BIRTH EXPERIENCES OF IMMIGRANT LATINA WOMEN IN A NEW GROWTH COMMUNITY

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A woman's birth experience is consistently described as one of the most psychologically significant events of a woman's life and has been shown to impact the physical, psychosocial, and mental well-being of mothers long after the birth of their child. There is increasing public health importance in assessing the health and wellbeing of the Latino community as this population continues to expand into new-growth areas. The purpose of this study was to understand Latina's perceptions of their childbirth experience, what factors impact their perceptions, and whether other variables, such as insurance status, English proficiency level, and education level are associated with childbirth experience. In-depth, semi-structured interviews were conducted with a non-proportional quota sampling of ten Latina women, five of whom had insurance and five who were uninsured. All women gave birth within the previous twelve months in Allegheny County and were recruited from a Spanish-speaking pediatrics clinic. After analysis of the interviews, common themes were coded and an analytic memo was written in order to connect the themes together. Most women reported a positive global experience, however all recalled negative moments. Birth outcome and the birth of a healthy child were the most important factors influencing birth experiences for participants. The presence of a support person throughout childbirth and into the postpartum period, specifically the participant's husband or partner, also played a large role in childbirth perceptions. Communication problems, particularly for those with lower levels of English proficiency, negatively contributed to the

event, while an amicable patient-provider relationship was associated with more positive memories. Locus of control, prior expectations of the birth event, and postpartum physical and emotional recovery also influenced experiences. There were differences found between insured and uninsured women, as insured women reported increased childbirth and postpartum support, decreased communication barriers, and higher levels of external control. Recommendations to improve birth experience are presented, and include increasing culturally sensitive care, and enhancing formal and informal postpartum support through strengthened social networks. Additional research is needed to further understand a number of themes, including desired locus of control, and the role of Latino culture during childbirth.

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PREFACE

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1.0 INTRODUCTION

According to the U.S. Census Bureau, by 2050, the minority population living in the United States will have increased by over 90% (Hutch, Bouye, Skillen, Lee, Whitehead, et al, 2011), and minorities are expected to make up over 50% of the U.S. population ("Projected population of the United States, by race and Hispanic origin: 2000-2050). Although some focus has been placed upon improving access, coverage, quality, and intensity of healthcare delivery, there remain large disparities in health experiences and outcomes between socioeconomic status and race/ethnicity (Williams, Costa, Odunlami & Mohammed, 2008). Minority populations and those at lower socioeconomic status experience higher rates of cancer mortality, diabetes, cardiovascular disease, unintentional injury, and sexually transmitted, just to name a few (Gallo, Penedo, Espinosa de los Monteros & Arguelles, 2009; "Highlights in Minority Health and Health Disparities," 2011). These disparities have staggering economic consequences, as health disparities cost the United States over $1 trillion dollars annually (Williams, et al, 2008).

The Latino population is the racial/ethnic minority group with the fastest growth rates ("State and County Quickfacts," 2010). Latinos suffer from some of the same health disparities that are present in other minority and low-income groups, including higher rates of cancer mortality and cardiovascular disease (Gallo, et al, 2009). As this community continues to grow, there is an urgent need to ensure that health disparities are understood and addressed in order to ensure human equality and economic stability.

One health experience in which research is lacking is childbirth. In recent years, research conducted with European or Caucasian women from the United States has shown the psychological and physical importance of childbirth on a woman's health and wellbeing for years after delivery (Callister 2004). However, little is known or understood about the thoughts, feelings, and perceptions Latina immigrants have regarding childbirth experience in the United States. Even less is known about Latina populations located in new-growth communities, where over 10 million immigrants live (Walker, 2009), and where health infrastructure is ill-equipped to deal with the cultural nuances and health needs of the Latino community, particularly during the important childbirth experience.

2.0 REVIEW OF LITERATURE

As demographic trends have shifted throughout the past decades, the Latino population is now the largest minority in the United States ("Distribution of U.S. Population by Race/Ethnicity", 2008). In 1990, 22.4 million U.S. Census respondents reported that they were Hispanic or Latino, which constituted 9% of the total U.S. population ("Summary Population and Housing Characteristics", 1990). However, the proportion of U.S. citizens who identified as Hispanic/Latino grew to 15.8% ("State and County Quickfacts", 2010) by 2009, and it is hypothesized that this group will make up 24.4% of the United States population by 2050 (Shrestha, 2006). Although the words Hispanic and Latino are often used interchangeably to describe a wide variety of people and nationalities, literature agrees that the term "Latino" is a more inclusive word used to describe those who are of Cuban, Mexican, Puerto Rican, South or Central American, or of other Spanish culture or origin, regardless of race (Diaz, 2002; Hayes-Bautista & Chapa, 1987), while the term "Hispanic" is typically associated with only those who are of Spanish-speaking ethnicity or origin (thereby excluding Portuguese-speaking Brazilians and Portuguese) (Passal & Taylor, 2009). Latinos can identify with any racial group, however are typically grouped together because they share a common ethnicity. The U.S. Census Bureau defines ethnicity as "the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States ("Questions and Answers for Census 2000 Data on Race", 2001). However, despite the fact that sub-groups of

Latinos are often grouped together in research and throughout political and social discourse (De Genova & Ramos-Zayas, 2006), it is important to remember the considerable variability which exists between subgroups with regards to beliefs, culture and socio-demographic characteristics (Gallo, Penedo, Espinosa & Arguelles, 2009). Individuals of Mexican descent make up the largest proportion of Latinos living in the United States, followed by Puerto Ricans and Cubans; in 2008, 65. 5% of U.S. Latinos were born in Mexico or had Mexican ancestry ("Latinos by County and Origin", 2010). Contrary to popular portrayals throughout the media, the majority of Latinos living in the United States are documented citizens through birth or naturalization, and only 27% are in the country without documentation ("Latinos by County and Origin", 2010).

The Latino population is, on average, ten years younger than the rest of the U.S. population (Chapa & De La Rosa, 2004). This age differential is one factor which contributes to high fertility rates and the expansive growth rate of this community (Chapa & De La Rosa, 2004). Recent studies have shown that Latinos have lower educational achievement than their white counterparts, and only 60.8% of Latinos have at least a high school degree (compared with 90% of White adults) ("Statistical portrait of Hispanics in the United States, 2008: Table 22. Educational attainment, by race and ethnicity", 2008). Lastly, although the number of Latinos living in poverty has decreased over the past few decades, Latinos still make up a disproportionate amount of those in poverty. Latinos make up approximately 15% of the general population, and 34% of Latinos live below the federal poverty line ("Poverty rate by race/ethnicity, states", 2009).

Approximately half of Latinos living in the United States have emigrated from a foreign country. Gallo, Penedo, Espinosa de los Monteros and Argulles (2009) argue that there is significant stress associated with immigration, and the immigrant community must:

> Reestablish their homes, social networks and educational or work with an unfamiliar environment. Further, adversities suffered by the overall Latino population, such as social marginalization, poor living environment and dangerous or low paying employment, may be experienced disproportionately among Latino immigrants. (p. 1710)

The authors continue to explain that language barriers further complicate access to resources, and that those barriers are even more pronounced for undocumented immigrants, who also are dealing with fear of deportation and, potentially, memories of a traumatic immigration experience.

2.1.1 Latino Culture

Culture can be characterized as "learned, shared, transmitted intergenerationally, and reflected in a group's values, beliefs, norms, practices, patterns of communication, familial roles, and other social regularities. Culture is…dynamic and adaptive" (Krueter & McClure, 2004). The Latino population is a very diverse group of individuals with a variety of personal values and behaviors, and it can be difficult to make broad cultural statements about the population as a whole. However, the U.S. context in which Latinos live today contributes to lasting cultural traits and characteristics that allow for very broad and general cultural identities to be associated with the Latinidad culture (DeGenova & Ramos-Zayas, 2006). Utilizing this perspective, there are a number of cultural norms which have been shown to impact Latino attitudes, decisions and behaviors (Diaz, 2002; Burk, Wiser & Keega, 1995; Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010; Berry, 1999; Campero, Garcia, Diaz, Ortiz, Renosa, et al, 1998).

First, the concept of familialism, or strong dependence upon family ties for emotional, physical and economic support, has been cited as one of the most important Latino cultural values (Diaz, 2002). *Familisimo* "weights on the interdependence among nuclear and extended

family members for support, emotional connectedness, familial honor, loyalty and solidarity" (Munoz-Laboy, 2008, para. 3). Importantly, the concept of family for many Latinos encompasses not only the nuclear family, but also grandparents, aunts or uncles, cousins, friends and godparents (Burk, Wieser & Keegan, 1995). During pregnancy, many Latina women report that their family, specifically their mother, grandmother and other female relatives, is the first place they turn to for information, advice and support (Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010), and many request the presence of these important people while giving birth (Berry, 1999). Additionally, many of these women depend on gui dance and input from their husband or partner in health decision-making processes (Burk, Wieser & Keegan, 1995) and many times, health and wellness are seen as social processes (Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010) as opposed to individual pursuits.

Two additional important cultural values are those of *respeto* (respect) and *personalismo* (positive personal relationships) (Díaz, 2002). Although many Latinos perceive physicians as authority figures and rely upon caregivers to help make health care decisions, Latinos still expect to be treated with respect during medical encounters (Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010). M any Latinos place a stronger emphasis on the importance of reciprocal politeness and pleasantness than many other cultural groups (Díaz, 2002); and most highly value if a provider demonstrates concern and courtesy throughout visits (Díaz, 2002). Latinos will often perceive the interactions with care providers as positive if physicians and nurses listen actively to their patients and communicate respectfully (Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010). Indeed, regardless of language concordance, Latinas receiving maternal health care reported that they were happy with the care they received if their physician and nurses were attentive and friendly (Gurman & Becker, 2008).

Another cultural trait which could influence attitudes, beliefs and behaviors for many Latinos is the importance of spirituality (Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010; Berry, 1999). Over 90% of U.S. Latinos report a religious affiliation (Gallo, Penedo, Espinosa de los Monteros & Arguelles, 2009), and those who identify themselves as spiritual report better self-ratings of health (Levin, Lyons & Larson, 1993) and an "improved ability to effectively cope with adverse health experiences" (Gallo, Penedo, Espinosa de los Monteros & Argulles, 2009, p. 1724).

Lastly, literature has pointed to the presence of *machismo*, or male dominance, throughout Latino communities (Diaz, 2002; Burk, Wieser & Keegan, 1995). Males are often portrayed as having unquestioned authority and are the sole decision-makers in their families (Burk, Wiser & Keegan, 1995). Although there are some positive components of *machismo*, including honor, courage, and responsibility for family, the concept is also associated with violence, risky sexual behavior, and alcoholism (Diaz, 2002). However, more recent research challenges this portrayal and concludes that Latino relationships are more democratic and have more relaxed gender roles than they are stereotyped as, particularly in immigrant communities (Hirsh, 2003).

2.2 POPULATION DISCRIPTION – ALLEGHENY COUNTY

Traditionally, Latinos have immigrated to cities in the Southwest and Northeast of the United States, which have historically had high number of Latino citizens. However, the 2000 census showed the interesting finding that new immigrants have started moving to areas with traditionally lower numbers of Latinos (Chapa & De la Rosa, 2004); and areas in the Midwest

and Pacific Northwest have seen a remarkable increase of this population within the past decade. These new-growth areas have experienced much higher growth rates than traditional immigrant communities, and the number of Latinos living in these cities has doubled between 1996-2003 (Cunningham & Banker, 2006). New-growth areas are often unprepared to meet the needs of this population and can be slow to realize the infrastructure and systematic changes that are needed to improve quality of life for their Latino citizens (Cunningham & Banker, 2006). Like many other areas in the Midwest, Allegheny County, in Southwestern Pennsylvania, has seen increased numbers of Latinos moving into the area over the past years. In 1996, only 0.6% of the Pittsburgh population consisted of Latinos (Cunningham & Banker, 2006), however over the next decade the Latino population grew 59% ("Data and resources: Allegheny County, Pennsylvania", 2010) to over 18,000 individuals, making up 1.5% of the general population (Documét & Sharma, 2004; "State and County Quickfacts: Allegheny County", 2010). Today, Mexicans make up the largest portion of Latinos living within Southwestern Pennsylvania (31.95%) followed by Puerto Ricans (19.85%) and Cubans (5.57%). here are also sizeable populations from various Central and South American countries (P. Documét, personal communication, 2/25/2011). A 2004 study (Documét & Sharma, 2004), conducted to understand Latino barriers toward health care access in Southwestern Pennsylvania (SWPA), established that 35% of SWPA Latinos have an income less than $20,000, 52.4% have low English proficiency, and 59.71% have low levels of acculturation. Furthermore, 40% of participants rated their physical health status as low, and 45% rated their mental health status as low. Although this study was conducted throughout the entire Southwestern Pennsylvania, it provides an accurate representation of those who are living in Allegheny County, the most populous SWPA county, and where over 60% of SWPA Latinos reside (Pielemeier, K., 2007).

2.3 LATINO HEALTH

2.3.1 The Hispanic Paradox

Interestingly, despite the fact that a large portion of the Latino population is living in lower socioeconomic status and is prone to adverse social circumstances, Latinos often have better health outcomes than non-Hispanic whites (Gallo, Penedo, Espinosa de los Monteros & Argulles, 2009) and U.S. born Latinos (Flores, 2005). Labeled "The Hispanic Paradox," Latino adults enjoy lower rates of mortality, mental disorders, obesity, and have higher rates of fruit and vegetable consumption (Flores, 2005). Additionally, the low birthweight rate within the Latina community is significantly lower than both non-Hispanic whites and U.S.-born Latina women (Dyer, Hunter & Murphy, 2010). Unfortunately, the positive health outcomes that many immigrant Latinos experience slowly dissipate as they acculturate to life in the United States, and those who show higher levels of acculturation are more likely to engage in substance abuse, poor nutrition and eating patterns, and experience worse health outcomes (Lara, Gamboa, Kahramanian, Morales & Hayes Bautista, 2005).

The protective factor of *familismo* is one hypothesis for this paradox. "Social support and social capital have been documented to have a substantial positive impact on health and health outcomes; the extensive social networks and support that often characterize immigrant communities may be critical to the healthy immigrant effect" (Flores, 2005, p. 295). However, as individuals and families begin the process of acculturation, a number of increased stressors arise which could decrease the positive impact of social support. Gallo et al (2009) emphasizes the loss of social support, loss of cultural values, changes in ethnic identity, and the increased familial conflict related to gender or generational differences as some of the important factors

which could decrease the protective factor of *familismo* throughout the acculturation process. Furthermore, as families migrate at different times and to different areas, many Latinos are left without the traditional strong support that family provides due to greater geographic separation (Kalofonos & Palinkas, 1999), and some have commented that they feel a sense of aloneness and isolation once they are settled in the United States (Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010). Therefore, the protective factor of *familismo* that may be seen in traditional immigrant communities could be weak or non-existent in new-growth communities, and could create unfavorable health conditions for many Latino families.

2.3.2 Barriers to health

Although there is data supporting the Hispanic Paradox and improved health outcomes for the Latino population, this population also suffers from a number of health disparities. Latinos have higher rates of diabetes mellitus, influenza, liver and heart disease, and have lower rates of screening for breast and cervical cancers, leading to higher cervical cancer mortality rates than all other racial or ethnic groups (Díaz, 2002). Additionally, Latinos report being less satisfied with their medical care (Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010), and have higher rates of being uninsured than other populations (Documét & Sharma, 2004). Due to the growing influence of the Latino population, increased attention has been focused on a number of important barriers which contribute toward health disparities found in this population.

2.3.2.1 Communication

One of the more prominent difficulties for Latinos in accessing needed care is language discordance and communication barriers which exist between physicians and their Latino

patients (Poureslami, Rootman, Doyle-Waters, Nimmon & Fitzgerald, 2010). For many Latino families, the maintenance of the Spanish language is an important cultural value, and 78% of Latinos report that Spanish is their primary language (Chapa & De la Rosa, 2004). Further investigation reveals a large gap between English comprehension and nativity. While 87.3% of U.S. born Latinos claim to be able to speak English well or very well, only 27.8% of foreign-born Latinos report the same ("Statistical portrait of Hispanics in the United States, 2008: Language spoken at home and English-speaking ability, by age, race and ethnicity", 2008). Individuals who do not speak English are less likely to have a regular source of medical care, less likely to have regular physician visits, decreased comprehension of medical diagnosis, and lower levels of patient satisfaction than those who report English proficiency (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003). Some Latina women have reported that they were unable to express their concerns or questions with care providers (Gurman & Becker, 2008), and non-English speakers have longer hospital stays and higher hospital readmission rates than patients who speak English due to difficulties in communicating care instructions between patient and physician (Karliner, Kim, Meltzer & Auerbach, 2010).

