should be noted that women with children were particularly vulnerable to situations of oppression, abuse, and racism by their employers or care recipients.

"...because in some jobs..., in one there was some racism (...), they humiliated me, well... I needed money to send to my children. The kids [care recipients] used to beat me (...). In Madrid they called me "fucking immigrant" in one house (...) the elderly for whom I worked." (Santiaga, urban city)

In spite of more work opportunities and wage stability, situations of abuse arose much more often in *bonded labour*. The main problems were sleep deprivation, lack of food, and no free time to rest:

"(...) the man had dementia (...). I slept in a room next to the man's and he knocked on the wall every two hours for attention. That work was 24 hours a day during 3 years. (...) They told me they would legalise my papers, but they never did." (Josefa, rural city)

As reported above, employers also used the promise of legal permits in order to retain women in precarious jobs.

Lack of access to and use of social services

Latin American women living in rural settings verbalized they had never tried to access social services, while the rest of participants did try, but could not use these services because of their legal status. Participants living in cities reported that the lack of legal status not only shaped government institutional policies, but also NGOs because they too just provided social services for documented immigrants.

"I can't get unemployment benefit, and can't go to the social worker all the time. She won't give me anything."(María, urban city)

"(...) and from social services I went to the Red Cross. I went many times. They said they'd call me, but they never did. I went to Cáritas in [rural city] and the same thing happened. The girls at the Red Cross said if I had papers I would be working already. But I don't have them, and she said she couldn't do anything, that they had their hands tied." (Miguela, rural city)

Additionally, participants who have tried to use social services expressed their frustration and channelled it by blaming social workers for the decisions made, failing to see that social workers were constrained by governmental or institutional policies:

"She could have helped me, at least with the food for the house or something... she helped a lot of people, but not me, she said she couldn't." (Denise, urban city)

Of all participants interviewed only one was able to use social services, in particular to get additional food, but this may have been because of her husband and sons' legal status.

"We had applied for supplementary economic assistance that the social worker had told us about. She said she could present our case because we're a large family and my husband and my children have papers and he's unemployed. (...) They give you 3 packs of milk and something else, but this is not enough (...) I went to the Red Cross because the food they gave us was insufficient; in the food bank they give you more rice and flour. But there's not even the basics, I mean, the kids want yogurt, sugar (...) basic things. I went [to the Red Cross] and she said the social worker had to refer me there, but the social worker well...she can't or she says no (Carmen, urban city)

Participants did not understand the rules that were being applied to different cases and were excluded from any form of social services.

Limited access to and use of health care services

The Latin American women interviewed indicated differences in registering and accessing the health care system according to place of residence. Participants who lived in rural settings described an easy process to obtain their health card, while those who lived in larger cities faced difficulties both to get their health card and in accessing health services. Lack of knowledge about how to register was not a barrier.

The barriers described included employers and landlords who refused to sign a contract to avoid paying taxes (and therefore women could not demonstrate their residence in order to obtain a health card) and administrative staff in hospitals, who "administratively screen" emergency clients.

"In Barcelona I lived in a room, and the owner of the apartment didn't want to register me, therefore I could never have a card. I only managed to register and get a health card here, in [rural village] (...) sometimes I have been to emergency, but they asked me for my card, on some occasions they didn't assist me. (Laura, rural village, talking about her previous experience when living in Barcelona)

However, being a card holder and living in a rural village did not guarantee access to health services either. Some participants could not afford the time or cost of travelling between the rural villages of the Pyrenees and the referral hospital (three-hour journey by public transport in good weather conditions).

"(...) at the beginning I was worried because it was hard to get an appointment and go to [urban city] to get tests done, because we couldn't get them done here." (Andrea, rural village)

In spite of the importance of the geographical area, the main barrier to the utilization of healthcare reported by participants was in relation to precarious working conditions and abusive employers. A single day off work represented losing a day's pay, but also carried the threat of being fired. Labour precariousness was more extreme again in the

case of *bonded labourers,* as their employers sometimes even denied them their right to access primary health care services, and made them work while sick:

"(...) I was off for a day, one Sunday, every fortnight and if I wanted to go to the doctor, the lady [the boss] said it had to be on that day. My back was very sore..." (Josefa, rural city)

Taking into account access barriers, the use of health care services in the case of participants who lived in rural villages was basically limited to the local primary health care centre. A few cases though were referred to the provincial hospital, when deemed necessary. The reasons for consultations were limited mainly to acute physical problems (e.g. stomach haemorrhage, back pain, etc.) and reproductive services and pre-natal care.

"*Once I went to the health centre because my face became swollen. (...) I was supposed to have some allergy tests done [at referral hospital], but I never went back.*" (Maribel, rural village)

Participants who lived in cities used the health system for physical and mental health problems. For the latter, they were not referred from primary health care to specialised centres.

"(…) *well, I have become very nervous. I have depression and anxiety problems. Before the baby, I was taking pills that the family doctor gave me, but when I got pregnant I gave them up.*" (Carmen, urban city)

Regardless of the geographical area, as Maribel and Carmen reported, once the acute stage of the disease is over, participants had limited follow-up and adherence to treatment. Once they were able to work again, they went back into their labour activities.

Discussion

In this study, we have identified that for undocumented Latin American women living and working in the province of Lleida, irrespective of region, the main barrier to accessing social and health services is precarious working conditions in caregiving and cleaning occupations. The intersection of several social determinants of health, in particular precarious working conditions associated with lack of status, nationality/race, and gender, places them in a vulnerable situation that is detrimental to their physical, mental and social health.

Over the last decade, scientific literature exposed immigrants' poor quality of life as well as physical and mental suffering as consequences of their precarious work in Spain (Borrell *et al.* 2008, García Mainar & Montuenga Gómez 2009, Ahonen *et al.* 2010, Sanchón-Macias *et al.* 2013). However, since the economic recession started, poor employment conditions and fear of unemployment have increased presenteeism (working while sick) and discouraged health-seeking behaviours (Galon *et al.* 2014, Ronda Pérez *et al.* 2015). The experience of other immigrants corroborates the description provided by our participants, who self-assessed their health as "able to work" –their sole indicator of good health.

In the informal labour market of cleaning and caregiving, occupational precariousness is socially reproduced because these jobs traditionally do not allow immigrant women to acquire legal status (Hondagneu-Sotelo 2001, Briones Vozmediano *et al.* 2014). In the context of the Spanish recession, study participants lost full-time jobs and were left with multiple part-time jobs, which according to Thomsen's model (2012), moved them from a position of "compliance" or "semi-compliance" to "non-compliance", and therefore, "trapped in illegality" and vulnerable to exploitation (Miklavcic 2011).

The fact that they were women and "Latinas" legitimized labour segmentation and

naturalized domestic activities as their occupation (Fernández & Ortega 2007, Porthé *et al.* 2010). The old colonial order still provides justification for exploitative relations, especially when nationality and race are seen as analogous to subalternity (Hondagneu-Sotelo 2001, Federici 2010, Bianchi Pernasilici 2014). Even though study participants seldom referred directly to racism, but rather spoke in generic terms about humiliation and discrimination, conceptually, they were talking about the colonial logic of servilism, which is supported by racism and sexism (Federici 2010, Agudelo Suárez *et al.* 2011, Bianchi Pernasilici 2014). It is paradoxical that Spanish women's liberation from caregiving and cleaning duties have been achieved in part at the expense of third world migrant women's rights and health, most of them their former colonial subjects (Domínguez Mujica & Guerra Talavera 2006, Ahonen *et al.* 2010, Briones Vozmediano *et al.* 2014).

In this context of neo-colonialism and non-compliance, trapped in illegality, access and utilization of social and health services was very limited. However, at the time data was being collected, Spain (together with other European countries, such as Italy and Portugal) was held as an examplar of good practice, with a legal framework that acknowledged full rights for undocumented immigrants to access social and health care services (Dias *et al.* 2011, Rechel *et al.* 2011). Our participants' reveal that access did not happen in the intended manner, that is: "providing the right services at the right time in the right place" (Rogers *et al.* 1999). Considering this definition, from resource allocation to actual service utilization, there was a clear service failure for undocumented Latin American women (Tanahashi 1978).

In the case of social services, the principles of social protection were breached when undocumented workers were denied access and coverage at a time of especial vulnerability. Data provided by the Colectivo IOÉ (2012) revealed that half of all

foreign workers fired in the last few years had no right to welfare protection, and consequently poverty and exclusion rates have dramatically increased for this group (Otazu Urra 2012).

The current policies of both the national and the autonomous communities transfer social assistance responsibility to NGOs which have been overwhelmed in recent years by requests for assistance with an increase of 170%, going back to the levels of the 1980s in the form of soup kitchens (Cáritas Española 2012). In the particular case of this study, NGOs did not provide any assistance to participants.

Regarding health care services, geographic location plays a role in access to services. In rural villages, for instance, there seem to be fewer administrative barriers to get a health card, and better information is provided in comparison to cities. In scientific literature, rural and remote locations have been habitually considered as generators of inequity for health care access and utilization (Canadian Population Health Initiative 2006, Bourke *et al.* 2012). Conversely, in the case of the undocumented women studied, it became a facilitator, as participants were able to bypass some formal barriers, such as census registration. However, geographic location remained a generator of inequity when travel to a hospital was needed, given the cost of travel and lost wages.

Social and health care needs also differed in some aspects according to the geographic location. For instance, undocumented women who lived and worked in cities had more needs related to mental health, such as anxiety disorders and depression. Yet, all participants limited their consultations to acute problems with the aim of keeping active, or to reproductive health issues. Prevention services, such as early detection of breast or cervical cancer, were not used, although many participants met inclusion criteria (Generalitat de Catalunya 2006a, b).

Therefore, the myth that exists in many countries that access to health care implies a massive utilization of services by immigrants or the perception supported by some studies that immigrants "abuse or misuse the health care system" is not supported by our findings (Solé Auró *et al.* 2010, Moreno Fuentes & Bruquetas Callejo 2011).

Conclusions

In this study, the undocumented women in the province of Lleida described barriers to access and use social and health care services despite the fact that, at the time, Spain had a legal provision to provide healthcare for everyone regardless of legal status. In order to guarantee a real path leading to health promotion and health equity for immigrant workers, workers should be offered dignified working and living conditions. Given the detrimental impact of undocumentedness, the first step would be to provide immigrant workers status that places them in a fully legal and licit space, to break the "*illegality trap*" by considering an individual's status as a social determinant of health. However, as our results reveal, such movement towards legal status through public policy is insufficient. Social values also determine what is licit, and where discrimination occurs in each society. If employers, care recipients, social and health care professionals, or the population as a whole do not believe immigrants should access social and health care, even in a province where the right is legal, it may not be enacted.

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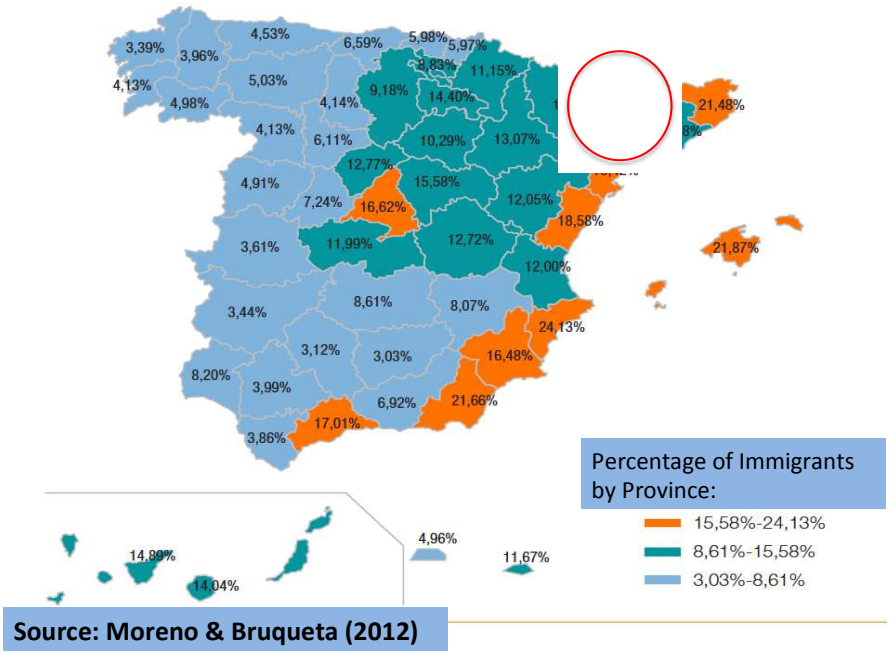
Map 1 - Percentage of Immigrants by Province in Spain