Positive communication between physicians and their Latino patients is often associated with higher levels of patient satisfaction and adherence to medical services (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003). Generally, physicians who are unable to communicate with their patients are left to use hand-gestures and body language to communicate complex health concerns, leading to decreased understanding and more confusion for the patient (Gurman & Becker, 2008). One 2008 study (Harari, Davis & Heisler) conducted semi-structured interviews with Spanish-speaking patients in order to understand how language differences between themselves and their provider impacts health care experiences. Patients stated that

disassociation in language leads to delays in seeking medical care because they were afraid they would not understand their doctor, or they needed to spend additional time finding somebody who spoke English that would translate for them during the appointment. Another issue reported by patients was that anxiety over language differences led to increased confusion. Many reported that they "left the appointment confused about the exact diagnosis or with questions unanswered" (p. 1360). Lastly, many respondents reported that they were unaware of interpreter services that were available to them. Importantly, this study was conducted in a new-growth population and could provide insight into language barriers present in Allegheny County. Further research confirms that language discrepancies are even more apparent in new-growth communities, as physicians report having more communication problems with Latino patients in areas such as Allegheny County as opposed to physicians practicing in established immigrant communities (Cunningham & Banker, 2008). In fact, physicians in new-growth areas describe problems communicating with their Spanish-speaking patients throughout 60% of interactions (Cunningham & Banker, 2008).

Many Latinos claim to have higher levels of satisfaction with their provider when there is language concordance (Arauz Boudreau, Fluet, Reuland, Delahay, Perrin, et al, 2010). Patients feel as if their doctor is better able to elicit their concerns and problems, and report less confusion and frustration during medical visits when their physician spoke Spanish (Fernandez, Schillinger, Grumbach, Rosenthal, Steart, et al, 2004). Unfortunately, there are only forty-eight Spanish-speaking physicians for every 100,000 Spanish-speaking patients (Yoon, Grumbach & Bindman, 2004), and this estimate is even lower in new-growth communities (Cunningham & Banker, 2006). Patients often take initiative to decrease language barriers between themselves and their physicians. Many rely upon ad hoc and untrained interpreters, such as family members

or friends, or professional interpretation services provided by medical clinics or hospitals to assist in communicating (Flores, Barton Laws, Mayo, Zuckerman, Abreau, et al, 2003). Not surprisingly, higher patient satisfaction levels are reported for those patients who utilize interpretation services, or for those who bring friends or family members to interpret, due to increased understanding between patient and physician (Locatis, Williamson, Gould-Kabler, Zone-Smith, Detzler, et al, 2010). However, many patients are unaware of their right to an interpreter and therefore do not access these services, and for those who do utilize these services, the wait for an interpreter can be over two to three hours (Harari, Davis & Heisler, 2008), which could be too long in an emergency situation. Even when a patient is able to utilize these services, there is a danger that the communication between patient, interpreter and physician becomes flawed. Trained interpreters make, on average, nineteen errors throughout each medical encounter while ad hoc interpreters make significantly more (Flores, et al, 2003). These errors, which include omitting key information, substituting or adding words, and editorializing problems or concerns, can often have clinically significant consequences (Flores, et al, 2003). Many physicians report difficulties "diagnosing patients, establishing a clinical relationship or providing adequate care to patients when using an interpreter, and hospitals and clinics often lament the additional costs of providing interpreters" (Davidson, 2000, p. 384). Some women have reported that they do not trust interpreters due to these issues, and others have cited lack of privacy felt during intimate medical visits as reasons why they have never used, or have stopped using, interpreters during medical visits (Gurman & Becker, 2008). Lack of standardized training for professional interpreters has further complicated this problem (Harari, Davis & Heisler, 2008).

2.3.2.2 Insurance

Another barrier faced by the Latino population is lack of health insurance and the inability to access medical services (Harari, Davis & Heisler, 2008). In 2006, 34.1% of the Latino population was uninsured, compared with only 14.9% of non-Hispanic whites, and the rate of Latinos without insurance grew over 50% throughout the past two decades (Rutledge & McLaughlin, 2008), making Latinos the racial or ethnic group with the highest rate of uninsured members ("Income, poverty and health insurance coverage in the United States: 2007", 2008). Mexican-Americans have the lowest rates of insurance coverage than all other Latino subgroups, and both low employment status and low income are associated with higher risk of being uninsured (Rutledge & McLaughlin, 2008). Although 62% of all U.S. citizens receive insurance through their employer, only 43% of Latinos are able to utilize employer-based insurance options (Cunningham & Banker, 2006). Furthermore, the number of Latinos who are able to receive employer-based insurance has actually declined 20% since the mid 1980s (Rutledge & McLaughlin, 2008), partly due to cut governmental funding for Medicaid insurance programs geared toward legal immigrants ("The impact of welfare reform on Puerto Rico and on Latino families in the U.S.: Policy directions for reauthorization", 2002). Additionally, many Latinos are ineligible for insurance programs based on immigration status, and therefore utilization and enrollment in these programs remains small within the Latino community and has fallen even lower in the past two decades (Burciaga Valdez, Giachello, Rodriguez-Trias, Gomez & De la Rocha, 1993). Other obstacles toward enrollment include lack of knowledge about the application process and eligibility, language barriers, immigration issues, misinformation from insurance representatives, social networks, and preferences for compensation in the form of

wages rather than benefits (Brotanek, Seeley & Flores, 2008; Burciaga Valdez, Giachello, Rodriguez-Trias, Gomez & De la Rocha, 1993).

As both public and private insurance rates continue to fall (Shah & Carrasquillo, 2006), a higher proportion of Latinos left without insurance. This can have devastating consequences. Latinos without insurance report poorer health status, are less likely to have a regular place of care and receive preventive care services, and are more likely to have unmet medical needs than those who have insurance (Burciaga Valdez, Giachello, Rodriguez-Trias, Gomez & De la Rocha, 1993; "Access to public health among Hispanic or Latino women: United States, 2000-2002", 2006). Lack of insurance is consistently reported as one of the largest barriers toward utilizing medical health services, including prenatal care (Harari, Davis & Heisler, 2008; Kalofonos & Palinkas, 1999).

For Latinos who do have health insurance or are able to access fee-for-service medical clinics, access to adequate care is still questionable ("Access to health care among Hispanic or Latino women: United States, 2000-2002; Burciaga Valdez, Giachello, Rodriguez-Trias, Gomez & De La Rocha, 1993). For many immigrants in new-growth communities, unfamiliarity with the U.S. healthcare system leads to lower rates of utilization for the Latino community compared with other racial and ethnic groups (Harari, Davis & Heisler, 2008). Due to the differences in health care structure between the United States and immigrants' countries of origin, many report being confused and not being able to understand how to receive medical services once they are settled in the U.S. (Harari, Davis & Heisler, 2008). Others cite concerns over the cost of check-ups and procedures as a barrier toward accessing needed healthcare (Harari, Davis & Heisler, 2008). Structural problems, such as long wait times, the inability to arrive late or reschedule

appointments, and the lack of transportation can also deter Latinos from attending medical appointments (Gonzalez, Vega & Terraf, 2010; Bork, Wiser & Keega, 1995)

2.3.2.3 Unfamiliarity and Discrimination

Distrust of the medical system and perceived discrimination are also obstacles in accessing medical care. Some Latinos feel as if U.S. physicians are cold, impersonal and are not invested in the well-being of their patient (Documét & Sharma, 2004; Campbell-Grossman, Brage Hudson, Keating-Lefler, Yank & Obafunwa, 2009). M any women remember instances where they felt looked down upon due to their appearance or language (Sanchez-Birhead, Kennedy, Callister & Miyamoto, 2010), and others distrust the health care system due to fears of deportation (Campbell-Grossman, Brage Hudson, Keating-Lefler, Yank & Obafunwa, 2009). Perceived discrimination is reported by many as a reason why they are unable to access medical care (Harari, Davis & Heisler, 2008; Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010). Some claim that they have been treated differently due to insurance status. These feelings of frustration are reported by many, and have led some to stop seeking care altogether.

Anti-immigrant sentiment has been increasing steadily over the past few decades, however it has become particularly hostile since 2008, when the United States entered a recession, and strict immigration policies were introduced in Arizona and California (Ayon, Marsiglia & Bermudez-Parsai, 2010). Throughout this time period, Latinos' fears of deportation have increased, as have feelings of perceived discrimination and prejudice from the general population (Ayon, Marsiglia & Bermudez-Parsai, 2010). In one survey, over 30% of Puerto Rican respondents reported increased discrimination in medical settings (Todorova, Falcon, Lincoln & Price, 2010) and Arcia, Skinner, Bailey & Correa (2001) discovered even higher levels of perceived discrimination for other Latino populations – close to 50% of Mexican

fathers report being discriminated against. One woman explained a time when there was a medical emergency and "the ambulance staff was very annoyed…and…were acting in a very rough and crude manner. They said that there was a 'barrier in communication' and that they could not attend to me" (Harari, Davis & Heisler, 2008, p. 1357). These experiences influence later use of medical care services, and perceived discrimination has been shown to impact both physical and mental health through explicit and implicit biopsychosocial pathways (Gurman & Becker, 2008).

2.3.2.4 Social Isolation

Another frequently cited barrier toward equitable health for the Latino population is the social isolation and the lack of social support that many in this community face, particularly in new-growth areas (Campbell-Grossman, Brage Hudson, Keating-Lefler, Yank & Obafunwa, 2009). In these communities, where many Latinos refer to themselves as "ghosts" because their presence is often ignored by the larger population, the networks necessary to achieve good health and have access to appropriate health care is lacking (Campbell-Grossman, Brage Hudson, Keating-Lefler, Yank & Obafunwa, 2009). Traditional immigrant cities often have large sections of the city where immigrants live and feel comfortable while being surrounded by other recent immigrants from the same country (Cunningham & Banker, 2006), however neighborhoods in new-growth areas are much more disorganized (Rankin & Quane, 2000). Whereas communities with high levels of organization are able to provide emotional, physical and economic support to each other, these disorganized networks spur even more distrust and fear of others, and can lead some to avoid contact with neighbors.

> The social organization of…neighborhoods exacerbates the social isolation of poor families by limiting the amount of social capital available in community networks. The lack of normative reinforcement and of useful information and the low levels of trust and

mutual obligation mean that families have few local social resources to aid them in their efforts to accomplish socially desired ends. (Rankin & Quane, 2000, p.142)

Being a member of a small group can hinder opportunities to make connections with others, which has been shown to lead to depression and can impact stress coping abilities (Documét & Sharma, 2004; Gallo, Penedo, Espinosa de la Monteros & Arguelles, 2009). Many Latinos have stated that living in these "ghost" communities creates conditions in which it is more difficult to access informational networks, and that they are unaware of available resources within a particular area (Harari, Davis & Heisler, 2008).

Social support is thought to impact health by providing a buffering effect on stress through increased coping responses and the number of resources available to tackle problems (Heaney & Israel, 2008). Many Latinos depend on referrals from friends and family to access health care, and social support can be seen as an "important determinant of who gets adequate care and who does not" (Kalofonos & Palinkas, 1999, p. 148). Additionally, the size of a social network can impact health outcomes. Dyer, Hunter and Murphy (2010) report that larger social networks are associated with positive physical health, healthy behaviors, and mental health outcomes. Therefore, the isolation that this community faces and the lack of an organized community, particularly in new growth areas, can be extremely detrimental to health.

2.4 MATERNAL HEALTH AND CHILDBIRTH

Although many studies have investigated factors which influence Latino health, less is understood about the importance that maternal health and childbirth experiences can have on new mothers and their babies, specifically for Latinas. For all women, the birth of a child is an

intense experience which can have an enormous impact throughout her life, and some have said that "of all life events, the childbirth experience is consistently described as a significant event of powerful psychological importance in a woman's life" (Callister, 2004, p. 510) . The labor process leaves lasting and ingrained memories in mothers and the perception of this experience has been shown to impact psychosocial and mental well-being of women (Simkin, 1991). Indeed, "few human experiences approach the intensity of emotions, stress, anxiety, pain, and exertion that can occur during birth" (Matthews & Callister, 2004, p.498). Most can recall exact details of labor and delivery for decades after the birth of their child, and many report a sense of empowerment and achievement when recalling their birth story (Goodman, Mackey & Tavakoli, 2004). Others claim higher levels of self-esteem and increased personal strength after delivery (Simkin, 1991).

Unfortunately, some women perceive their birth experience as negative, and as many as one third report their birth experiences were emotionally traumatic (Anderson, 2010). While the definition of an emotionally traumatic childbirth is individual, women who perceive emotional birth trauma often experience transient and acute symptoms, including dazed, overactive or agitated, withdrawn, anxious, disoriented or depressed states, re-experiencing, avoidance, arousal or dissociation states of mind (Anderson, 2010). There are a number of factors which can influence the occurrence of an emotionally traumatic birth, including emergency cesarean delivery, fear of epidural, infant abnormalities, separation from infant, infant death, severe toxemia, rapid delivery, and a degrading experience (Anderson, 2010). Additionally, many who report a negative experience also cite lacking a sense of control, uncontrolled pain, a feeling of powerlessness, increased medical interventions, feelings of anxiety or pain, feeling alone and without support, and inadequate birth information (Anderson, 2010). Interestingly, women can

perceive some parts of the birth process as positive while simultaneously perceiving other aspects negatively (Goodman, Mackey & Tavakoli, 2004), therefore, most research looks at both global and more specific satisfaction levels in order to understand a woman's childbirth experience.

The perception of a negative birth can impact feelings of disappointment, anger and loss, and has been linked to an increased risk of postpartum depression (Waldenstrom, Hildingsson, Rubertsson & Radestad, 2004). Maternal depression is a serious illness that impacts approximately 14% of new mothers. It can reduce quality of life, functional status, parenting skills and, in some cases, can result in psychiatric illness and cause harm to the entire family (Hunker, Patrick, Albrecht & Wisner, 2009). Some who develop depressive symptoms also develop signs of Post Traumatic Stress Disorder, and the comorbidity between the two psychiatric disorders has been noted by many (Anderson, 2010). Previous studies suggest that up to 9% of women who have given birth have developed PTSD by 24 weeks postpartum (Alcorn, O'Donovan, Patrick, Creedy & Devilly, 2010). Many women who meet this diagnosis experience reoccurring trauma symptoms, including fear, helplessness and terror. These women also report explicit memories of the birth, flashbacks, nightmares, and increased irritability (Elmir, Schmied, Wilkes & Jackson, 2010; Alcorn, O'Donovan, Patrick, Creedy & Devilly, 2010). One study reported that "re-experiencing the event affected their lives and ability to function on a daily basis; they felt trapped, with no way of escaping from their ordeal, as they experienced the constant reminder of the event" (Elmir, Schmied, Wilkes & Jackson, 2010, p.2149). Women who develop PTSD or experience some PTSD symptoms often report the inability to discuss their feelings with their partners or members of the medical community (Elmir, Schmied, Wilkes & Jackson, 2010).

For the majority of women who deliver a child, the relationship that exists between themselves and their newborn is filled with joy and elation from the moment the child is born (Simkin, 1991). However, for some who have experienced a negative birth, the maternal bond that exists is one of detachment and disconnectedness stemming from the birth experience (Elmir, Schmied, Wilkes & Jackson, 2010). Some women who have had a negative childbirth report a lack of emotional connectedness with her child, and although most women work through this difficult time within a few weeks of the birth, others continue to feel distant through her child's toddler years (Elmir, Schmied, Wilkes & Jackson, 2010). The lack of connection reported impacts the communication between mother and child, which can derail the baby's development and have repercussions throughout the child's lifetime. Studies have shown that maternal depression can affect the bonding process, mother-infant interaction, and childhood cognition and motor development (Tronick & Reck, 2009). Furthermore, adults who had a mother who was diagnosed with postpartum depression after they were born are at an increased risk for a number of psychosocial disorders, including depression, behavioral problems, and psychopathology (Reck, Hunt, Fuchs, Weiss, Noon, et al, 2004).