Source: Moreno & Bruqueta (2012)

Table 1 - Profile of Participants

Pseudonym	Age	Nationality	Education	Residence	Years in Spain	Jobs	Dependents
Denise	19	Dominican	High School	Urban city	4	Domestic and Bar Cleaning (on demand)	Yes
Maribel	20	Brazilian	Primary	Rural Village	2	Domestic cleaning (on demand)	No
Laura	22	Brazilian	Primary	Rural Village	5	Domestic and Hotel Cleaning (on demand)	No
Santiaga	28	Bolivian	University (unfinished)	Urban city	6,5	Domestic cleaning (on demand)	Yes
Andrea	29	Brazilian	University (unfinished)	Rural Village	3,5	Domestic cleaning (on demand)	Yes
Fidela	29	Brazilian	Primary	Rural Village	2	Domestic and Hotel Cleaning (on demand)	Yes
Carmen	32	Bolivian	Primary	Urban city	6	Domestic cleaning (on demand)	Yes
Ana	33	Bolivian	High School	Urban city	7	Caregiver and domestic cleaning (on demand)	Yes
María	36	Colombiana	Primary	Urban city	13	Caregiver and domestic cleaning (on demand)	Yes
Miguela	46	Brazilian	Technical Diploma	Rural City	1,5	Domestic and Hotel Cleaning (on demand)	Yes
Josefa	50	Chilean	Technical Diploma	Rural City	8	Caregiver and domestic cleaning (on demand)	No
Juana	52	Chilean	Technical Diploma	Rural City	5	Caregiver at hospital and domestic cleaning	Yes

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Title: CONFLICTOS ÉTICOS DE LAS ENFERMERAS Y ENFERMEROS ANTE EL REAL DECRETO-LEY 16/2012 THE ETHICAL CONFLICTS OF NURSES FACED WITH ROYAL DECREE-LAW 16/2012

Article Type: (OA) Original / Original Article

Keywords: ética enfermera; determinantes sociales de la salud; derechos humanos; población vulnerable; conflicto

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Abstract: Resumen

Antecedentes: La regulación de la actividad de las enfermeras está sujeta al código ético del colegio de enfermería y a las leyes sanitarias del país donde ejercen su profesión.

Objetivo: Evidenciar los dilemas éticos que pueden surgir por la disyuntiva entre los discursos legal y ético, a través de explorar el contenido del Real Decreto-ley 16/2012 y de los códigos deontológicos.

Metodología: Análisis crítico del discurso para extraer las diferencias entre los códigos éticos y la ley atendiendo a los conceptos de: equidad, derechos humanos, derecho a la salud, accesibilidad y continuidad de los cuidados.

Resultados: El análisis ha revelado la existencia de diferencias en el uso de los términos estudiados entre los discursos éticos y el discurso legal. Mientras que los códigos éticos definen la función enfermera en función a la equidad, derechos humanos, derecho a la salud, accesibilidad y continuidad de los cuidados, el discurso legal se centra en el concepto de beneficiario o asegurado para legitimar la discriminación de colectivos vulnerables

Conclusiones: La aplicación de la ley produce restricción en el acceso a la salud a los colectivos vulnerables como los inmigrantes indocumentados, lo que atenta contra los derechos humanos y la ética de los cuidados. La divergencia entre los discursos ético y legal puede producir dilemas éticos que afectan a la práctica de la profesión enfermera.

Abstract

Background: Nurses activity is subject to the Nursing College code of ethics and to the healthcare regulations of the country in which they practice.

Objective: To reveal the ethical dilemmas that may arise between the legal and ethical discourses by exploring the content of Royal Decree-law 16/2012 and the codes of ethics.

Methodology: Critical analysis of the discourse to identify the differences between the codes of ethics and the law from a standpoint of the concepts of: equity, human rights, right to healthcare, access to and continuity of care.

Results: The analysis has revealed differences in the use of the terms in the ethical and the legal discourses. While codes of ethics define the nursing function according to equity, human rights, right to healthcare, access to and continuity of care, the legal discourse focuses on the concept of beneficiary or being insured to legitimate the discrimination of vulnerable collectives.

Conclusions: The application of the law causes a restriction in the access to healthcare of vulnerable collectives, such as undocumented immigrants, something that violates human rights and the ethics of care. The divergence between the ethic and the legal discourses may cause ethical dilemmas that affect the professional nursing practice.

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TITLE PAGE

CONFLICTOS ÉTICOS DE LAS ENFERMERAS Y ENFERMEROS ANTE EL REAL DECRETO-LEY 16/2012

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CONFLICTOS ÉTICOS DE LAS ENFERMERAS Y ENFERMEROS ANTE EL REAL DECRETO-LEY 16/2012

Resumen

Antecedentes: La regulación de la actividad de las enfermeras está sujeta al código ético del colegio de enfermería y a las leyes sanitarias del país donde ejercen su profesión.

Objetivo: Evidenciar los dilemas éticos que pueden surgir por la disyuntiva entre los discursos legal y ético, a través de explorar el contenido del Real Decreto-lebBy 16/2012 y de los códigos deontológicos.

Metodología: Análisis crítico del discurso para extraer las diferencias entre los códigos éticos y la ley atendiendo a los conceptos de: equidad, derechos humanos, derecho a la salud, accesibilidad y continuidad de los cuidados.

Resultados: El análisis ha revelado la existencia de diferencias en el uso de los términos estudiados entre los discursos éticos y el discurso legal. Mientras que los códigos éticos definen la función enfermera en función a la equidad, derechos humanos, derecho a la salud, accesibilidad y continuidad de los cuidados, el discurso legal se centra en el concepto de beneficiario o asegurado para legitimar la discriminación de colectivos vulnerables

Conclusiones: La aplicación de la ley produce restricción en el acceso a la salud a los colectivos vulnerables como los inmigrantes indocumentados, lo que atenta contra los derechos humanos y la ética de los cuidados. La divergencia entre los discursos ético y legal puede producir dilemas éticos que afectan a la práctica de la profesión enfermera.

Palabras clave: ética enfermera; determinantes sociales de la salud; derechos humanos; población vulnerable; conflicto

Abstract

Background: Nurses activity is subject to the Nursing College code of ethics and to the healthcare regulations of the country in which they practice.

Objective: To reveal the ethical dilemmas that may arise between the legal and ethical discourses by exploring the content of Royal Decree-law 16/2012 and the codes of ethics.

Methodology: Critical analysis of the discourse to identify the differences between the codes of ethics and the law from a standpoint of the concepts of: equity, human rights, right to healthcare, access to and continuity of care.

Results: The analysis has revealed differences in the use of the terms in the ethical and the legal discourses. While codes of ethics define the nursing function according to equity, human rights, right to healthcare, access to and continuity of care, the legal discourse focuses on the concept of beneficiary or being insured to legitimate the discrimination of vulnerable collectives.

Conclusions: The application of the law causes a restriction in the access to healthcare of vulnerable collectives, such as undocumented immigrants, something that violates human rights and the ethics of care. The divergence between the ethic and the legal discourses may cause ethical dilemmas that affect the professional nursing practice.

Keywords: nursing ethics; social determinants of health; human rights; vulnerable population; conflict

INTRODUCCIÓN

En octubre de 2008, la Dirección General de Salud Pública puso en marcha la Comisión para Reducir las Desigualdades Sociales en Salud en España con el fin de elaborar un documento con medidas de intervención para disminuir las desigualdades en salud en el ámbito de la salud pública. En el documento se definen como principales ejes de desigualdad con enorme impacto en la salud de la población la posición socioeconómica, el género, el territorio y la etnia[1]. En el año 2012, con la aprobación del RDL 16/2102 (RDL) se limita el acceso al sistema nacional de salud de muchas personas en situación de vulnerabilidad, lo que aumenta su riesgo de exclusión social y supone un gran aumento de las desigualdades sociales en España[2-3].

El nuevo marco legal de la atención sanitaria restringe el acceso al Sistema Nacional de Salud (SNS) de diferentes colectivos a los servicios de Urgencias, salud reproductiva y atención a las personas menores de 18 años; principalmente, personas inmigrantes sin permiso de residencia legal, españoles residentes en el exterior, mujeres en situación de dependencia económica, personas con discapacidad y jóvenes que no han conseguido su primer empleo[2]. La promulgación del RDL supuso la transición de un acceso a la salud universal y gratuito a la limitación de acceso dependiendo de la situación laboral y/o económica de la persona usuaria. Alrededor de un millón de personas se quedaron fuera de la asistencia primaria y especializada y se interrumpió el tratamiento de sus enfermedades crónicas, hasta el punto de haberse dado el caso de un inmigrante fallecido por Tuberculosis en Baleares por no habérsele facilitado el tratamiento[4-5]. Además, algunas personas inmigrantes pueden no utilizar los servicios de urgencias por miedo o desconocimiento[6]. Por todo ello, distintos colectivos sanitarios se han ido manifestando en contra del RDL[7].

Como en el resto de las profesiones, las y los profesionales de enfermería (en adelante, las enfermeras) se adhieren a un colegio profesional que se encarga de la ordenación del ejercicio profesional, la representación y la defensa de los colegiados y forma parte de sus competencias la elaboración del código ético que sirva de base para las actuaciones de sus colegiados[8]. La regulación de la actividad de las enfermeras también está sujeta a las leyes sanitarias del país donde ejercen su profesión, con lo cual pueden aparecer diferencias de objetivos e intereses entre los dos mecanismos de regulación. El presente estudio surge de la necesidad de conocer

los códigos enfermeros españoles y Europeo y las condiciones legales en las que se desarrolla la práctica enfermera.

El objetivo de este estudio es evidenciar los dilemas éticos que pueden surgir por la disyuntiva entre marco legal y marco ético, a través de explorar el contenido del Real Decreto-ley 16/2012 y los discursos de los códigos deontológicos.

METODOLOGÍA

Análisis crítico del discurso (ACD) de cinco códigos éticos enfermeros (de ámbito autonómico, nacional y europeo) y de la ley sanitaria vigente en España (Tabla 1). Se escogió el ACD puesto que analiza el lenguaje con un enfoque que se interesa por el contexto político y social[9-11]. El ACD de los documentos seleccionados estuvo guiado por la búsqueda en el contenido de los textos de referencia en base a 5 conceptos clave sobre los que se sustentan y compartidos por el modelo de los Determinantes sociales de la salud y de la ética del cuidado[12-13]: “Equidad”, “Derechos Humanos”, “Derecho a la salud”, “Accesibilidad” y “Continuidad de los cuidados”, a través de la identificación de palabras y/o expresiones clave (Tabla 2).

RESULTADOS

Los resultados se estructuran en los cinco conceptos del marco conceptual que han guiado el ACD (Tablas 3 y 4).

La equidad se entiende en el RDL como una de las condiciones que debe disfrutar la población cubierta, entendida como cohesión territorial entre CCAA. Los códigos éticos reconocen que la salud es un derecho fundamental de la persona y otorgan responsabilidad a la enfermera de cuidar a todos los pacientes por igual, de defender la distribución equitativa de los recursos, comprometerse con la reducción de los determinantes sociales de la salud y participar en las políticas de salud, velando para que la legislación se adapte a las necesidades de las personas en cuanto a accesibilidad, calidad y coste, y poseer formación en equidad y que los/as formadores/as incluyan esta formación en los planes de estudio.

Mientras que en el RDL no se mencionan los derechos humanos ni sinónimos, los 5 códigos apelan a la enfermera a respetarlos y no ejercer discriminación de ningún tipo. Incluso el Código de Barcelona la considera responsable de generar conciencia social ante la vulneración de los derechos humanos, y el CIE insta a ofrecer formación en

este tema y que las asociaciones de enfermería se posicionen y dirijan sus actuaciones a favor de los derechos humanos.