A negative birth experience has also been shown to decrease breastfeeding rates (Elmir, Schmied, Wilkes & Jackson, 2010; Hunker, Patrick, Albrecht & Wisner, 2009). Some women who were dissatisfied with childbirth said that "they felt empty and demonstrated little emotion or feelings toward their baby during breastfeeding sessions; some would rarely make eye contact and interact with their babies. In a few cases, breastfeeding was linked with the violation experienced during birth" (Wilmir, Schmied, Wilkes & Jackson, 2010, p. 2149). However, for other women who had a negative experience, breastfeeding provides an opportunity to reclaim their womanhood and compensates for the fact that they did not have a better delivery. In these

situations, breastfeeding and the skin-to-skin contact between mother and child helped women heal from their psychological pain (Wilmer, Schmied, Wilkes & Jackson, 2010).

2.4.1 Locus of Control

Although some factors which precipitate a negative childbirth experience are sometimes unavoidable, such as induction of labor (Waldenstrom, 1999) and infant transfer to the NICU (Waldenstrom, Hildingsson, Rubertsson & Radestad, 2004), locus of control, support from a caregiver, and expectation congruencies are often reported as some of the more influential factors in childbirth experience (Goodman, Mackey & Tavakoli, 2004; Waldestrom, 1999; Waldenstrom, Hildingsson, Rubertsson & Radestad, 2004). Women who report a positive birth experience also report higher levels of control throughout labor and delivery (Simkin, 1991; Goodman, Mackey & Tavakoli, 2004; Waldestrom, Hildingsson, Rubertsson & Radestad, 2004). In the childbirth context, control entails the concepts of self-determination, directing, decision-making, and self-respect (Namey & Drapkin Lyerly, 2010). Research has classified control into distinct categories, including external control and internal control (Simkin, 1991). High levels of external control refer to having decision-making capabilities and self-determination, or "the ability to have a birth that is shaped and guided by one's own inclinations and values rather than those of others" (Namey & Drapkin Lylerly, 2010, p. 771). Internal control, on the other hand, refers to a woman's ability to manage her own behavior, thoughts and actions during birth (Namey & Drapkin Lylerly, 2010). Having the desired level of control and influence in decision making processes during childbirth can lead to increased self-worth and feelings of empowerment (Matthews & Callister, 2004). Many women have reported that they expected their physician to keep them well-informed throughout the childbirth process, and that they

would be pivotal in decision-making throughout labor (Elmir, Schmied, Wilkes & Jackson, 2010). However, women who report a negative birth experience claim that they felt ignored, faceless (Elmir, Schmied, Wilkes & Jackson, 2010), powerless, and that they lacked control over decisions that were made throughout their child's delivery (Simkin, 1991). Furthermore, feeling "out of control led to a sense of powerlessness, vulnerability and inability to make informed decisions about their care. They felt betrayed, and some indicated that they agreed to procedures…in an attempt to end the trauma they were experiencing" (Elmir, Schmied, Wilkes & Jackson, 2010, p. 2147). It is important to note that individuals desire different levels of control, and it is unknown whether Latinas desire a large level of control during childbirth, or if they are comfortable deferring decision-making to the physicians due to the cultural view of physicians as authority figures. Previous research has emphasized the importance of striking a balance between patient autonomy and direction from caregivers throughout the birth process, and all women report that effective communication between herself and her caregivers was a major factor in her perception of control (Matthews & Callister, 2004).

2.4.2 Labor and Delivery Support

Many immigrant Latina women depend on their partner or husband as their strongest source of support throughout the pregnancy and delivery (Dyer, Hunter & Murphy, 2010). However, receiving positive support and respect from caregivers (including doctors, nurses and hospital staff) has also been associated with a better birth experience (Simkin, 1991; Waldestrom, 1999; Matthews & Callister, 2004). Women who have good memories of childbirth remember caregivers with positive and humorous reactions and often recall good-natured communication between themselves and their physicians (Simkin, 1999). Latinas, in particular, have mentioned

the importance of having doctors and nurses who are *bien amables* (very friendly) throughout maternal health experiences (Gurman & Becker, 2008). However, most women who leave the hospital unsatisfied have complaints about actions or comments from their caregivers (Simkin, 1999), and felt that they lacked support from hospital staff (Waldestrom, Hildingsson, Rubertsson & Radestad, 2004). Some report being treated inhumanely or "like a slab of meat," and others believe that they were treated insensitively or rudely by caregivers (Elmir, Schmied, Wilkes & Jackson, 2010, p. 2147). Furthermore, most women who expressed negative feelings toward their caregivers believe it has impacted their trust in the medical establishment well past the birth of their child (Simkin, 1991).

2.4.3 Expectations of Childbirth

Another important factor which impacts a woman's childbirth satisfaction is her expectations of the event, specifically if those expectations are congruent with the actual events of her child's birth (Goodman, Mackey & Tavakoli, 2004; Elmir, Schmied, Wilkes & Jackson, 2010; Waldenstrom, Hildingsson, Rubertsson & Radestad, 2004; Waldestrom, 1999). If expectations remain unmet, women are more dissatisfied with childbirth, regardless of the amount of pain she perceived (Matthews & Callister, 2004). A 2008 study, which utilized both in-depth interviews and focus groups, reports that many immigrant Latina women have either direct experience with the maternal health system in her country of origin, or have heard stories from friends and families. The authors claim that:

> These experiences shaped women's evaluations of their hospital experience in the United States. Women who had given birth in health facilities in their countries of origin often had experienced care settings with lower standards of care than what is common in many U.S. hospitals. (Gurman & Becker, 2008, p.518)

The participants in this study expressed that they had lower expectations of what their birth experience in the United States would be like due to the different standards of care which some anticipate being the norm. If these expectations of the birth were similar to what happens during labor and delivery, these women could perceive their birth experience as positive. However, if a Latina woman is unfamiliar with the birth process in the U.S. health care system, she could be unprepared for the highly technical and medicalized childbirth approaches common in many U.S. hospitals, which could lead to a sense of hopelessness and frustration (Matthews & Callister, 2004). Additionally, due to the strong influence of traditional folk medicines in some Latino cultures (Burk, Wiser & Keega, 1995), many of these women could be unsatisfied if they are unable to express or utilize some of these medicinal beliefs during childbirth. Although Gurman and Becker's research arrives at an interesting conclusion, their findings could be difficult to translate to Allegheny County. The subjects who participated in the 2008 study came from an established immigrant community, in which there were more opportunities to interact and share birth stories from one's country of origin, as well as experiences and expectations from the United States. In Allegheny County, however, women could be relatively isolated and may not have the networks available to gather as much information before she goes into labor.

3.0 OBJECTIVES

Recent scholars have emphasized the interconnectedness between the biological, the social, health, illness, and society (Greenhalgh, 1995). The theory of political-economy emphasizes the "embeddedness of community institutions…in structures and processes operating at regional, national, and global levels, and to have the historical roots of those macro-micro trends" (Greenhalgh, 1995, p. 13). Indeed, many of the barriers that Latinos face in achieving health and wellbeing are affected not only by individual pursuits, but by a combination of the cultural, political and economic system in which they are interacting. Insurance status eligibility, for example, is dictated by federal and state government and has a great impact on health access and outcomes, whereas the social and economic influence of discrimination and isolation has been shown to influence health as well. The political-economy perspective is a useful theory to better understand Latino health because it seeks to understand health outcomes from the relations between culture, and social and political systems.

The cultural protective factors which help to reduce health barriers for the Latino population could be non-existent in new-growth communities. T he importance of *familismo* could serve as a protective factor during childbirth, as women report a more positive experience when they have caring and supportive family members present (Callister & Khalaf, 2010). However, as families migrate at different times and to different areas, many Latinos are left without the traditional strong support that family provides due to greater geographic separation

(Kalofonos & Palinkas, 1999), and some have commented that they feel a sense of aloneness and isolation when interacting when the United States medical system (Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010). Therefore, the protective childbirth factor of *familismo* that may be seen in traditional immigrant communities could be decreased in new-growth communities, and could make labor and delivery even more difficult for some Latina women. Likewise, the lower levels of English proficiency in new-growth communities (Documét & Sharma, 2004) could make doctor-patient communication more difficult, further diminishing the opportunity for a positive birth experience.

As the Latino population continues to grow and expand into new parts of the country, it will be important to understand their thoughts, feelings and perceptions regarding childbirth experiences. Throughout labor and delivery, "a woman's confidence and ability to give birth and to care for her baby are enhanced or diminished by every person who gives her care, and by the environment in which she gives birth" (Matthews & Callister, 2004, p.504). In order to make sure all women have a positive childbirth experience, some have emphasized the importance of culturally sensitive care (Burk, Wiser & Keegan, 1995; Sanchez-Birkhead, Kennedy, Callister & Miyamoto, 2010; Berry, 1999; Campero, Garcia, Diaz, Ortiz, Reynosa, et al, 1998). This care is:

> Based on respect for the beliefs, attitudes and cultural lifestyles of clients. It acknowledges that culturally constructed concepts of health and illness are important aspects of healthcare. Culturally sensitive care is flexible and accessible to clients. It recognizes that cultural heritage provides patterns for group reference while allowing for intracultural and individual variance in beliefs and behaviors (Burk, Wiser & Keega, 1995, p. 38).

Culturally sensitive care allows the cultural views and norms which serve as protective factors for health and a positive childbirth experience to be expressed by caregivers, clinics and hospitals, while simultaneously minimizing some of the barriers present in the Latino population.

Although there have been studies looking at Latina's experiences seeking prenatal care (Gurman & Becker, 2008), not much is known about Latino perceptions of childbirth experiences, and if the barriers impacting health care access for the general population are present during childbirth. Therefore, it is unknown whether barriers such as language discordance, ineffective communication, unfamiliarity and perceived discrimination within the health care system, and social isolation could significantly impact a Latina women's childbirth experience, particularly in a new-growth community, where systematic changes to better serve the Latino population could be lacking. Furthermore, the majority of studies on the prevalence and impact of a negative childbirth experience have been conducted with middle-class, Caucasian women from the United States or Europe (Simkin, 1991; Goodman, Mackey & Tavakoli, 2004; Elmir, Schmied, Wilkes & Jackson, 2010; Waldenstrom, Hildingsson, Rubertsson & Radestad, 2004; Alcorn, O'Donovan, Patrick, Creddy & Devilly, 2010; Beck & Watson, 2008; Waldenstrom, 1999). It could be difficult to conclude that these findings are representative of the unique Latino immigrant community present in new-growth communities. This study will add to general knowledge on Latina perceptions of childbirth experiences in new-growth areas, and how both Latino social and cultural norms and U.S. health care structure can impact this important time in a woman's life. Specifically, this study will explore:

(1) How Latina women perceive their birth experience
(2) Factors which are most important in creating positive or negative birth experiences
(3) Whether other variables, such as insurance status, English proficiency level, and education level are associated with childbirth experience
(4) How birth experience impacts the health of Latina mothers and their children.

4.0 METHODS

The University of Pittsburgh's Institutional Review Board approved the study as exempt on November 29, 2010. The primary data collection instrument was an open ended interview. Latina women who gave birth at an Allegheny County Hospital were recruited from a local pediatrics clinic, and those who chose to participate were interviewed at a scheduled time. After the interviewers were completed, a qualitative analysis was conducted to look for common themes.

4.1.1 Population and Sampling

Nonproportional quota sampling was utilized to recruit ten participants in order to assure that a diverse group of women would be interviewed. Specifically, five women who had insurance during childbirth and five women who did not have insurance were recruited to participate. The rationale for choosing half of participants with insurance and half without insurance was to search for differences in birth experience between the two populations. It was hypothesized that five women would provide enough unique experiences which would allow for common themes to emerge within each group, and within the larger group as a whole. Previous research pointed to the fact that women with insurance and those without insurance choose to give birth at different hospitals, therefore, it was important to speak with women who had given birth at

different hospitals in order to gain a broad understanding of Latino experiences throughout the county and not just in one particular hospital. Research suggests that additional recall bias could be introduced in interviews which take place after twelve months postpartum (Gurman & Becker, 2008). Therefore, only women who had delivered a child in an Allegheny County hospital during the previous twelve months were eligible to participate in the study. Other eligibility requirements included self-identification as a Latina woman and being over 18 years of age. Only immigrant Latina women were eligible; however women could have emigrated from any Spanish-speaking country. This broadened the potential participant pool and introduced new cultural childbirth viewpoints. Additionally, women from different countries of origin could have different previous experiences and expectations, which could influence their birth experience.

All ten participants were recruited from Salud Para Niños, a Spanish-speaking pediatric clinic, through face-to-face and telephone recruitment. Women who brought their child for a well-child checkup were approached by their child's pediatrician. The pediatrician introduced the researcher to the women, and the researcher was then able to further explain the study to potential participants and answer any questions. Women were also contacted by the pediatrician via telephone and introduced to the researcher. The researcher then discussed the study over the phone and scheduled an interview with future participants. There were additional efforts made to recruit participants who did not attend Salud Para Niños. The researcher conducted face-to-face meetings with community leaders to explain the project; these leaders then attempted to contact women they knew who were eligible and explained the study. Additionally, the researcher sent flyers to two Family Health Centers who displayed the flyers in common areas. The flyer provided information about the study and a phone number to call for women who were

interested in talking about their birth experiences. The researcher then called each woman a day before the scheduled interview to confirm the interview time and location.

4.1.2 Instrument

An interview guide was developed in English and Spanish and was reviewed with key leaders in the Latino community to ensure cultural sensitivity. Questions were centered on the woman's perceptions of her birth experience and included questions related to the hospital she gave birth at; her interactions with care providers; and her locus of control throughout the labor and delivery process and postpartum period. Additionally, women were given the opportunity to share what worked well for her during labor and delivery, as well as what could be improved to make the experience better for other Latina women in the future. Self-report was used to measure English proficiency level. *(See Appendix A for a copy of the interview guide, p. 76).*

4.1.3 Interview Procedures

Each interview lasted about an hour and took place in the participant's homes. A consent script was read at the beginning of the interview and participants were informed that they were free to refuse to participate, or may stop the interview at any point in time. Women were given the option of completing the interview in English or Spanish.

4.1.4 Data Analysis

The interviews were transcribed by the researcher and each interview was read multiple times in order to find common responses. If two or more participants mentioned the same response, that theme was coded and an analytic memo was written with the hopes of connecting the themes together, and connecting the themes with previous research. See *Table 1* for a complete list of themes. The information will be shared and disseminated back in into the community through a public presentation at a Spanish-language prenatal support group, and at a Health Disparities poster competition at a large public University.

Table 1 Theme List

5.1.1. Communication
5.1.1.1. Language
5.1.1.2. Interpreters
5.1.2 Support
5.1.3. Patient-Provider Relationship
5.1.3.1. Care Providers
5.1.3.2. Discrimination
5.1.4. Birth Outcomes
5.1.4.1. Vale La Pena
5.1.4.2. Medical Interventions and Birth Complications
5.1.5. Expectations
5.1.6. Locus of Control
5.1.6.1 External Control
5.1.6.2. Internal Control
5.1.7. Postpartum Recovery
5.1.7.1. Physical Recovery
5.1.7.2. Emotional Recovery

5.0 RESULTS

All ten participants were recruited from Salud Para Niños through both face-to-face and telephone contact. The recruiting process went relatively easily, as all women who were approached agreed to participate in study. Only two of the scheduled interviews were missed, and attempts were made to reschedule; however neither interview was able to be rescheduled. Two additional participants were recruited to take their place. Although community leaders and organizations attempted to recruit participants from their sites, there were no women who returned phone calls or showed additional interest in participating from locations outside of Salud Para Niños. This is most likely due to the introduction of the researcher by a trusted physician and the face-to-face contact between the participants and the researcher that was possible in the clinic. Nine of the interviews were conducted in Spanish, and one participant preferred to complete the interview in English.

All ten participants have lived in the United States for less than ten years, and eight moved directly to Pittsburgh from their countries of origin. Six of the participants lived in Pittsburgh for less than three years. The participants primarily migrated from Mexico (7 participants) and the other three emigrated from Guatemala, Puerto Rico, and Costa Rica. All participants lived with their husbands or boyfriends, and all spoke primarily Spanish at home. Three of the participants had private insurance, two had Medicaid, and the other half did not have insurance. All five participants who had insurance during childbirth self-reported higher

levels of English proficiency. These participants self-reported being able to speak English well or very well, and said they did not have many problems holding conversations in English. Two of the participants who did not have insurance reported that they spoke a small amount of English but were unable to hold conversations, and the other three participants reported that they did not speak any English. Seven of the participants had vaginal births, while three had C-Sections (one was planned, one was due to prolonged labor, and the third was an emergency situation). The ten participants gave birth at three different hospitals within Allegheny County. Six pregnancies were unplanned, however all participants reported being extremely happy when they found out they were pregnant, and none of the participants reported an unwanted pregnancy. Refer to *Table 2* for complete demographic information.

All of the participants reported that they enjoyed sharing their birth experience and seven reported being pleasantly surprised how good they felt about themselves after the interview was over. One participant who had a particularly difficult experience commented that she had not been able to talk about what she had been through with anybody, and that she felt better after sharing the experience with somebody. Another participant added that she was happy to tell her story and felt that she was given a voice by sharing her childbirth experience. Two participants commented that this was a good study and that it is important to work with the growing Latino community.

Table 2. Interviewee Demographics

	Number of Participants
County of Origin	Mexico - 7 Guatemala - 1 Puerto Rico - 1 Costa Rica – 1
Years Living in Pittsburgh	3 Years or Less - 6 More than 3 years – 4
Insurance Status	Uninsured - 5 Medicaid - 2 Private Insurance – 3
English Proficiency Level	Low - 5 Medium or High – 5
Education Level	Less Than a High School Diploma - 4 High School Diploma - 2 Bachelors Degree or Above – 4
Number of Children	One - 7 More than one – 3
Type of Birth	Vaginal - 7 C-Section – 3
Doula Present	Yes - 5 No – 5
Number of Weeks After Birth When Interview Took Place	1-16 Weeks – 5 16-40 Weeks - 5

5.1 THEMES

5.1.1 Communication

Throughout the interviews, participants who reported better communication between themselves and their care providers also reported higher satisfaction levels with their birth experience. There were two subthemes which emerged related to conversation: language barriers and the use of interpreters to overcome language barriers.

5.1.1.1 Language

All ten participants reported that their care providers, which included physicians, nurses, lactation consultants, anesthesiologists, and other hospital staff, spoke primarily English. Five participants had stories of a Spanish-speaking care provider entering the room once or twice, and others told of times in which their physician or nurse attempted to tell them something in Spanish. Although one woman felt much more comfortable with English than her husband or her mother, she stated that:

> *Even my husband and my mom were able to communicate with him…the nurses were very good with me, I think they understood me…the doctor was very nice; he was actually trying to speak Spanish with me!*
> *(Interview 7)*

The other four participants added that it made them feel more comfortable when their care providers spoke Spanish or attempted to speak Spanish, and they appreciated any efforts on the part of care providers.

Five of the participants reported high English proficiency (the same five who had insurance). These participants commented that speaking English helped them to communicate their concerns, questions and desires with care providers. Participants remembered times in which they needed something from a nurse, or had a medical problem, and were able to call upon

care providers with their questions. They also reported that the open communication allowed them to be more informed and educated about medical procedures as they happened, and one stated that the open communication created a teamwork-like environment. Although these five participants did report higher levels of English proficiency, some spoke about the difficulties of giving birth in two different languages. One Mexican woman said that when a Spanish-speaking physician entered the room:

> *Ya estaba tan cansada que no sabía en que lenguaje estaba hablando. Le dije, 'no sé si estás hablando en inglés o en español, pero sé que no entiendo.' Fue bastante curioso.*
>
> *I was so tired that I didn't know what language he was speaking. I told him, 'I don't know if you're speaking English or Spanish, but I know that I don't understand you!' It was very strange.*
> *(Interview 1)*

The same participant expressed appreciation that her anesthesiologist was very patient with her while she was receiving an epidural and explained things very slowly after she told him that she did not speak English fluently.

The five participants who reported lower English proficiency reported different communication experiences between themselves and care providers. All five of these participants described times in which they were unable to tell their care provider something, or instances when they were left with questions and concerns. One participant, who had experienced high levels of pain during a previous birth, wanted local anesthesia immediately after her baby was born to decrease potential pain during this childbirth. She commented that:

> *Había un problema en la comunicación, porque yo dije tal vez igual si había anestesia después de que nació el bebe, para [que no tenía] ningún sentimiento. Pero, por falta de comunicación…desgraciadamente, mi esposo no pudo explicar…que si me pusieran anestesia local, pero desgraciadamente no funcionó la llamada.*
>
> *There was a communication problem because I really wanted anesthesia after the baby was born so that I wouldn't be able to feel anything. But, unfortunately, because of the*

communication problem, my husband wasn't able to explain...that they give me local anesthesia. So, unfortunately, our appeal didn't work.
(Interview 4)

This participant later reported a high level of pain during childbirth and expressed regret that her husband was unable to hug their newborn because she needed his hand to squeeze in order to cope with the pain. Other participants reported lingering questions and confusion due to language differences. One stated:

> *Pero ya después, cuando llegaron los doctores, que ellos hablaban en inglés y yo no entendía. Decían que tenía que firmar aquí y el otro. Yo no sabía lo que estaba firmando, como nadie me traducía y yo dije que no entendía inglés…Yo les decía que no entendía…pero fue duro.*
>
> *When the doctors arrived, they only spoke English and I didn't understand. They told me that I needed to sign here, and some other things. I didn't understand what I was signing because nobody translated it for me even though I told them I didn't speak English. I told them I didn't understand…it was very difficult.*
> *(Interview 5)*

A second participant reported that:

> *Llegué aquí a la casa un poquito confundida porque de hecho llegamos y, ay, ¿cómo se llama la leche que vamos a dar el bebe? No nos dijeron este…Entonces no sé si realmente nos explicaron algo y no lo comprendimos bien, o no nos explicaron la verdad. No tengo idea.*
>
> *When I arrived home I was a little bit confused because we arrived and it was like, what is the name of the milk that we are supposed to give the baby? They never told us what the name of the formula was…Realistically, I don't know if they explained it to us and we didn't understand, or if they actually didn't explain it to us at all. I have no clue.*
> *(Interview 4)*

Another interviewee recalled a time during labor in which she thought she was receiving a second dose of pain medication and became confused when she started feeling stronger contractions. However, nobody explained to her what medicine she was getting, and instead of pain medication, she was actually receiving a dose of Pitocin to help augment labor. She was unaware of what medication she was receiving and unable to ask hospital staff due to a language

barrier. A fourth interviewee had a very difficult birth experience because her child was born four months prematurely. She stated that she arrived at the hospital by herself, overwhelmed and confused after being sent by the clinic where she was receiving prenatal care. She remembers:

> *Cuando llegué…me empezaron [decir] muchas cosas de él y [yo pensaba] ¿cómo es que ellos iban a hacer así? Me empezaron a explicar. Me dijeron muchas cosas, pero ya mi mente no estaba para este.*
>
> *When I arrived…they started to do a lot of things to him [the baby], and I thought how are they going to do these things? They started to explain to me. They were telling me a lot of things, but I did not understand.*
> *(Interview 6)*

This participant said she was in the hospital a few hours before the physicians determined that she would need an emergency C-Section. However, throughout these few hours, she remembered that the physicians:

> *Me empezaron a decir que…corría yo el peligro, yo y él, y eso es lo que me dijeron. Y después me empezaron decir que es un chiste, y que todo estaba bien.*
>
> *They continued tell me that my baby and I were in a lot of danger. But later, they started to tell me that it was a joke and that everything was OK.*

This participant made multiple references to the fear that she felt because did not understand what was happening due to the fact that she did not speak English. After an emergency C-Section, the baby was born and, weighing approximately one pound, stayed in the NICU for three months before coming home. The family visited often and this participant expressed gratitude that her son's nurses and physicians were so caring with him while he was in the NICU. However, she told the researcher that the nurses communicated her son's complex medical conditions with her using only signals or simple words. There was one point in which she said she received a phone call from a nurse at the NICU while she was at home and did not understand what the nurse was telling her. She recalled:

Yo me asustó, y dije, ¿qué está pasando con mi bebe? Me tocaba mi cita, preferí ir a ver a mi bebe y no a mi cita. Y me fui a ver al bebe, y después me dijeron que él estaba bien, que fue por simplemente una vacuna. Por eso me llamaron, pero porque no entendía, me daba miedo y mi fui. Había esto miedo que algo iba a pasar.

It scared me and I was like, what is going on with my baby? I had a visit [6-week postpartum checkup] for myself, but I would rather go see my baby and skip my visit. And I went to see my baby and later, they told me that he was OK but that it was simply that they were giving him a vaccine. That's why they called me, but I didn't understand and it made me so scared and I went there. It was that fear that something had happened to him that I didn't go to my visit.

5.1.1.2 Interpreters

All five participants with lower levels of English proficiency said they relied upon trained and ad hoc interpreters at some point throughout their childbirth experience. None of the participants interacted with in-person interpreters during their stays in the hospital, however three of the five used telephone interpretation services provided by the hospital at least once prior to discharge. All participants said they had no continuous access to the telephone interpretation system. The telephone was offered by hospital staff during the postpartum period (as none of the participants had access to it during labor and delivery), and none of the participants actively requested these services. All three liked using the telephone and stated that it helped them to understand what was happening. One participant said that using the telephone made her feel more trusting of her care providers because she knew that there was somebody there that spoke Spanish. The participant who gave birth prematurely reported a few occasions when she communicated with her son's NICU nurses via the telephone, however she commented that most of the time they tried to talk with her without the use of an interpreter. Although these women appreciated being offered the telephone, there were multiple instances when they felt confused and were not able to access the telephone. One interviewee stated that the only time she used the telephone was:

Cuando ya salimos del hospital…nos preguntaron ¿qué íbamos hacer con la niña? Que nos pidieron la sillita y nos dijeron que fue vencida…Nos dijeron que no la podíamos usar, entonces tuvimos que mandar a comprar otro. Eso fue.

When we were being discharged from the hospital…they [the nurses] were asking what we were going to do with the baby and they asked us for her car seat…and told us that it was expired…Then they told us that we needed to go buy another one. That was it. (Interview 8)

The same participant continued to say that before being discharged she and her husband were unsure whether they needed to sign more papers or needed more information, however were not offered the telephone to ask these questions.

Although only three participants utilized formal interpretation services, all relied upon their husbands or doulas as informal interpreters. All five participants with low levels of English proficiency reported that their husbands spoke more English than they did, however none of their husbands were fluent in English and two spoke only a bit of English. When asked how the communication was with her care providers, one participant responded that:

Todos hablaban inglés. Pero como yo no manejo el inglés…él [mi esposo] fue lo que estuvo allí conmigo. La mujer que me alivió, ella no sabía español. Pero estaba mi esposo…Él me estaba diciendo las cosas porque él entendía todo.

They all spoke English. And since I don't know any English…he [my husband] was there with me. The woman who delivered my baby didn't know Spanish, but my husband was there with me…he was telling me things because he understood everything. (Interview 9)

Five participants worked with bilingual doulas, or women who are trained to provide continuous physical, emotional and information support to a woman throughout childbirth (Dona International, 2010). In addition to support, education and advocacy, the doulas also served as informal translators throughout childbirth for these families. One participant commented that:

La doula estuvo con nosotros y lo que me decían los doctores, ella me decía en español. Me decía que tenía que empujar para que ella naciera, o que respirar, que me sintiera tranquila, que no fuera preocupada de nada. Y tenía que ser fuerte para que ya pudiera nacer para que no durará mucho más tiempo así. Eso fue lo que ella me dijo.

The Doula was with us and when the doctors were telling me things, she said it in Spanish. [When I was pushing] she told me that I had to push so that she could be born, or that I needed to breathe, and feel calm and not worry about anything. And that I needed to be strong so that [my baby] could be born quickly. That's what she was telling me.
(Interview 8)

All ten women, regardless of their English-speaking abilities, depended upon their husbands to fill out all forms that were needed by the hospital, including social security forms and insurance information.

5.1.2 Support

Participants stated that feeling supported by a loved one helped to encourage participants throughout childbirth and postpartum. All ten participants said they were accompanied by their husband or boyfriend during childbirth. The men were reported to have provided a tremendous amount of encouragement, and all ten stated that their partners were their main source of support while giving birth and in the weeks following discharge. When asked about the moment in which her baby was born, one woman said that:

En el momento en que nació, que salió, pues yo estaba feliz porque su papa también estaba feliz. Creo que me animaba de ver que mi esposo esperaba a conocer…Eso me puso feliz - nunca me dejó sola.

When she was born, I was so happy because her father was happy too. I think it made me excited to see that my husband was finally able to meet her…That is what made me happy – that he never left me alone.
(Interview 8)

Another participant added:

Tuve muchos problemas porque tenía los dolores de cabeza muy horribles, pero lo que me ayudó fue mi esposo. Fue él que se encargó del bebe todo este tiempo en que estuve en el hospital. Yo, sí le daba de vez en cuando…pero se encargó de alimentarlo, de cuidarlo, de verdad me ayudó.

I had a lot of problems because I had really bad headaches, but my husband helped me. He was the one who took care of the baby while we were still in the hospital. I fed him [the baby] once in a while…but my husband was in charge of feeding him, taking care of him, honestly he was a huge help.
(Interview 4)

Six participants explicitly stated that they depended upon their husbands to help make decisions throughout labor and delivery, such as whether or not to receive an epidural.

Six participants had additional support from extended family members and friends during childbirth and in the postpartum period. Four of the five insured women had their mothers come to Pittsburgh from their countries of origin to stay with them after the delivery. The interviewees said that the additional support that her mother, additional family members, and friends provided to her was invaluable. One woman shared:

At the time of the birth, my mom and my husband's parents…were here. So it was nice that they were able to buy food or prepare food or something, and we were more taking care of the baby…they helped a lot.
(Interview 7)

A second participant commented:

Dos de mis amigas me apoyaron mucho porque estás sola. Entonces tus familiares están aquí dos semanas y el resto del tiempo estarás sola. Me ayudaron mucho…[porque] todas los pasamos por lo mismo. Si, obtuve mucha ayuda de ellas.

My two friends helped me a lot because you're all alone. Your family is there for two weeks, but the rest of the time you are alone. So they helped a lot…because we all go through the same things. I got a lot of support from them.
(Interview 1)

None of the uninsured participants were able to have their mothers with them, and only two had extended family living in Allegheny County who could help after the baby was born. One participant expressed the difficulty of giving birth far away from family members.

¡Pero imagínate, uno sin familia! Yo sentía mucho miedo y yo decía, ¿qué voy a hacer yo solita? ¿Cómo le voy a hacer para cuidar el bebe?

But just imagine being without family! I was so scared and I said to myself, 'what am I going to do by myself? How am I going to care for this baby?'
(Interview 6)

Participants stated that doulas also provided support during childbirth. Participants who had a Doula with them throughout the process expressed that having a doula improved their childbirth experience. One woman exclaimed that:

Gracias a dios tuve mi doula. Ella sirvió de mucho, mucho, mucho en este momento. Estaba conmigo allí, dándome al mano y diciendo 'tranquilo, ya vas a ver tu bebe, mira que vas a ver un momento rapidísimo.' Me dio muchos ánimos.

Thank God I had my Doula. She helped me so much in the moment. She was with me, giving me her hand and saying, 'calm down, you're going to see your baby soon, this is all going to pass so quickly.' She gave me so much encouragement.
(Interview 3)

5.1.3 Patient-provider relationship

Participants reported that the relationship they had with their care providers while in the hospital played a large role in her perception of the childbirth experience. Participants spoke about nurses with whom they interacted more than any other care provider. Whereas nurses were reported to play a large role in participant's experiences, reported discrimination by c are providers and the hospital system as a whole damaged the patient-provider relationship and, according to interviewees, diminished the childbirth experience.

5.1.3.1 Care Providers

All ten women reported that most of their care providers were attentive and treated them well. Many mentioned specific care providers who were by their sides and provided reassurance throughout the labor process. Furthermore, three women gave additional validity to the support

provided by their care provider, as they were a member of the hospital community and were more familiar with hospital procedures. One participant stated:

> *The nurse…was with me all the time. Even the three hours and a half plus [I was pushing]…she was with me the whole time…and encouraging me to push. She was awesome, awesome…The nurse was very nice. If I have that nurse, I will want to have children in the future. I mean of course my husband and my mom [provided encouragement], but I think the nurses know more of the processes.*
> *(Interview 7)*

Participants also spoke about the importance of having trust in her providers and feeling comfortable with her physicians. One participant chose to see the same physician she had been with during the birth of her first child because she was confident in his abilities and enjoyed their prior relationship. Four participants mentioned the importance of putting trust in their doctors and giving them the space to do their work.