El derecho a la salud es contemplado en el RDL como un derecho de las personas que tengan reconocida la condición de asegurado o beneficiario. Se modifica el artículo 12 de la Ley Orgánica 4/2000 sobre derechos y libertades de los extranjeros en España y el derecho a la asistencia sanitaria de los extranjeros está sujeta a la legislación vigente. El derecho a la protección de la salud de los españoles residentes en el exterior se regirá por la ley 40/2006, y el derecho a la asistencia sanitaria a través del SNS de los españoles trabajadores por cuenta ajena residentes en países que no forman parte de la CEE y que se desplacen temporalmente a España. Por su parte, los códigos atribuyen a la enfermera la responsabilidad de defender el derecho a la salud y asistencia sanitaria de los pacientes como derecho fundamental de las personas a obtener el grado máximo de salud, incluso ante casos de objeción de conciencia y negación de atención. Incluso el CIE insta a la enfermera a emprender y mantener acciones para satisfacer las necesidades de salud y sociales de todas las personas y en particular de las personas vulnerables,

Mientras que la accesibilidad depende del reconocimiento de la condición de asegurado o beneficiario en el RDL, los códigos posicionan a la enfermera en la defensa de que el acceso a la salud sea accesible a todas las personas en base en los principios de equidad y justicia social y calidad. Incluso el Código de Cataluña matiza que especialmente las personas vulnerables, y que la enfermera participe en las políticas de salud que afecten a la accesibilidad.

En el RDL, la continuidad de los cuidados es una de las condiciones que debe disfrutar la población cubierta. Los códigos consideran que la enfermera debe garantizar la continuidad de los cuidados pues su deber fundamental es el cuidado integral de la persona con el registro de las actuaciones de enfermería, instruir a los pacientes en los cuidados, así como en la búsqueda de estrategias para dar continuidad en los cuidados en caso de escasez de recursos y proteger el derecho de asistencia en situaciones excepcionales como son la objeción de conciencia y la huelga. El CIE vela por cuatro niveles de atención en salud: promoción de la salud, prevención de la enfermedad, restauración de la salud y el alivio del sufrimiento.

DISCUSIÓN

El análisis ha mostrado que existen diferencias sustanciales entre los conceptos de equidad, derechos humanos, derecho a la salud, accesibilidad y continuidad de los cuidados entre los códigos éticos y el RDL. Mientras que los Códigos éticos definen la función de las enfermeras basadas en estas condiciones, en el RDL quedan supeditados al concepto de asegurado/beneficiario, que legitima las prestaciones definidas de las que debe disfrutar la población cubierta y la regularización del SNS. Los cambios administrativos en el SNS sucedidos en las últimas décadas han transitado desde la premisa de la base de cotización en el 1963 hacia una tendencia a la universalización en el año 1986 a través del término ciudadano o residente y llegando a la última regularización en el año 2012 introduciendo de nuevo el término asegurado o beneficiario. Este concepto clave se contrapone a los términos de persona o ser humano presentes en los códigos éticos analizados.

El discurso del RDL se vertebra en torno al término de asegurado o beneficiario, lo que conlleva un cambio de paradigma en el quehacer profesional de enfermería y se utiliza para legitimar la discriminación y exclusión del sistema sanitario de colectivos vulnerables: justifica la aprobación de medidas restrictivas de acceso al SNS con la situación socioeconómica y establece requisitos para obtener la condición de asegurado o beneficiario que da acceso al sistema sanitario público.

Esta limitación de acceso y uso al SNS promueve un marco de acción donde se impide que las enfermeras presten sus cuidados a colectivos no asegurados, y las expone a situaciones en las que hay que tomar decisiones que pueden provocarles una gran tensión emocional[8-17]. Por ejemplo, pueden aparecer conflictos éticos cuando las enfermeras que han de tomar decisiones sanitarias se encuentren con la imposibilidad de elegir acciones que satisfagan sus criterios éticos y que se adapten a la normativa vigente en el Estado donde actúan, dado que los códigos deontológicos se desarrollan desde un punto de vista universal pero se aplican a situaciones concretas y hay condicionantes que se derivan del marco legal donde desarrollan su actividad y que no pueden modificarse.

En el RDL, la accesibilidad se reduce a las personas que tienen la condición de asegurado o beneficiario, quedando obviadas del acceso a todas las prestaciones ofertadas del SNS personas que no cumplan estos criterios, como extranjeros en situación irregular o jóvenes mayores de 26 años que no han accedido al mercado laboral. Esta situación produce discriminación y exclusión de estos sectores de

población que se legitima por el RDL. A su vez, entran en conflicto con los códigos éticos que consideran que el acceso a la salud debe ser universal. El que legislativamente se discrimine y excluya a personas como los inmigrantes ilegales puede tener implicaciones a nivel de salud de estas personas, puesto que dificultar el acceso a los medicamentos y a los servicios de atención primaria provoca el agravamiento o cronificación de enfermedades ocultadas o atendidas con retraso; es el caso de enfermedades como el VIH, la tuberculosis, el cáncer, la insuficiencia renal, la leucemia o la esquizofrenia[2,18]. A su vez, esto puede generar importantes problemas de salud pública, como ha ocurrido en otros países de nuestro entorno que están sufriendo una crisis económica, como Grecia[19].

En los códigos éticos la equidad se refiere a la distribución de los recursos según la necesidad sanitaria de las personas y en el RDL la equidad se reduce a la igualdad de derechos en el acceso a la salud y en la provisión de servicios de salud de las personas que cumplen unos requisitos administrativos y cuya diferencia es vivir en una determinada región. Por su parte, el objeto de la ley es salvar estas diferencias dando homogeneidad en los servicios y prestaciones a todos los usuarios que acceden al sistema de salud. No obstante, la respuesta de las administraciones de las CCAA ha sido muy variada y la aplicación de la ley en algunas CCAA se ha retrasado tras presentar recurso de inconstitucionalidad, y en el resto se ha aplicado de formas muy diversas, lo que ha aumentado las inequidades entre CCAA[20].

La diferencia entre el concepto equidad en los códigos enfermeros (entendida como igualdad o justicia en la distribución de los recursos) y en el texto legal (la igualdad entre las personas que tienen un determinado estatus -asegurado o beneficiario-) puede impulsar la aparición de dilemas éticos en las/os enfermeras/os. El hecho de limitar la equidad en salud a cuestiones territoriales y de servicios, y que el acceso al sistema sanitario se vea supeditado al cumplimiento de una serie de requisitos, hace que la ley promueva la inequidad en salud, ya que ser equitativo significa igual acceso al sistema sanitario a igual necesidad médica[21].

En los cinco códigos estudiados se toma como base el respeto a los Derechos Humanos, mientras que en el RDL no aparece alusión al concepto ni se utilizan sinónimos. La ausencia de este precepto en un texto legal sobre un derecho fundamental de las personas tan relevante como es el derecho a la salud sugiere que la ley obvia los derechos humanos. Puesto que en la Declaración de los derechos humanos se defiende la no discriminación por cualquier motivo[15], en el RDL se

discrimina a las personas por su situación administrativa al determinar condiciones de acceso al servicio sanitario como son la situación económica o laboral.