Eight of the participants did have problems with at least one care provider while they were in the hospital. Two of participants mentioned that they received less attention while in the postpartum unit than in labor and delivery, and the other six had problems with lactation consultants, Residents, or other staff. One interviewee reported that:

> *The only problem we had while we were at the hospital was that I couldn't breastfeed…So we tried to talk to a lactation consultant, but she didn't come until the day that I left, and she was with us for like, five minutes…I've heard that they don't have many lactation consultants, but that was the only problem. I wish we had more help.*
> *(Interview 7)*

Another participant added:

> *Una cosa que no me gustó es que [me examinaban todos los practicantes.] Durante el tacto…entraron en grupos de 4 o 5 y no era como que uno practicaba, pero tres o cuatro practicaban…Yo sé que tienen que practicar, pero…practica uno, que no practique la otra, ¡pero no al mismo tiempo! Este me [puso] un poco más nerviosa.*

The only thing that I didn't like was all of the Residents. During the exams…they came in groups of 4 or 5, and it wasn't like only one practiced, but three or four practiced...I understand that they need to practice, but only one should practice and the others should not, but not all at the same time! This made very nervous.
(Interview 1)

5.1.3.2 Discrimination

Although the majority of participants said that they felt as if they were treated with respect, one woman reported being discriminated against due to being uninsured. She began by saying that:

Mi experiencia con este bebe fue demasiado diferente porque...no tenía seguro. Me dijeron desde el principio, '¿sabe qué? No le podemos atender, tiene que irse de aquí porque no tiene seguro.'…Desde el principio donde estuvimos en [el hospital], sentí que no es la misma atención. Le dije a mi esposo que son tantas mujeres que van embarazadas, una ya no más que otra. Pero francamente, yo soy sincera, y francamente la atención de parte de muchas personas del hospital no me daba feliz.

My experience with this baby was very different … because I didn't have insurance. They told me from the beginning that 'we can't take care of you; you have to go somewhere else because you don't have insurance.'…So from the beginning, when we were at the hospital, I felt that it was not the same care. I told my husband that we are all pregnant women, one woman is not more important than the other. But honestly, the attention that I received from some hospital employees made me unhappy.
(Interview 4)

This participant continued to explain that she was felt ignored and cast aside. She told similar stories about experiences her friends had with maternal health care in Allegheny County. One of her friends was turned away from care and:

Le dijeron, '¿sabe por qué tiene que ir? Porque usted no tiene seguro. No tiene seguro, no es residente, no hay atención para ustedes aquí porque no pagan.' Fue tan cortante esta persona. Son comentarios increíbles.

They told her, 'do you know why you have to leave here? Because you don't have insurance, you're not a resident, there is no medical attention here for all of you because you don't pay.' They were so biting. These are incredible comments.
(Interview 4)

5.1.4 Birth Outcome

5.1.4.1 Vale La Pena

One of the most important factors influencing Latina women's childbirth experience was the birth outcome. When asked the question "Is there something that you really liked and that made the birth experience better," all ten women became very animated and answered the same – the moment their child was born. All participants said that the best moment of their labor process was when they were able to see, touch and hold their baby. In this instant, participants forgot everything that they had been through, and seeing their baby made the pregnancy, labor, and delivery *vale la pena*, or worth all the difficulties. Five stated that they felt overwhelmed with indescribable emotion after hearing their baby cry. One woman tried to explain:

> *Me gustó mucho cuando le vi…¡se me olivó de todo! Si, quería llorar por alegría porque ya queríamos tener un bebe desde antes, entonces cuando ella nació, fue algo muy emocionante que yo decía, 'ay, por fin, ¡ya tengo mi hija, mi bebe!' Eso es lo más bonita.*
>
> *I was so happy when I saw her…I forgot about everything else. I wanted to cry out of happiness because we had wanted to have a baby for so long, so when she was born…it was something so exciting that I was like, finally! I have my daughter, my baby! This is the most wonderful part.*
> *(Interview 8)*

Three of the participants had the opportunity to participate in skin-to-skin contact after giving birth.[1] This practice, in which the newborn is placed on the mother's stomach for skin-to-

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[1] Although participants called this practice "Kangaroo Care", the term has been changed to skin-to-skin contact throughout this paper to clarify the practice. Traditional Kangaroo Care is the placement of a diaper-clad infant (often a premature baby) under a cover and against the mother's chest to promote metabolic and cardio-respiratory stability. The term Kangaroo Care has become more widespread in recent years, and now includes all skin-to-skin contact between mother and baby immediately following delivery (Morrison, 2006).

skin contact immediately after birth, improves thermal regulation, breastfeeding and maternal-infant bonding (Ahmed, 2011). The three women who participated in skin-to-skin contact all exclaimed how incredible the experience was, and that the time they were able to share with their newborn before the baby was taken away for further tests was an unforgettable time and the highlight of childbirth.

Giving birth held additional meaning for two of the participants who reported suffering from depression throughout their pregnancy. Both stated that they cried often and became upset about minor things for periods while they were pregnant. These women said they were very nervous that their depression would negatively impact the health of their child and were both elated when their children were born without any medical problems. One of the participants shared that:

> *Era fuertemente, muy emociónate para mí porque pensaba que iba a estar un poquito malito por toda la depresión que la tuve en los primeros meses. Yo decía, 'ay, tal vez el niño no [salga] bien porque no me cuidé en los primeros tres meses'…Entonces cuando lo ubiqué y el doctor me dijo que estaba bien, estaba como...'Oh My God…¡estoy feliz! ¡Estoy totalmente feliz!' Entonces eso es lo más bonito – cuando ves al niño, y lo puedes revisar, y pues decir, ¡aquí esta!...Yo creo que es lo más bonito.*
>
> *It was so exciting for me because I went through a hard time with the depression that I had in the beginning months. I always said, 'maybe the baby will not be OK because I wasn't taking care of myself…so when I saw him and the doctor told me that he was OK I was like…oh my God…It was incredible, I was so happy! I was completely happy. That is the most incredible - when you see your baby, and you can check him, and you can say, he is here!...I think that that is the most incredible.*
> *(Interview 3)*

5.1.4.2 Medical Interventions and Birth Complications

Participants stated that medical interventions, specifically anesthesia and epidurals, influenced their perceptions of childbirth experience. Before labor began, none of the participants wanted an epidural, however as contraction pain became increasingly difficult to

cope with, seven of the eight women who delivered vaginally or labored before having a C-Section chose to receive an epidural. Five women were satisfied with the process and reported that receiving the epidural gave them the strength to push. However, the epidural process was reported to have led to increased anxiety and pain for two participants. In order for an epidural to work, it is necessary for the receiver to rotate from side to side to ensure that the medication reaches both sides of her body (American Pregnancy Association, 2011). One participant said she was forced to lie on bed on one side so that the baby's monitors would measure the baby's vital tones – if she flipped the monitors would not pick up the baby. This participant reported a tremendous amount of pain on one side, however needed to lie still on the bed so vitals could be measured. She was in labor for 32 hours, pushed for 3 hours and finally had a C-Section. In the end, she reported that she felt disempowered because of the epidural process and the surgery, and that the 35 hours she was working in labor went to waste. A second participant spoke at length about the back pain and intense headaches she continued to have for weeks after delivery that she said she believed were due to the epidural. The headaches caused her a tremendous amount of pain and interfered with her daily functioning. She commented that she felt as if the nurse waved her off and told her that the pain would only last for a few days even though she tried to tell a nurse about the pains multiple times. Two of the three participants who had C-Sections said they remembered very little about seeing their child for the first time due to heavy amounts of anesthesia they had received.

Participants commented that birth complications also significantly impacted their experiences. The participant who had had an emergency C-Section during her sixth month of pregnancy reported a very tough experience throughout childbirth. She said her baby had a number of serious medical complications and stayed in the hospital NICU for over three months.

The participant recalled being filled with fear, anxiety and worry multiple, and often thought that her baby would not survive.

> *Imagínate cuando uno no tiene una experiencia, es muy difícil. Y en eso momento creía que no había salida. En eso momento uno solo piensa en cosas malas – se da muchas malas pensamientos. Yo pensaba que ¿cómo iba a quedar yo después de hacerme esto? Tenía mucho miedo.*
>
> *Just imagine, when one does not have any prior experience with these types of things, it is very difficult. In that moment, I didn't think that there was any way out. In that moment, one only thinks about bad things – only bad thoughts. I thought that something was going to happen to me. I was so scared.*
> *(Interview 6)*

This participant said it took her two months to begin visiting her child in the hospital because she continued to have traumatic memories from his birth and was fearful that her son would not survive. When she first started visiting him, she commented that she could not believe that he was actually her own child. Although it took some time to form a strong bond with her son, she commented that now, over four months after he was born:

> *Estoy bien feliz al tenerlo conmigo, a poner abrazarlo, cuidarlo, cambiarlo, bañarlo, todo esto con una alegría que nunca pensé en un bebe. Si, es lo más bonito que le pasa uno, si, es lo más bonito.*
>
> *I am so happy to have him with me, hugging him, taking care of him, changing him, bathing him. I never thought that taking care of a baby could bring such happiness. I think that is the most wonderful thing that somebody can go through – the most wonderful.*

5.1.5 Expectations

The participants shared that expectations they had before they gave birth influenced their perception of their birth experience and that being informed about the childbirth process helped to know what to expect from labor and delivery. Five of the participants had taken classes or attended hospital tours, while three received childbirth education from their Doula. The three

participants who had given birth previously utilized their recollections from prior childbirths to help them understand the labor and delivery process throughout this event. These participants also based this childbirth experience off of their previous births – one participant who reported a very positive experience from previous birth was unsatisfied with this experience because it did not live up to her previous expectations, where as one participant who had an emotionally traumatic birth with a previous child reported a very positive experience this time.

Five of the first-time mothers reported feelings of fear or anxiety at different points throughout the labor process because they were unsure whether what they were experiencing was normal. Four interviewees said they felt scared when they started feeling contraction pain because they were nervous it was abnormal. Two women reported anxiety when they began pushing. The participant who gave birth prematurely said that she was extremely scared, because:

> *Yo me asustó y dije, '¿cómo van a hacer eso? Nunca he visto esto, que el bebe no es más de seis meses. Yo me asustó y dije, '¿si va a vivir mi bebe?'...Mi doula me contaba del parto normal, como pasa todo esto, y como viene el dolor. ¡Y ya no tenía dolor! Yo decía '¿Cómo van a hacer eso?'...Yo no sabía, yo tenía miedo. ¿Cómo me van a sacar el bebe? Tenía mucho miedo.*
>
> *It scared me, how are they going to do this? I never saw a baby that was only six months [when it was born]. It scared me, and I said, 'is my baby going to live or not?'...My Doula told me about how normal births go and about how the contraction pain is. But I didn't have any contraction pain! So I kept telling myself, how are they going to do this... I didn't know, I was scared. How are they going to deliver my baby? I was so scared.*
> *(Interview 6)*

Participants also mentioned childbirth expectations that they brought with them from their countries of origin. Two participants who came from two different large cities in Mexico commented that the prevalence of C-Sections in their hometowns is extremely high; one of the two said that she thought that up to 90% of births in her hometown were done via C-Section, and

that most of those surgeries are planned beforehand. These two women reported being very happy that they were not forced into having surgery and were given the opportunity to labor. A third participant who had previously given birth in Mexico spoke about how much better her experience was in Allegheny County because her husband was able to be with her throughout labor and delivery.

> *Cuando uno tiene un bebe, es diferente en México porque en México cuando uno se va a aliviar, no puede haber nadie más que la que va a aliviar…no puede haber su familia ni su marido. Están afuera, no están adentro. Cuando me alivié primero, estaba solita con los doctores. Uno está con su dolor y no hay alguien como dando apoyo, que te diga que 'estás bien, que todo va a salir bien,' y dando ánimos. Pues aquí estaba mi esposo, una amiga, y mi doula. No estaba más solita. Si, fue mejor mi experiencia.*
>
> *When somebody has a baby in Mexico, it's different, because in Mexico, women give birth without anybody there except the doctor…neither your family nor your husband can be there, they are outside. I was alone with the doctors when I gave birth before. You are there with your pain and there isn't anybody giving you support and telling you, 'it's OK, everything is going to be OK,' and giving you encouragement. But here I had my husband, my friend, and my doula, I wasn't alone. This was a better experience. (Interview 5)*

Another participant shared that she heard many stories about giving birth from friends and family in Costa Rica before becoming pregnant. She was very satisfied with her birth experience due to the differences between her experience in Allegheny County and the experiences had by loved who delivered in Costa Rica. She commented:

> *El hecho es que se queda en cuarto sola, es otra cosa. En Costa Rica, en el sistema público, son grandes salas con todas mujeres, pero en el hospital privado, pagando, puedes tener. Pero en el público, no. Y creo que aquí el personal médico explica mucho más que lo que hacen en otros países…En cambia aquí, tienen que explicar que te van a hacer…Y el hecho que esta la familia afuera...Digamos, que yo estoy en hospital en Costa Rica en el tercer piso dando luz, mi familia está en el primer piso porque no pueden subir, y tienen que esperar a visitar. Es muy diferente que yo estoy aquí, y ellos están en la puerta de afuera. Si yo quería presentar mi suegra para acompañarme, podría estar ella sin ningún problema.*
>
> *The truth is, it is something else when you are all alone in your room. In public hospitals in Costa Rica, there are just huge rooms of women, but in private hospitals, you pay, and you can have what you want. But not in the public ones. I also think that the medical*

providers explain things a lot more here than in other countries…It's different here, they have to explain everything they are doing to you…And just the fact that the family is right outside the room…If I were giving birth on the third floor of a hospital in Costa Rica, my family would be on the first floor, waiting because they could not come up to see me. It's very different here. I am in here, and they are right outside the door. If I wanted my mother-in-law to keep me company, it wouldn't be any problem.
(Interview 10)

5.1.6 Locus of Control

Another theme discussed throughout the interviews was the amount of control they felt they had throughout labor and delivery. Concepts of control included external control (self-determination, directing, and decision-making) and internal control (self-respect, and the ability to manage one's behavior, thoughts and actions).

5.1.6.1 External Control

Four of the five participants who had insurance said that they had full control over the decisions that were made throughout labor and delivery. These participants said they felt as if they could impact their own childbirth experience and play a role in decision-making processes. Four reported instances when they spoke up and told care providers what their wishes were, which was followed by their physicians listening to and respecting the participant's desires. One interviewee had been trying to deliver her baby for a long time when her doctor said that he would need to use forceps or vacuum to assist in the delivery. She was able to communicate to the doctor her that she wanted her baby to be born without further intervention. She shared:

I think I had pretty much full control. Even the time I was so tired to push, I said no, I'm the one deciding what I want, not the doctor, unless there is a complication. But I want to make sure that I want this, this, and this, not whatever the doctor said…so I think I was able to have control of everything.
(Interview 7)

Another participant had a more difficult time controlling her surroundings. She had wanted to have a natural birth and prepared a birth plan to show her doctors. However, she shared that:

> *Yo insistí en levantarme para caminar un poco porque ayuda, pero la enfermera me decía 'no puedes moverse,' estaba monitoreando el bebe…Y la bola, el Red Ball era una posibilidad, pero digan 'no puedes hacer.'… Entonces, yo quería caminar, y no podía. Quería la bola, y no podía. Entonces el epidural fue la única decisión que tomé al final…Con el epidural, participé. Lo demás, no tenía ni voz ni voto.*
>
> *I wanted to get out of the bed to walk a bit because that can help, but the nurse told me that I can't move because they were monitoring the baby…We had also wanted to use the red ball, but they told us we couldn't…So, I wanted to walk, but I couldn't. I wanted to use the ball, but I couldn't. So the only decision I was able to make was the epidural…With the epidural, I participated. I had no say over anything else.*
> *(Interview 10)*

Although this participant was satisfied with her global experience, she reported being upset due to the fact that she was unable to have decision-making abilities in the birth of her daughter.

The five participants who did not have insurance reported more difficulty talking about the amount of external control they had during childbirth. Four of these women said they had trouble understanding the question "how much control do you feel you had throughout labor and delivery", and three were unable to answer after the question was rephrased to, "did you feel that you had a voice in what was happening, or that you had a say in what was going on?" There were no points in which any uninsured participants mentioned having external control or being able to directly tell their care providers what they wanted throughout their childbirth experience.