Mientras que en los códigos éticos el derecho a la salud se otorga a todos los seres humanos, en el RDL se otorga a las personas que cumplen con unos requisitos administrativos. Este hecho puede generar un dilema ético al suprimir el derecho a la salud a las personas que no cumplen estas condiciones y puede contravenirse con la Constitución Española y con el Pacto Internacional sobre Derechos Económicos, Sociales y Culturales que todos los estados miembros de la UE han firmado[22-23].

Es destacable que el RDL recoge la posibilidad de conflictos éticos de las enfermeras, ya que la prestación de los servicios debe ser accesible a toda la población cubierta. Si la enfermera debe asegurar la continuidad de los cuidados, ésta depende (además del autocuidado) de la coordinación entre los diferentes profesionales y niveles asistenciales del proceso[24]. Si el acceso de las personas no aseguradas o beneficiarias está limitado al servicio de urgencias, (con la excepción de la atención a la maternidad y a las personas menores de 18 años), una vez ofrecida la atención urgente la persona no tiene acceso a los medicamentos, a la atención primaria de salud ni a la atención especializada[15.]. Por ello, con esta legislación, el personal de enfermería no puede asegurar la continuidad de los cuidados a todas las personas atendidas.

Las implicaciones de los resultados que arroja este estudio suponen que la aplicación del RDL produce restricción del derecho a la salud de colectivos vulnerables, con la consiguiente afectación de la salud de las personas y de la salud pública. A su vez, la divergencia entre los códigos éticos y la normativa legal puede ser origen de conflictos éticos que afecten a la práctica de la profesión y al bienestar moral de las enfermeras. Este estudio puede servir para orientar cuestiones éticas con el objeto de organizar una respuesta de las enfermeras y enfermeros a las políticas que limitan el acceso a la salud de las personas más vulnerables y con alto riesgo de exclusión social.

El instrumento con el que se ha llevado a cabo la reforma sanitaria es un Real Decreto-ley, una ley de medidas urgentes, con la situación socioeconómica actual. Sin embargo, por una par tela aplicación de la ley atenta contra los derechos humanos e incrementará las desigualdades en salud[25-26]. Por otra, atenta contra la ética de los cuidados al divergir con los códigos éticos. La contradicción evidenciada entre el discurso legal y el discurso deontológico puede generar conflictos éticos en la práctica

profesional enfermera, por lo que sería interesante abordar en estudios posteriores cómo estos cambios se reflejan y se conforman en el quehacer diario enfermero.

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Tabla (Table)

TABLAS

Tabla 1. Documentos analizados

	Nombre del documento
Códigos Éticos	Código Deontológico CIE para la profesión enfermera de 1953, en su versión revisada el año 2012
	Código de Ética de Enfermería elaborado el año 1986 por el Colegio Oficial de Ayudantes Técnicos Sanitarios y Diplomados en Enfermería de Barcelona
	Código deontológico de la enfermería española elaborado por el Consejo General de Enfermería de España en el año 1989 en su versión revisada en el año 1998
	Código Ético y Deontológico de la Enfermería Europea elaborado por la Federación Europea de Órganos Reguladores de Enfermería en el año 2007
	Código de Ética de las Enfermeras y Enfermeros de Catalunya elaborado por el *Consell de Col•legis d'Infermeres i Infermers de Catalunya* en el año 2013
Ley	Real Decreto Ley 16/2012. de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones.

Tabla 2. Conceptos clave aplicados en el análisis

Conceptos	**Definición**	**Palabras clave**
Equidad	Los recursos deben ser asignados según la necesidad sanitaria de las personas y en ella se incluye el acceso al sistema sanitario[14].	"equidad" "equitativo" "reducir las desigualdades"
Derechos Humanos	Derechos inherentes a todos los seres humanos, sin distinción alguna de nacionalidad, lugar de residencia, sexo, origen nacional o étnico, color, religión, lengua, o cualquier otra condición[15].	"derechos humanos" "por igual" "con el mismo respeto" "no discriminación" "sin hacer distinción por razones de…"
Derecho a la salud	Es uno de los derechos humanos. Derecho a tener un nivel de vida que asegure a las personas la salud y el bienestar a través de la alimentación, el vestido, la vivienda, la asistencia médica y los servicios sociales[15].	"derecho a la protección de la salud" "derecho a la asistencia sanitaria" "derecho a la salud" "derecho a la asistencia" "derecho de cobertura sanitaria"
Accesibilidad	Para que el sistema de salud sea accesible las instituciones deben tener en cuenta la provisión eficiente de los servicios sanitarios en relación con las barreras organizacionales, económicas, culturales y emocionales[6].	"accesibilidad" "alcance a toda la población" "acceso equitativo" "oposición a la negación de la asistencia sanitaria" "acceso a los cuidados enfermeros" "acceder" "obtención de la prestación de asistencia sanitaria" "acceso" "igualdad de acceso"
Continuidad de los cuidados	Un elemento de calidad de la asistencia sanitaria[16].	"continuidad de los cuidados" "continuidad de su cuidado" "garantía de los cuidados" "garantizar las atenciones" "continuidad asistencial" "continuidad de tratamiento" "continuidad de los tratamientos"

Tabla 3. Comparación de los discursos ético y legal

Concepto	**Códigos éticos**	**Ley**
Equidad	*La enfermera defenderá la equidad y justicia social en la distribución de los recursos, en el acceso a los cuidados de salud y en los demás servicios sociales y económicos.*	*La prestación de estos servicios se hará de forma que se garantice la continuidad asistencial, bajo un enfoque multidisciplinar, centrado en el paciente, garantizando la máxima calidad y seguridad en su prestación, así como las condiciones de accesibilidad y equidad para toda la población cubierta.*
Derechos humanos	*El cuidado y promoción de la salud y el respeto a todos los derechos humanos y sociales del individuo, de la familia y comunidad ha de constituir la actitud ética fundamental de la conciencia profesional. Los profesionales de Enfermería nunca utilizarán sus conocimientos ni colaborarán, aunque sea indirectamente, en ninguna actividad destinada a la manipulación de las conciencias o a la coacción física o psíquica de las personas.*	*No menciona los derechos humanos.*
Derecho a la salud	*Las enfermeras/os tienen el compromiso de reconocer que la salud es un derecho fundamental de la persona y defenderán este derecho previniendo enfermedades, cuidando de los pacientes y llevando a cabo tareas de rehabilitación.*	*Una vez reconocida la condición de asegurado o de beneficiario del mismo, el derecho a la asistencia sanitaria se hará efectivo por las administraciones sanitarias competentes, que facilitarán el acceso de los ciudadanos a las prestaciones de asistencia sanitaria mediante la expedición de la tarjeta sanitaria individual.*
Accesibilidad	*La enfermera, personalmente y participando con los colegios y las asociaciones profesionales, trabaja para que la aportación enfermera esté presente en la planificación y en la remodelación de las políticas de salud, académicas y sociales, y vela para que la legislación que afecta a la accesibilidad, la calidad y el coste de la salud se adapte a las necesidades de las personas.*	*En todas las informaciones se tendrá en cuenta la accesibilidad para la personas con discapacidad.*
Continuidad de cuidados	*El profesional de Enfermería en el ejercicio de su profesión no abandonará el enfermo/usuario que precise vigilancia o cuidados de enfermería sin asegurar la continuidad de los mismos.*	*La prestación de estos servicios se hará de forma que se garantice la continuidad asistencial, bajo un enfoque multidisciplinar, centrado en el paciente, garantizando la máxima calidad y seguridad en su prestación, así como las condiciones de accesibilidad y equidad para toda la población cubierta.*

Tabla 4. Tratamiento de los conceptos clave en los diferentes documentos analizados

Concepto / Documento	Equidad	Derechos humanos	Derecho a la salud	Accesibilidad	Continuidad de los cuidados
Código CIE	Defender la equidad en la distribución de los recursos y en el acceso a los cuidados; Poseer formación en equidad y que los/as formadores/as incluyan esta formación en los planes de estudio.	Debe respetarlos; No debe ejercer discriminación de ningún tipo; Promover un entorno de respeto de los derechos humanos; Ofrecer formación en este tema; Las asociaciones de enfermería deben posicionarse y dirigir sus actuaciones a favor.	Emprender y mantener acciones para satisfacer las necesidades de salud y sociales de todas las personas y en particular de las personas vulnerables	Defender que el acceso a los cuidados se base en los principios de equidad y justicia social	Promoción de la salud; Prevención de la enfermedad; Restar la salud y aliviar el sufrimiento, siendo estos los cuatro niveles de atención en salud.
Código del Consejo Español		Salvaguardarlos y no ejercer discriminación y respetar a todas las personas, pues el ser humano tiene derecho a la vida, a la seguridad y a la protección de la salud.	Defender los derechos del paciente, incluso ante la negación de atención, pues defiende el derecho del ser humano a la protección de la salud.		
Consell Català	Defender la distribución equitativa de los recursos; Comprometerse con la reducción de los determinantes sociales de la salud; Participar en las políticas de salud, velando para que la legislación se adapte a las necesidades de las personas en cuanto a accesibilidad, calidad y coste.	Respetar los derechos humanos y la no discriminación; Responsable de generar conciencia social ante la vulneración de los derechos humanos.	Proteger a las personas de su derecho a la asistencia en caso de objeción de conciencia.	Procurar que el acceso a la salud sea accesible a todas las personas en función de su situación de salud, especialmente las personas vulnerables, y asume la participación en las políticas de salud que afecten a la accesibilidad, velando para que ésta se adapte a las necesidades de las personas.	Garantizar la continuidad de los cuidados; Instruir a los pacientes en los cuidados y en la búsqueda de estrategias para dar continuidad en los cuidados en caso de escasez de recursos Proteger el derecho de asistencia en situaciones excepcionales como son la objeción de conciencia y la huelga;
Código de Barcelona		Respetar todos los derechos humanos y sociales del individuo, familia y comunidad y la no discriminación.	Contribuir al derecho fundamental de la persona el obtener el grado máximo de salud.	Velar para que el sistema sanitario sea accesible a toda la población con alto grado de calidad.	Deber fundamental del cuidado integral de la persona; Asegurar la continuidad de los cuidados.
Código Europeo	Cuidar a todos los pacientes por igual; Reconocer que la salud es un derecho fundamental de la persona.	Cuidar a todos los pacientes por igual sin discriminación porque los/as pacientes tienen derecho a la dignidad humana	Defender el derecho a la salud.		
RDL	Una de las condiciones que debe disfrutar la población cubierta.	No se mencionan los derechos humanos ni sinónimos.	Derecho de las personas que tengan reconocida la condición de asegurado o beneficiario, estableciendo los mecanismos de reconocimiento de tal derecho.	Depende del reconocimiento de la condición de asegurado o beneficiario.	Una de las condiciones que debe disfrutar la población cubierta.

***¿Qué se sabe?¿Qué se añade?**

¿Qué se sabe sobre el tema?:

La regulación de la actividad enfermera está sujeta al código ético del colegio de enfermería y a las leyes sanitarias del país donde ejercen su profesión, mecanismos entre los que pueden aparecer diferencias de objetivos e intereses.

¿Qué añade el estudio?:

La promulgación del RDL puede dificultar el normal desempeño de las funciones enfermeras. La contraposición entre el discurso legal y deontológico puede generar conflictos éticos en la práctica profesional enfermera

10.2. Dissemination activities

I. Conference Contributions

Authors: Montserrat Gea Sánchez; Annabel Fernández Cuesta; Mercè Folguera Arnau; Ana García López; Santiago Miguelsanz García

Title: Inmigración y formación continuada en el colectivo de enfermería de la región sanitaria de Lleida

Type of participation: **Oral Communication

Conference: V Jornadas internacionales de cultura de los cuidados

National / International: International

Organizer Entity: 4308 - Asociación Nacional de Historia y Antropología de los Cuidados

City: Alicante **Country:** SPAIN **Year:** 2006

Keywords: 200404 - etnicidad / 206740 - Migración. Actitudes profesionales salud

Authors: Annabel Fernández Cuesta; Montserrat Gea Sánchez; Alicia Márquez Vidal; Mónica Guillen Mesalles

Title: La matrona y la población inmigrante en una ABS rural.