The five participants who had insurance also all made conscious choices to give birth in the hospital where their child was born. Two women chose their hospital because they had positive experiences during previous births at the same hospital. The other three women took advice from friends and family, and discussed different options with their husbands before making a final decision as to where to give birth. The five women who did not have insurance

did not have a choice where they gave birth, but all delivered at the hospital where their prenatal care providers sent them to. These participants typically attended prenatal care clinics after hearing about the clinic from a friend or family member. Each of the clinics had one hospital where physicians had admitting privileges, and the participants were told that is where they were to go once they were in labor.

5.1.6.2 Internal Control

All five participants who did not have insurance and who reported having little, if any, external control throughout their childbirth experiences spoke about how they were able to control labor and delivery through internal, emotional processes. One participant, who almost lost her baby in the early months of pregnancy, spoke about how she maintained control over her actions and behaviors during her difficult pregnancy and childbirth by saying:

> *Desde los cuatros meses para acá, aprendiendo a tener control sobre quiero que mi bebe nazca, ¿no?...Tengo que controlar, tengo que cuidarme lo mas que pueda.*
>
> *Since I was four months pregnant through today, I was learning to have control so that my baby would be born…I have to have control, take good care of myself more than anything.*
> *(Interview 4)*

All of these participants, as well as two of those who had insurance, spoke about having faith in God, and praying throughout labor and delivery for her health and her baby's wellbeing. In giving advice to other Latina women who are going to give birth in Allegheny County, one interviewee recommended that:

> *El miedo no deja nada. El miedo, es una sobra porque de todas maneras el miedo no soluciona nada. Lo que pudiera hacer es tener valor y fe. Sí, valor y fe. Porque como yo, yo todo miedo, pero ¿de que sirviera el miedo si todo salió bien?*

Fear doesn't help at all. Fear is like a shadow and it doesn't do anything. She should be brave, and have faith. Bravery and faith. I only had fear, but it doesn't do anything because everything ends up OK.
(Interview 6)

Six participants added that having faith in God helped them cope throughout childbirth and during the postpartum period.

5.1.7 Postpartum Recovery

All of the interviewees shared memories of both physical and mental recovery after childbirth. Physical recuperation dealt with lingering pain and physical recovery from childbirth, whereas emotional recuperation referred to postpartum emotions which were shared throughout the interview.

5.1.7.1 Physical Recovery

All participants reported that it took them some time to get back to feeling like themselves after giving birth. Participants who needed medical interventions, such as an episiotomy or a C-Section, reported increased physical pain following childbirth. Eight of the participants specifically reported that they relied upon their husbands or other family members to help them take care of the baby in the first few weeks due to the pain they felt. One participant commented that the postpartum period:

Fue muy difícil con él porque yo estaba operada. Entonces le encargaba todo a su papa, entonces él despertaba todas las noches con el niño. Fue difícil para mí desde que salí del hospital, y había veces en que me estaba lastimado, y no pude ir al baño o bañarme. Necesité un poco de ayuda. Entonces sí, fue muy difícil.

Was very difficult because I had a C-Section. So I entrusted everything to the baby's father, so he was the one waking up with him throughout the night. It was very hard for

me ever since I had left the hospital, and there were times that I really hurt, and I couldn't go to the bathroom or shower. I needed some help. So it was very, very difficult.
(Interview 3)

Three participants reported increased difficulty due to the lack of support they felt. Two of the uninsured women said they were left by themselves during the days after discharge while their husbands went to work. One commented that:

Yo no podía dormir porque lo estaba cuidando…Estaba sola aquí porque mi esposo trabaja todo el día, así que me dormía pero nada más que por ratitos. Tenía que dar de comer también, pero sí, me sentí un poco incomoda, así pues, débil.

I couldn't sleep because I was taking care of him…I was all alone because my husband works all day, so I wasn't able to sleep except for little bits of time. I had to feed the baby, but I also felt a bit uncomfortable and weak.
(Interview 5)

Another problem mentioned by six participants was difficulty breastfeeding, particularly for those who had not given birth previously. Eight of the ten participants breastfed their children for at least one month. Six of the eight interviewees who breastfed their child spoke about the physical pain that feeding caused, or questions surrounding breastfeeding that nobody answered for them in the hospital. Although three remembered receiving help from a nurse or lactation consultant while they were in the hospital, two of these participants said they still had trouble once they got home. One participant who had a particularly difficult time producing milk stated that:

It's really hard…Sometimes, I just want to say stop, don't do it anymore…But I think it's good for her and I'm going to try my best…But there were times that I was really frustrated…I just wanted to cry, like I cannot do this. I wanted to do this, it was very good for the baby, but I just wanted to cry.
(Interview 7)

Seven of the eight participants who breastfed their child continued breastfeeding for at least two months, regardless of how much pain was reported in the beginning.

5.1.7.2 Emotional Recovery

Three of the participants mentioned the adjustment they experienced coming home with their newborn. Even participants who had another child said it took time to get used to the new responsibility of having an infant. One woman remembered a few times during the first few days home with her baby in which she forgot that she had a child until she heard him crying upstairs because it was such a new experience for her. Another spoke of the accountability she felt after being discharged home with her newborn, and the difficult time she had getting used to the lack of freedom she felt.

Although all of the participants spoke about the emotional demands after childbirth, four women reported that they felt sad, upset, angry, anxious, or lonely at some point after their baby was born. These four women (one with insurance and three without insurance) spoke about the difficulty they had in managing their thoughts and feelings, and two described this time as a rollercoaster of emotions. Three of the four women who reported having depressive symptomology remembered going through particularly difficult childbirth experiences, including an extremely prolonged labor and delivery, feelings of discrimination and postpartum headaches, and giving birth prematurely. One of these participants described her thoughts throughout the interview:

> *Después [del parto], me sentía muy angustiada, sin ganas de nada. Tenía miedo, tenía mucho sueno… Me entraron muchos pensamientos que me dieron mucho miedo…No quería quedarme solita. Tenía mucho miedo, sentía que me iba a pasar algo…Fueron muy duros.*
>
> *After [the birth], I felt so distressed, I didn't feel like doing anything. I was so scared, I was so tired…I thought about so many things that were really scary...I didn't want to stay at home by myself. I was so scared that I thought something was going to happen to me…This time was very tough.*
> *(Interview 6)*

A second participant remembered:

> *Yo lloraba, me enojaba, me lo pasaba llorando todo el tiempo…Y ya después de que me alivié, igual…todavía lo tengo. Me da por llorar. Me da sentimiento.*
>
> *I cried, and I got mad, and I cried again...And after I gave birth, it is the same thing, I still feel the same. I am still crying. I still have these same feelings.*
> *(Interview 9)*

In the second case, the participant said she also struggled with depressive symptoms throughout her pregnancy and hoped it would subside, however she continued to struggle with her emotions nine months after she gave birth. None of the four participants said they sought professional help or treatment for their depressive symptoms. One participant reported utilizing informal support from friends to talk about her feelings, however the other three said they kept their thoughts to themselves, hoping that they would decrease over time. One of the participants commented that she wanted to talk with somebody, but they felt scared to reach out. She commented:

> *No puedo guardar mi coraje, no lo puedo esconder si no luego exploto…Fíjate, no les hablo con nadie. Hay cosas como así que me guardo y me siento bien mal. Me siento mal porque quiero decirlo, pero no puedo.*
>
> *I can't hide my anger, I can't run and hide, I just explode…And imagine, I don't talk with anybody. These are things I keep to myself, and I feel so bad. I feel bad because I want to share them with somebody, but I can't.*
> *(Interview 9).*

These four women also spoke about the importance of moving on from the difficult experience and said that they were able to improve their emotions by focusing on their child. Furthermore, they commented that it was better to think about the future than the past in order to move forward so that they can be better mothers. Two spoke about learning from their experience to make sure that it does not happen in the future.

6.0 DISCUSSION

This study's results confirms the work of Simkin (1991), who concluded that "it is clear that the birth experience has a powerful effect on women with a potential for permanent or long-term positive or negative impact" (p. 210). During the interviews, participants were not merely recalling their experiences, but seemed to be reliving the moment through excited expression, laughter, and raised voices. These women enjoyed remembering childbirth, and often commented that sharing their experience had a positive effect on them and improved their mood. The themes which were discussed by the participants demonstrated the importance of childbirth perceptions for the participating Latina women, as well as which factors were most important in the development of those perceptions.

6.1 PERCEPTIONS OF CHILDBIRTH

The majority of Latina participants appraised their birth experience as a positive experience. These global perceptions were influenced by a number of factors, however, most importantly, childbirth was the process through which they were able to hold, see and physically love their new child. Therefore, the childbirth experience was perceived as a spiritual and emotional process through which they were able to meet their babies and become mothers, in addition to the medical process through which their baby was born. For participants who reported suffering

from perinatal depression throughout their pregnancy, the birth of a healthy child was a relief. Berry (1999) contends that some Latina women believe that strong emotions "affect the body and harm the fetus by causing spontaneous abortion, premature delivery, or knots in the umbilical cord" (p. 206). For these participants, the guilt they felt about being depressed decreased following the birth of a healthy child.

Although most participants reported a positive global experience, many still perceived certain aspects of their birth experience as negative or frustrating. Specifically, low satisfaction with the epidural process, breastfeeding support, and patient-provider communication were reported. Three participants spoke about being less satisfied with their global experience. These experiences were significantly influenced by difficult or traumatic moments during childbirth: one participant reported having a prolonged labor before her physician decided that she would need a C-Section; a second participant perceived discrimination while she was giving birth and suffered from painful postpartum headaches; and a third participant gave birth prematurely via emergency C-Section. This confirms previous findings which suggest that traumatic birth events can negatively influence childbirth experience (Gottvall & Waldenstrom, 2002). Although these participants reported going through difficult childbirths, they all emphasized the importance of putting their experiences behind them to feel better about themselves, be a good mother, and move forward into the future.

6.1.1 Characteristics of Insured versus Uninsured

There were different characteristics associated with those participants who were insured versus those who were uninsured. Participants who were insured reported higher levels of English proficiency and higher levels of education. Most of these participants had husbands who were

doctoral students or employed in well-paying jobs at local Universities, while the husbands of those who were not insured were employed in manual labor positions. This confirms previous data, stating that insurance status within the Latino community is associated with occupational status, income level, and English proficiency (Rutledge & McLaughlin, 2008). Throughout the remainder of this paper, insurance status will be used to identify a number of differences between the two groups of participants. However, it is important to remember that insurance status may not be the causal factor influencing birth experiences. Rather, the characteristics associated with insurance status, such as higher English proficiency, higher education level, and higher income level could be contributing factors to the differences between insured and uninsured participants.

6.2 FACTORS IMPACTING LATINA CHILDBIRTH EXPERIENCE

As mentioned previously, different factors had an increased level of importance for each participant in shaping their perceptions of childbirth; however the key themes of communication, locus of control, support from husbands, family and friends, and expectations of the birth experience were some of the more important factors impacting experience for Latina participants.

6.2.1 Communication and Control

Childbirth experience for Latina participants in this study was a complex event which was impacted by a number of important factors. However, certain factors were more salient for each participant. As expected, language barriers were more prominent for participants who had lower

English proficiency than those who felt more comfortable speaking English. Participants reported that language barriers did decrease quality of care, and made it very difficult to voice their questions and concerns throughout labor and delivery. Additionally, participants stated that language discordance led to increased confusion and a decreased sense of being informed.

Interestingly, participants who reported fewer language barriers also reported a higher level of external control. These participants said they had more decision-making capabilities, increased self-determination and more power to direct their labor; in essence, they had more power. Therefore, the themes of communication and control were intricately linked, affirming previous research which suggests that, "many women found that communicating effectively with providers was a key component of maintaining a sense of control and promoting dignity" (Matthews & Callister, 2003, p. 499). Again, it is important to note that although insurance was associated with both higher levels of English proficiency and higher levels of external control, insurance status is not the causal factor linking birth experience with English proficiency and self-determination, but merely an association between the different factors. However, all participants with higher levels of education and socioeconomic status had insurance, therefore, higher education levels and socioeconomic status could have contributed to the higher levels of external control had by those participants.

Matthews and Callister (2004) discuss the importance of recognizing that individuals desire different levels of external control throughout childbirth. Therefore, insured participants and uninsured participants could have wanted different levels of external control throughout labor and delivery. Self-determination and the ability to effectively communicate with and to direct care providers in a hospital setting requires a high level of health literacy. Previous findings suggest that Latinos are the ethnic group with the highest rates of low health literacy,

and that minority groups, low-income individuals, individuals with lower educational attainment, and individuals with lower English proficiency have lower health literacy levels ("Just what the doctor ordered," 2007; Hinojosa, Hinojosa, Nelson, Delgado, Witzack, et al, 2010). Additionally, individuals with lower health literacy have been reported to have less active participation in medical settings (Ishikawa & Yano, 2011). All five uninsured participants had lower levels of education and English proficiency; therefore, these participants could have had a lower health literacy level and could have been comfortable with the lower levels of external control which they reported. Additionally, the political-economy perspective suggests that the loss of control in medical settings "can be more powerfully reproduced because of the social relationships involved in its production. The idea that it is only the doctor who can cure, and the belief that one's mind and body can be separated…serve to emphasize the loss of individual autonomy and the feelings of powerlessness so common in other areas of social and economic life" (Doyal, 1991). These women could perceive lower levels of power over their birth experience due to the social and political context of being an uninsured immigrant in the United States healthcare system. Another consideration is the cultural importance of control. Previous research has suggested that Latinos view physicians as authoritative figures, and that some may see their health with a fatalistic view (Burk, Wieser & Keegan, 1995). These cultural beliefs could influence the level of desired control for the Latino population; therefore, the Latina participants may have been more comfortable entrusting their care to their physician than having external control over childbirth. Perhaps the difference is a combination of educational status and health literacy, in addition to cultural beliefs of control. The theoretical concept of control within the Latino population warrants further exploration.

Language discordance disproportionately frustrated participants without insurance. Physicians and nurses often used hand signals or simple words to communicate complex directives, leaving many participants confused during medical procedures. Importantly, participants perceived increased confidence and faith in care providers when an interpreter was present. For childbearing women in Allegheny County, interpretation services included a telephone system provided by the hospital, however, more often, informal interpretation was provided by their husbands or bilingual doulas. Although this situation allowed participants to have a higher degree of communication, there remained gaps in understanding and communicating. While most relied upon her husband for interpretation, only three women were offered use of the telephone system, and, as in other Latino populations, all participants were unaware of their right to interpretation services at government-funded medical facilities (Harari, et al, 2008). Uninsured participants who reported lower external control further ceded power by relying upon her husband and other interpreters during childbirth, as they were unable to communicate directly with care providers, but were only able to speak through the help of others. However, even with interpreters present, major communication gaps still exist and the lack of trained, in-person interpreters in area hospitals can be seen as problematic, as both informal and telephone systems can lead to adverse clinical consequences (Flores, et al, 2003).

6.2.2 Support

Another key factor influencing participant's experience was the level of perceived support and attention from loved ones. Campero, et al (1998) suggests that "support during labor accelerates recovery, favors early bonding between mother and child, decreases anxiety and depression…and reduces the time spent in labor" (p. 395). Husbands and partners provided a

tremendous amount of emotional encouragement and decision-making support to participants during childbirth. Many Latina women giving birth in Allegheny County also rely on the support and education provided by doulas. Interestingly, in Allegheny County, doulas are more accessible to women of low socioeconomic status than they are to women with higher incomes, and many uninsured Latina women who receive prenatal care are offered the services of a doula (A. de Chellis, personal communication, February 18, 2011). Campero et al (1998) suggests that the presence of a doula can help women have a higher sense of internal control and can provide them with the ability to take an active part in their labor. In this study, Latinas who had a support person or a doula with them throughout childbirth said they remained more encouraged throughout labor and delivery, were better informed of the childbirth process, and reported more positive experiences.