Type of participation: **Póster

Conference: V Jornadas internacionales de cultura de los cuidados

National / International: International

Organizer Entity: 4308 - Asociación Nacional de Historia y Antropología de los Cuidados

City: Alicante **Country:** SPAIN **Year:** 2006

Keywords: 200404 - etnicidad / 206740 - Migración. Actitudes profesionales salud

Authors: Montserrat Gea Sánchez; Fidel Molina Luque; Josefina Vendrell Justribo

Title: Actitud de las enfermeras de Lleida ante el fenómeno migratorio

Type of participation: **Póster

Conference: VI Jornadas internacionales de cultura de los cuidados

National / International: International

OrganizerEntity: 4308 - Asociación Nacional de Historia y Antropología de los Cuidados

City: Alicante **Country:**: SPAIN **Year:** 2008

Keywords: 200404 - etnicidad / 206740 - Migración. Actitudes profesionales salud

Authors: Gea Sánchez M, Molina Luque F, Allende Monclús P

Title: 'Actitudes y prejuicios ante el fenómeno migratorio ¿Estamos preparados?'

Type of participation: **Oral Communication

Conference: XIV Encuentro Internacional de Investigación en Enfermería. Investen (Isciii)

National / International: International

City: Burgos **Country:** SPAIN **Year:** 2010

Keywords: 001491 - Migraciones / 208842 - salud inmigrantes

Activity: International Nursing PhD Collaboration: Presentation 'Access to health care services of Latin American undocumented women. A Critical and territorial analysis of Spanish and Canadian policies'

Dates: 23/05/2011 - 04/06/2011

Scope: International

Organization: Universitat de les Illes Balears

Activity: Workshop “Diversity management: critical thinking and inequities in health” at Master Program on Advances on Public Health and Community Nursing

Dates: - 10/05/2012

Scope: National

Classification: Graduate Courses - Taught

Organization: Universitat de Barcelona IL3

Authors: Montserrat Gea-Sánchez

Title: Access to health care services to Latin American undocumented women in Spain and Canada

Type of participation: **Oral Communication

Conference: Transnational migration and global development PhD Conference

National / International: International

Organizer Entity: UBER - University of Bergen

City: Bergen **Country:** NORWAY **Year:** 2012

Keywords: 208848 - undocumented / 208849 – health care services

Authors: Montserrat Gea Sánchez, Maria Gasull Vilella, Jordi Martínez Soldevila, Cristina Serrabassa Funoll

Title: Results of the participatory survey for the drawing up of a next code of ethics for Catalan nurses

Type of participation: **Oral Communication

Conference: 13th International Nursing Ethics Conference

National / International: International

Organizer Entity: USUR - University of Surrey

City: **Country:** TURKEY **Year:** 2012

Authors: Otero-Garcia L, Goicolea I, Gea-Sánchez M, Sanz-Barbero B

Title: Immigrant women's access and participation in family planning, prenatal and postnatal care programs

Type of participation: **Oral Communication

Conference: XVII Encuentro Internacional de Investigación en Cuidados

National / International: International

Organizer Entity: 5290 - INVESTEN Instituto de Salud Carlos III

City: Lleida **Country:** SPAIN **Year:** 2013

Authors: Serrabassa Funoll C, Gea Sánchez M, Montero Parés C, Martínez Soldevila J.

Title: RESULTADOS DEL CUESTIONARIO DE PARTICIPACIÓN PARA LA ELABORACIÓN DE UN NUEVO CÓDIGO ÉTICO PARA LAS ENFERMERAS CATALANAS

Type of participation: **Póster

Conference: XVII Encuentro Internacional de Investigación en Cuidados

National / International: International

Organizer Entity: 5290 - INVESTEN Instituto de Salud Carlos III

City: Lleida **Country:**: SPAIN **Year:** 2013

Authors: Gea-Sánchez M, Gastaldo D, Molina-Luque F, Otero-García L, Blanco-Blanco J

Title: Traps of illegality. Access and utilization of social and health services by undocumented Latin American women

Type of participation: **Oral Communication

Conference: XVIII Encuentro Internacional de Investigación en Cuidados

National / International: International

Organizer Entity: 5290 - INVESTEN Instituto de Salud Carlos III

City: Vitoria **Country:** SPAIN **Year:** 2014

Keywords: 210221 - gender / 211926 - Social determinants of health / 208848 - undocumented

Authors: Gea-Sánchez, M.; Gastaldo, D.; Molina-Luque, F.; Otero-García, L; Blanco-Blanco, J.

Title: 'Gramma can not be left alone' Access and utilisation of social and health services by undocumented Latin immigrant women working in Lleida (Catalonia, Spain)

Type of participation: **Oral Communication

Conference: 6th International in Sickness and in Health Conference (ISIH)

National / International: International

City: Palma de Mallorca **Country:** SPAIN **Year:** 2015

Authors: Gea-Sanchez,M; Gastaldo,D; Molina Luque,F; Otero Garcia,L; Blanco-Blanco,J; CampsBalagué,JM.

Title: “No había con quién se quede la abuela” Acceso y utilización de servicios sociales y de salud por parte de trabajadoras inmigrantes latinoamericanas indocumentadas en Lleida

Type of participation: **Oral Communication

Conference: Conferencia del Congreso Internacional de Enfermeras

National / International: International

Organizer Entity: 5886 - Consejo Internacional de Enfermeras

City: Seul **Country:** REPUBLIC OF KOREA **Year:** 2015

Activity: Interview in local press “La Mañana” about access to health care services of vulnerable groups.

Dates: April 2015

Scope: Regional

Activity: Interview in local press “El Segre” about access and utilization of health care services by undocumented immigrants.

Dates: April 2015

Scope: International

II. Research stays abroad

Center: Lawrence S. Bloomberg Faculty of Nursing. University of Toronto.

Place: Toronto **Country:** CANADA **Year:** 2009 **Duration:** 0 Years 6 Months

Issue: Participatory Action Research in Health Sciences

Key: * Instituto de Salud Carlos III. Nº Registro 4669/RG 943974

Center: Lawrence S. Bloomberg Faculty of Nursing. University of Toronto.

Place: Toronto **Country:** CANADA **Year:** 2013 **Duration:** 0 Years 2 Months

Issue: Qualitative data analysis

Key: * Universitat de Lleida. Vicerectorat de Recerca.

Center: Lawrence S. Bloomberg Faculty of Nursing. University of Toronto.

Place: Toronto **Country:** CANADA **Year:** 2015 **Duration:** 0 Years 2 Months

Issue: Scoping reviews and Mix methods in qualitative research