In addition to support from loved ones, encouraging support from care providers, coupled with a respectful and amicable relationship between providers and participants, were reported to improve experiences. Participants who chose to have the same obstetrician for multiple deliveries or throughout prenatal care stated they developed higher levels of trust with their physicians, which increased their perception of quality of care during childbirth. Interestingly, communication and patient-provider relationship were independent factors. More specifically, all participants reported that they had a positive relationship with their physicians, regardless of language or communication barriers. Previous studies demonstrate that Latina women perceive their quality of care as being influenced by the interpersonal treatment they receive (Gurman & Becker, 2008), and that “common social interactions, such as addressing the client by last name, inquiring about family members, and making general conversation before beginning nursing care were viewed as being respectful in this culture” (Berry, 1999, p. 209). These cultural concepts of

respeto and *personalismo* were discussed by all participants throughout the interviews; participants perceived high quality of care when their care providers were attentive, respectful, informative, and patient. Although the majority of participants believed they received high quality care throughout childbirth, some felt discriminated against due to their lack of insurance. Few women in this study experienced discrimination first-hand, however others reported stories about somebody they knew who was treated differently due to their insurance status, appearance or language abilities. Feelings of discrimination made participants feel dehumanized, disempowered, and negatively impacted childbirth experiences.

6.2.3 Expectations

Another important factor for participants were their expectations of what childbirth would be like before they went into labor. Participants who had experiences which were congruent with their expectations perceived a more positive experience, whereas childbirth experiences which were different from expectations led to more negative experiences. Additionally, participants remembered stories from their countries of origin and used personal memories to shape what their expectations of the event will be. Four participants spoke about the differences between childbirth in the United States and childbirth from their countries. For these participants, the presence of a support person in the labor and delivery suite was one of the most important differences, as al l reported that these support persons positively influenced their experience. However, expectations also differed depending upon participant's life experiences - although participants from larger cities in Mexico reported being pleased with lower medical interventions compared with the high C-Section rate from their hometowns, other participants from rural areas

in Mexico and Central America reported being confused at the highly technical childbirth approach.

6.3 CHILDBIRTH IMPLICATIONS ON POSTPARTUM HEALTH

Childbirth is a physically and emotionally exhausting experience which can have lasting implications on the health and wellbeing of the mother (Simkin, 1991); Latina women in new-growth communities report the same sentiments, and the key themes of support, physical, and emotional recuperation all impacted postpartum health for Latina participants. Many participants reported being in pain and mentally drained after childbirth, and the physical and emotional support of their husbands, partners, family and friends for help in taking care of their new babies and their households after discharge was essential. *La cuarentena* (the first 40 days postpartum) is an important time for Mexican childbearing women (Burk, Wieser & Keegan, 1995). Traditionally, this period was a time for women to recuperate from childbirth and allowed both the mother and father to transition from individuals to their roles as parents. Many women avoid certain foods, abstain from sexual relations, and it is during this period that husbands often increase their share of household tasks to help their wives physically heal. Women's mothers or other female relatives usually come to stay with the new parents during periods of *la cuarentena* to teach childrearing skills and provide additional support (Niska, Snyder & Lia-Hoagberg, 1998). Although changing lifestyle patterns could make this practice more difficult for families in immigrant communities, the majority of Mexican American immigrants still follow at least some of the cultural patterns of *la cuarentena* (Niska, Snyder & Lia-Hoagberg; Berry, 1999). Indeed, many of the Mexican women in this study, as well as those from other countries who

gave birth in Allegheny County, did use the postpartum period as a time for recuperation and transition into motherhood. Husbands or partners took increased responsibility for household chores, and many participants reported that they entrusted the care of their newborns to the father while they physically recovered from childbirth.

Latino fathers were reported to welcome changes where they took charge of their babies. This finding directly contradicts the popular stereotype of *machismo,* which portrays Latino men as dominant, authoritative figures and has often been associated with spousal abuse and family conflict (Gallo, et al, 2009). Instead, Husbands readily adapted to their new familial roles and participants said that their husbands enjoyed their increased responsibilities. We do not know if these husbands changed their behaviors because they desired to have increased familial responsibilities, or if they changed their behaviors because it was something they felt they needed to do. The fathers also could have been drawing on the positive aspects associated with *machismo*, such as increased honor, courage, and familial responsibility (Diaz, 2002). However, recent research has found that the *machismo* concept can have a belittling effect on Latino men, and that in today's culture, particularly in immigrant families, the Latino family appears to be more democratic, with both husbands and wives are sharing authority and responsibility within the marriage (Burk, Wieser & Keega, 1995; Hirsch, 2003).

Participants who were insured reported the additional support of family and friends throughout the postpartum period. Support in the postpartum context included emotional support (encouragement, informal counseling, or informational), and tangible support (providing childcare, cooking meals). Many of the participant's mothers were able to travel to Allegheny to live with the participants an extended period of time. These participants also specifically mentioned larger social networks which supplied assistance, advice and help after the baby was

born. Participants without insurance reported having less emotional and tangible support throughout the postpartum period because their husbands returned to work sooner after the birth than the husbands of the insured participants. None of the mothers of the five uninsured participants were able to travel to Allegheny County after participants were discharged. Those who were uninsured also perceived lower amounts of support from friends. This could be particularly true in new-growth communities, where social networks are not as developed as established Latino immigrant communities (Dyer, Hunter & Muphy, 2010; Rankin & Quane, 2000; Kalofonos & Palinkas, 1999; Harari, Davis & Heisler, 2008). The reliance on family support and the cooperative networks between individuals during the postpartum period affirms the importance of *familismo* for Latina participants (Burk, Wieser & Keegan, 1995). It also suggests that the lack of community cohesiveness could negatively impact postpartum support for Latina women in new-growth communities.

This study suggests that postpartum feelings of depression are a major problem for Latina women in new-growth communities. Specifically, participants without insurance were at a higher risk of reporting that they felt depressed than participants that had insurance. A negative or traumatic birth experience is associated with higher rates of postpartum depression (Anderson, 2010); however this study confirms previous research and demonstrates that lack of support after childbirth also influences postpartum emotions for some Latina women (Gurman & Becker, 2008). Specifically for participants, support from one's husband or partner can significantly impact postpartum affect (Sheng, Le & Perry, 2010) and lower amounts of social support could contribute to depressive symptomology. The social isolation present in new-growth communities could further increase negative affect (Cacioppo, Hawkley & Thisted, 2010).

Importantly, zero participants chose to receive formal services when they thought they were depressed, and only one participant utilized informal treatment, such as talking with friends or family members, but instead preferred to keep it to themselves. Latinas are less likely to seek professional psychological treatment than other racial or ethnic groups (McGarry, J., Kim, H., Sheng, X., Egger, M. & Baksh, L., 2009) due to "lack of insurance, a tendency to attribute mental health problems to religious and other culturally sanctioned belief systems, and a lack of access to…culturally compatible providers" (Chun-Chung, Jaffee, & Snowden, 2003). These barriers are present in Allegheny County, and the lack of Spanish-speaking psychiatrists, counselors, and culturally sensitive care could further increase reluctance toward help-seeking behavior. Realizing the importance of *familismo*, it will be important to develop postpartum interventions at not only the individual level, but also at the interpersonal level, utilizing concepts of social networks and social support.

6.3.1 Limitations

This study has several strengths. First, there a scarcity of information on the Latino community in new-growth communities. This study provides additional details on the health status and quality of care received by immigrant Latina women. Second, the literature which exists on childbirth experience is heavily biased toward middle-class, Caucasian women from the United States or Europe. This study is one of the few to gain an in-depth look into the factors that influence this important time within the Latino community. This study also allows Latina women to share their experiences from their own point-of view and through their own words. Lastly, although there have been studies completed which look at differences in health care

access and utilization with regards to insurance status, there is a lack of research published on differences in quality of care between Latinos who have insurance versus those who do not have insurance.

Despite these strengths, there are a number of limitations. First, although an effort was made to recruit participants from various locations throughout the county, all participants came from the same pediatrics clinic. These women could have different traits than those who do not attend the clinic, and they could be more connected to the Latino community to know about the Spanish-speaking clinic. This could be influenced by the amount of support they receive, their level of English proficiency, the amount of time they have been living in Allegheny County, and their ability to navigate the health care system.

Lastly, it should be noted that I did have a bias in favor of the participants being studied. I have spent time working as a doula with immigrant Latina women and have been in situations in which these women were treated differently or had additional difficulties present during childbirth due to being an immigrant. As a result of my experiences and this bias, I was surprised that there were not more negative comments made about communication barriers and patient-provider relationship. It is possible that the interviewees viewed me as an authority figure due to the fact that participants were approached in a medical setting. Some could have been concerned that I was going to report my findings to the hospital system, ignoring confidentiality. Additionally, since I was a stranger and not a native Spanish-speaker, many could have felt uncomfortable sharing intimate details or criticisms of the care they received during childbirth. Furthermore, recall bias could have influenced the women's memories of the events. Even though all women were interviewed within a year of giving birth, some could have forgotten pertinent information.

7.0 CONCLUSIONS AND RECOMMENDATIONS

This study sought to understand how immigrant Latina women evaluate their birth experience and what factors impact their perceptions. A number of important themes were identified, including: communication, support, patient-provider relationship, birth outcomes, expectations, locus of control, and postpartum recovery. These themes were impacted by the cultural, social and political context in which immigrant Latina women lived. Cultural variations, including the concepts of *familismo, respeto, personaliso*, spirituality, and *machismo* were explicitly discussed, whereas power relationships between participants and the medical system, discrimination, and support were likely influenced by macro-level social and political processes such as insurance status and eligibility, and socioeconomic status. While many women reported being satisfied with their global childbirth experience, there remain many opportunities for improvement to ensure that all Latina women have a positive childbirth experience.

Increasing culturally sensitive care in medical settings improves outcomes, quality, costs, and satisfaction with care (Flores, 2003). As this study shows, the perceived lack of culturally sensitive care during childbirth can influence perceptions of the experience and often impacts postpartum health. There are a number of recommendations to assist in the implementation of culturally sensitive maternal health practices.

> To ensure optimal access to high-quality care for low English proficiency patients and their families, trained medical interpreters should be available at all time, prescription labels and instructions should be dispensed in the family's primary language, consent forms and patient handouts should be available in multiple languages…Simple measures

> that enhance patient satisfaction and comfort include providing culturally appropriate cuisine, wall decorations, and linguistically appropriate television programming. Patients and families appreciate and notice diversity in healthcare workforce…that reflects the racial/ethnic make-up of the local community. (Flores, 2003, p.1-2)

An important aspect in culturally sensitive care, particularly related to Latina childbirth experience, is the need for language concordance between patient and physician. It is recommended that the medical system not only encourage physicians to speak Spanish if possible, increase the numbers of Spanish-speaking physicians, and increase the formal interpretation services available to women throughout not only the postpartum period but also labor and delivery, but also provide formal training to interpreters to decrease medical errors and increase cultural sensitivity from interpreters. These solutions require institutional commitment and constant evaluation. However, the cultural emphasis on *respeto* and *personalismo* indicate that individual care providers can improve Latina women's experiences by providing respectful treatment, regardless of language concordance.

This study brought to the forefront many gaps related to Latina childbirth experiences. More research needs to be conducted to further understand particular factors which influence the labor and delivery process for this growing community, particularly looking at the characteristics associated with insurance status and the impact those characteristics have during maternal health experiences. Specific hypotheses were raised as a result of this study, including: (1) Do Latina women with lower levels of education and English proficiency desire lower levels of control, or are they unable to advocate for the type of birth experience that they wish for? (2) How are Latina women who feel depressed in a new-growth community able to cope with their emotions, and what types of treatment would be effective in reaching those women? What, if any, is the role of social networks and support in postpartum depression? (3) Are women from poorer, more rural areas more unprepared than immigrants from larger cities to give birth in the highly

medicalized childbirth system in the United States? And, (4) how does the concept of *machismo* impact childbirth experience? A re Latina women able to have increased power within their domestic relationships and how does that translate to labor and delivery?

In conclusion, as the Latino population continues to expand in new-growth communities, it will be important to continue investigating the health status of this population to ensure that all individuals and families have access to high quality care. The theory of political-economy provides an interesting perspective to understand the influence of micro and macro level cultural, social, political, and economic influences on health and wellbeing of the Latino community. This is especially true during childbirth - one of the most important times in a woman's life. This thesis was written to provide insight for policy makers, hospital administrators, community organizations and the Latino community to see what can be done to assure that women – regardless of their insurance status – have an equal opportunity to have a positive birth experience which will empower and strengthen Latina women for years after the birth.

APPENDIX

INTERVIEW SCRIPT

1. How many children do you have? How old are they?
2. How many years have you been in the United States? And in Pittsburgh?
3. Today, we are going to talk about your most recent birth experiences here in Pittsburgh. We are going to talk a bit about your birth story, and then I am going to ask you a few more specific questions about your experience. I would like to start with the events. If you could please tell me from the very beginning when you realized you were pregnant and what happened during the prenatal period, and continue with labor and delivery, from the beginning of contractions until you returned home after the baby was born.

BIRTH:

1. Hospital:
    1. Tell me about your decision to give birth at the hospital where the baby was born.
    2. How did you feel about the care you received at that hospital?
    3. Now, please tell me about your interactions with the doctors, nurses and hospital staff.
    4. What language did your caregivers use while they were taking care of you?

        Probes:

        How was the communication between yourself and the doctor?

        Did you use any interpretation services while you were at the hospital? Can you please explain how you started using these services and how they worked for you?
2. Labor:
    1. I would like you to think back about the decisions that needed to be made during labor. Could you please explain how you made the decision and how was the process?

        Probes:

        What sort of input did you have in that decision?
    2. Tell me about your decision to get or not get an epidural.

        Probes:

        How were you able to labor through contraction pain?

        Was there anything that could have helped you get through pain better?

        IF YES:

        How was the process of getting the epidural? Did you feel that you understood instructions while receiving the epidural?

        Tell me about the time after you received the epidural.
3. Delivery:
    1. Next, please tell me about the delivery and what happened after the delivery.

        Probes:

        What happened once the baby was born? Did you hold the baby? Did they take the baby?

Did you require any medical care after the delivery (for example, an episiotomy)?

4. Postpartum:
    1. Describe your time at the hospital after the baby was born.
        Probes:
        Explain the way care-instructions and instructions of filling out paperwork fo rhte baby were given to you.
    2. How did you want to feed the baby before the birth?
        Probes:
        How did breastfeeding go for you? Did you have any help or assistance?
        Did you change your decision after you gave birth?
        Did you change your decision during the postpartum period?
5. Emotions:
    1. How much control do you feel that you had during labor and delivery?
    2. Was there any moments when you felt that everything was out of your control? Can you talk a little about that?
    3. Explain your emotions during labor and after the baby was born. Did you feel anxious, nervous or angry? What made you feel like this?

GENERAL THOUGHTS:

1. Was there anything that happened during labor and delivery that you liked and made the process better for you?
2. Was there anything that happened that you did not like and that made the experience worse for you?
3. What advice would you give to a friend who was going to give birth in Pittsburgh?

DEMOGRAPHICS:

1. How old are you? :
2. What is your country of origin?
3. Did you speak English?
4. How many years of school have you completed?
5. Do you have insurance? What type?
6. Did you have any medical problems throughout your pregnancy, such as high blood pressure, diabetes or preeclampsia?
7. Was there any support persons with you during birth or postpartum? Who was there?
8. *IF SHE HAS CHILDREN:*
    Where were your other children born? How was this birth in comparison to the others?
9. Do you have any other comments to add about your experience?

BIBLIOGRAPHY

Ahmed, S., Mitra, S.N., Chowdhury, A.M., Camacho, L.L.Winikoff, B., et al. (February 10, 2011). Community kangaroo mother care: Implementation and potential for neonatal survival and health in very low-income settings. *Journal of Perinatology*, 1-7. doi: 10.1038/jp.2010.131.

Alcorn, K.L., O'Donovan, A., Patrick, J.C., Creedy, D. & Devilly, G.J. (2010). A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychological Medicine*, 40, 1849-1859.

American Pregnancy Association. *Epidural Anestesia*. Retrieved April 4, 2011 f rom http://www.americanpregnancy.org/labornbirth/epidural.html

Anderson, C. (2010). Impact of traumatic birth experiences on Latina adolescent mothers. *Issues in Mental Health Nursing*, 21, 700-707.

Arauz Boudreau, A.D., Fluet, C.F., Peck Reuland, C., Delahay, J., Perrin, J.M., et. al. (2010). Associations of providers' language and cultural skills with Latino parents' perceptions of well-child care. *Academic Pediatrics*, 10(3), 172-178.

Arcia, E., Skinner, M., Bailey, D. & Correa, V. (2001). Models of acculturation and health behaviors among Latino immigrants to the US. *Social Science & Medicine*, 53, 41-53.

Ayon, C., Marsiglia, F.F. & Bermudez-Parsai, M. (2010). Latino family health: exploring the role of discrimination and familismo. *Journal of Community Psychology*, 38(6), 742-756.

Beck, T.C. & Watson, S. (2008). Impact of birth trauma on breastfeeding: a tale of two pathways. *Nursing Research*, 57(4), 228-236.

Berry, A.B. (1999). Mexican American women's expressions of the meaning of culturally congruent prenatal care. *Journal of Transcultural Nursing*, 10, 203-212.

Betancourt, J.R., Green, A.R., Carrillo, J.E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Reports*, 118, 293-318.

Brotanek, J.M., Seeley, C.E. & Flores, G. (2008). The importance of cultural competency in general pediatrics. *Current Opinion in Pediatrics*, 20, 711-718.

Burciaga Valdez, R., Giachello, A., Rodriguez-Trias, H., Gomez, P. & De La Rocha, C. (1993). Improving Access to health care in Latino communities. Public Health Reports, 108(5), 534-539.

Burk, M.E., Wieser, P.C. & Keegan, L. (1995). Cultural beliefs and health behaviors of pregnant Mexican-American women: Implications for primary care. *Advances in Nursing Science*, 17(4), 37-52.

Cacioppo, J.T., Hawkley, L.C. & Thisted, R.A. (2010). Perceived social isolation makes me sad: 5-year cross-lagged analyses of lonliness and depressive symptomatology in the Chicago health, aging, and social relations study. *Psychological Aging*, 25(@), 453-463.

Callister, L.C. & Khalaf, I. (2010). Spirituality in childbearing women. *The Journal of Perinatal Education*, 19(2), 16-24.

Callister, L.C. (2004). Making meaning: Women's birth narratives. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 33, 508-518.

Callister, L.C., Corbett, C., Reed, S., Tomao, C. & Thornton, K.G. (2010). Giving birth: The voices of Ecuadorian women. *Journal of Perinatal and Neonatal Nursing*, 24(2), 146-154.

Campbell-Grossman, C., Brage Hudson, D., Keating-Lefler, R., Yank, J.R. & Obafunwa, T. (2009). Community leaders' perceptions of Hispanic, single, low-income mothers' needs, concerns, social support and interactions with health care services. *Issues in Comprehensive Pediatric Nursing*, 32, 31-46.

Campero, L., Garcia, C., Diaz, C., Ortiz, Ol, Reynosa, S., et al. (1998). "Alone, I wouldn't have known what to do": A qualitative study on s ocial support during labor and delivery in Mexico. *Social Science Medicine*, 47(3), 395-403.

Centers for Disease Control. (2006). *Access to health care among Hispanic or Latino women: United States, 2000-2002*. (DHHS Publication No. 368). Washington, DC: U.S. Government Printing Office.

Centers for Disease Control. (2011). [Table illustration on Examples of Important Health Disparities]. *Highlights in Minority Health and Health Disparities*. Retrieved from http://www.cdc.gov/omhd/Highlights/Highlight.htm#DISPARITIES0.

Chapa, J., & De La Rosa, B. (2004). Latino population growth, socioeconomic and demographic characteristics, and implications for educational attainment. *Education and Urban Society*, 36, 130-149.

Chun-Chung, J., jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health*, 93(5), 792-797.

Creedy, K.D., Sochet, M.I. & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. *Birth*, 27(2), 105-111.

Cunningham, P., & Banker, M. (2006). Health coverage and access to care for Hispanics in "new growth communities" and "major Hispanic centers". In S. Artiga & J. Tolbert (Eds.), *Kaiser Commission on Medicaid and the Uninsured*: The Henry J. Kaiser Family Foundation.

Dailey, D.E. (2009). Social stressors and strengths as predictors of infant birth weight in low-income African American women. *Nursing Research*, 58(5), 340-347.

Davidson, B. (2000). The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics*, 4(3), 379-405.

De Genova, N. & Ramos-Zayas, A.Y. (2006). Latino racial formations in the United States: An introduction. *Journal of Latin American Anthropology*, 8(2), 2-16.

Díaz, A.V. (2002). Cultural factors in preventive care: Latinos. *Primary Care*: Clinics in Office Practice, 29, 503-517.

Documet, P.I. (2001). Latinos' health care access in Southwestern Pennsylvania. (Doctoral dissertation). Retrieved from the University of Pittsburgh PittCAT+! Database.

Documét, P.L., Sharma, R.K. (2004). Latinos' health care access: Financial and cultural barriers. *Journal of Immigrant Health*, 6(1), 5-13.

Dona International. (2005). *What is a Doula*? Retrieved from http://www.dona.org/mothers/index.php.

Doyal, L. (1991). *The political economy of health*. London: Pluto Press.

Dyer, J.M., Hunter, R. & Murphy, P.A. (27 February, 2010). Relationship of social network size to infant birth weight in Hispanic and non-Hispanic women. *Journal of Immigrant and Minority Health*. doi: 10.1007/s10903-010-9331-y.

Elmir, R., Schmied, V., Wilkes, L. & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced Nursing*, 66(10, 2142-2153.

Fernandez, A., Schillinger, D., Grumbach, K., Rosenthal, A., Stewart, A.L., et. al. (2004). Physician language ability and cultural competence. *Journal of General Internal Medicine*, 19, 167-174.

Flores, G. (2005). The healthy immigrant effect: A greater understanding might help us improve the health of all children. Archives of Pediatric and Adolescent Medicine, 159, 295-296.

Flores, G., Barton Laws, M., Mayo, S.J., Zuckerman, B., Abreau, M., et. al. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*, 111, 6-14.

Gallo, L., Penedo, F.J., Espinosa de los Monteros, K. & Arguelles, W. (2009). Resiliency in the face of disadvantage: Do Hispanic cultural characteristics protect health outcomes? *Journal of Personality*, 77(6), 1707-1746.

Gonzalez, H.M., Vega, W.A. & Terraf, W. (2010). Health care quality perceptions among foreign-born Latinos and the importance of speaking the same language. *Journal of the American Board of Family Medicine*, 23(6), 745-752.

Goodman, P., Mackey, M.C. & Tavakoli, A.S. (2004). Factors related to childbirth satisfaction. *Issues and Innovations in Nursing Practice*, 46(2), 212-219.

Gottvall, K. & Waldenstrom, U. (2002). Does a traumatic birth experience have an impact on future reproduction? *BJOG: an International Journal of Obstetrics and Gynecology*, 100, 254-260.

Greenhalgh, S. (1995). Anthropology theorizes reproduction: Integrating practice, political economic, and feminist perspectives. In S. Greenhalgh (Ed.), *Situating Fertility: Anthropology and Demographic Inquiry* (pp. 2-28). Cambridge: Cambridge University Press.

Gurman, T.A., & Becker, D. (2008). Factors affecting Latina immigrants' perceptions of maternal health care: Findings from a qualitative study. *Health Care for Women International*, 29, 507-526.

Harari, N., Davis, M. & Heisler, M. (2008). Strangers in a strange land: Health care experiences for recent Latino immigrants in Midwest communities. *Journal of Health Care for the Poor and Underserved*, 19, 1350-1367.

Hayes-Bautista, D.E. & Chapa, J. (1987). Latino terminology: Conceptual bases for standardized terminology. *American Journal of Public Health*, 77(1), 61-68.

Heaney, C. & Israel, B. (2008). Social networks and social support. In K. Glanz, B.K. Rimer & K. Viswanath (Eds.), *Health Behavior and Health Education* (pp. 189-210). San Francisco: Jossey-Bass.

Hirsch, J.S. (2003). *A Courtship After Marriage: Sexuality and Love in Mexican Transnational Families*. Berkley and Los Angeles, CA: University of California Press.

Hinojosa, M.S., Hinojosa, R., Nelson, D.A., Delgado, A., Witzack, B., et al. (2010). Salud de la mujer: Using fotonovelas to increase health literacy among Latinas. *Progress in Community Health Partnerships: Research, Education, and Action*, 4(1), 25-31.

Hunker, D.F., Patrick, T.E., Albrecht, S.A. & Wisner, K.L. (2009). Is difficult childbirth related to postpartum maternal outcomes in the early postpartum period? *Archives in Women's Mental Health*, 12(4), 211-219.

Hutch, D.J., Bouye, K.E., Skillen, E., Lee, C., Whitehead, L., et al. (2011). Potential stragies to eliminate built environment disparities for disadvantaged and vulnerable communities. *American Journal of Public Health*, 101(4), 587-595.

Ishikawa, H. & Yano, E. (2011). The relationship of patient participation and diabetes outcomes for patients with high vs. low health literacy. *Patient Education and Counseling*. DOI: 10.1016/j.pec.2011.01.029.

Kaiser Commission on Medicaid and the Uninsured. (2003). *How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population.* Washington, DC: Leighton Ku & Timothy Waidmann.

Kaiser Family Foundation. (2008). [Graph illustration]. *Distribution of U.S. Population by Race/Ethnicity*. Retrieved from http://facts.kff.org/chart.aspx?ch=362.

Kaiser Family Foundation. (2009). [Illustrated chart]. *Poverty rate by race/ethnicity, states (2008-2009), U.S. (2009)*. Retrieved from www.statehealthfacts.org/comparebar.jsp?ind=14&cat=1.

Kalofonos, I. & Palinkas, L.A. (1999). Barriers to prenatal care for Mexican and Mexican American women. *Journal of Gender, Culture and Health*, 4(2), 135-152.

Karliner, L.S., Kim, S.E., Meltzer, D.O. & Auerbach, A.D. (2010). Influence of language barriers on outcomes of hospital care for general medicine inpatients. *Journal of Hospital Medicine*, 5(5), 276-282.

Kreuter, M.W. & McClure, S.M. (2004). The role of culture in health communication. *Annual Review of Public Health*, 25, 439-455.

Ku, L. & Waidmann, T. (2003). *How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population.* Washington, DC: The Henry J. Kaiser Family Foundation.

Lara, M., Gamboa, C., Kahramanian, M.I., Morales, L.W. & Hayes Bautista, D.E. (2005). Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context. *Annual Review of Public Health*, 26, 367-397.

Law, J. & VanDerslice, J. (February 19, 2010). Proximal and distal determinants of access to health care among Hispanics in El Paso County, Texas. *Journal of Immigrant and Minority Health*. DOI: 10.1007/s10903-101-9327-7.

Locatis, C., Williamson, D., Gould-Kabler, C., Zone-Smith, L., Detzler, I., et. al. (2010). Comparing in-person, video, and telephonic medical interpretation. *Journal of General Internal Medicine*, 25(4), 345-350.

Matthews, R. & Callister, L.C. (2004). Childbearing women's perceptions of nursing care that promotes dignity. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 33, 498-507.

McGarry, J., Kim, H., Sheng, X., Egger, M. & Baksh, L. (2009). Postpartum depression and help-seeking behavior. *Journal of Midwifery and Women's Health*, 54(1), 50-56.

Morrison, B. "Kangaroo Care: Nature's Best for our Little Ones." Case Western Reserve University. Cleveland, Ohio, 2006.

Munoz-Laboy, M.A. (2008). Familism and sexual regulation among bisexual Latino men. *Archives of Sexual Behavior*, 37(5), 773-782.

Namey, E.E. & Drapkin Lylerly, A. (2010). The meaning of "control" for childbearing women in the US. *Social Science & Medicine*, 71, 769-776.

National Council of La Raza. (2002). *The impact of welfare reform on Puerto Rico and on Latino families in the U.S.: Policy directions for reauthorization*. Washington, DC: Sonia M. Pérez.

Niska, K., Snyder, M. & Lia-Hoagberg, B. (1998). Family ritual facilitates adoption to parenthood. *Public Health Nursing*, 15(5), 329-337.

North Carolina Institute of Medicine. (2007). *Just what the doctor ordered? Addressing low health literacy in North Carolina*. North Carolina. Retrieved from: http://www.ncmedicaljournal.com/wp-content/uploads/NCIOM/projects/health_literacy/Preface.pdf.

Pielemeier, K. (2007, February 23). Rift growing in local Latino population. *Pittsburgh Post-Gazette*. Retrieved from http://www.post-gazette.com/pg/07054/764337-28.stm.

Pew Hispanic Center. (2010). [Illustrated chart]. *Latinos by country and origin*. Retrieved from http://pewhispanic.org/.

Pew Hispanic Center. (2008). *Data and resources: Allegheny County, Pennsylvania*. Retrieved from http://pewhispanic.org/states/?countyid=42003.

Pew Hispanic Center. (2008). *Statistical portrait of Hispanics in the United States, 2008: Language spoken at home and English-speaking ability, by age, race and ethnicity: 2008.* Retrieved from http://pewhispanic.org/files/factsheets/hispanics2008/Table%2020.pdf.

Pew Hispanic Center. (2008). *Statistical portrait of Hispanics in the United States, 2008: Table 22. Educational attainment, by race and ethnicity: 2008.* [Data file]. Retrieved from http://pewhispanic.org/files/factsheets/hispanics2008/Table%2022.pdf.

Poureslami, I., Rootman, I., Doyle-Waters, M.M., Nimmon, L. & Fitzgerald, J.M. (October 12, 2010) Health literacy, language and ethnicity-related factors in newcomer asthma patients to Canada: A qualitative study. *Journal of Immigrant and Minority Health*, doi: 10.1007/s10903-010-9405-x.

Rankin, B.H. & Quane, J.M. (2000). Neighborhood poverty and the social isolation of inner-city African American families. *Social Forces*, 79(1), 139-164.

Reck, C., Hunt, A., Fuchs, T., Weiss, R., Noon, A., et. al. (2004). Interactive regulation of affect in postpartum depressed mothers and their infants: an overview. *Psychopathology*, 37, 272-280.

Rutledge, M.A. & McLaughlin, C.G. (2008). Hispanics and health insurance coverage: The rising disparity. *Medical Care*, 46(10), 1086-1092.

Sanchez-Birkhead, A.C., Kennedy, H.P., Callister, L.C. & Miyamoto, T.P. (2010). Navigating a new health cultural: Experiences of immigrant Hispanic women. *Journal of Immigrant and Minority Health*. DOI: 10.1007/s10903-010-9369.

Shrestha, L.B. (2006). *CRS Report for Congress: The changing demographic profile of the United States*. Washington, DC: Congressional Research Service, the Library of Congress.

Simkin, P. (1991). Just another day in a woman's life? Women's long-term perceptions of their first birth experience. Part I. *Birth*, 18(4), 203-210.

Shah, N.S. & Carrasquillo, O. (2006). Twelve year trends in health insurance coverage among Latinos, by subgroup and immigration status. *Health Affairs*, 25(6), 1612-1919.

Todorova, I.L.G., Falcon, L.M., Lincoln, A.K. & Price, L.L. (2010). Perceived discrimination, psychological distress and health. *Sociology of Health & Illness*, 32(6), 843-861.

Tronick, E., & Reck, C. (2009). Infants of depressed mothers. *Harvard Review of Psychiatry*, 17(2), 147-156.

U.S. Census Bureau. (1990). *Summary Population and Housing Characteristics*. Washington, DC: U.S. Government Printing Office.

U.S. Census Bureau. (2000). [Chart illustration on population projection]. *Projected population of the United States, by race and Hispanic origin: 2000-2050*. Retrieved from http://www.census.gov/population/www/projections/usinterimproj/natprojtab01a.pdf.

U.S. Census Bureau. (2008). *Income, poverty and health insurance coverage in the United States: 2007*. (U.S. Department of Commerse No. P60-235. Washington, DC: U.S. Government Printing Office.

U.S. Census Bureau. (2009). *State and County Quickfacts: Allegheny County, Pennsylvania*. Retrieved December 12, 2010, from http://quickfacts.census.gov/qfd/states/42/42003.html.

Waldenstrom, U. (1999). Experience of labor and birth in 1111 women. Journal of *Psychosomatic Research*, 47(5), 471-482.

Waldenstrom, U., Hildingsson, I., Rubertsson, C. & Radestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth*, 31(1), 17-27.

Walker, L.A. (2009). *How do prenatal care clinicians perceive their role in care for Latina immigrants in Allegheny County, PA?* Retrieved from PittCat. Retrieved from http://etd.library.pitt.edu/ETD/available/etd-04082009-142528/.