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Article · August 2015

DOI: 10.1007/s40615-015-0159-y

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Birth Experiences of Immigrant Latina Women in a New Growth Community

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Received: 11 May 2015 / Revised: 6 August 2015 / Accepted: 11 August 2015

Abstract A woman's birth experience can impact the physical and mental well-being of mothers long after the birth of their child. Little is known about the experiences of Latina women in areas with small, yet growing Latino populations. To understand Latina's perceptions of their childbirth experience and to see how insurance status impacts that experience, we conducted in-depth, semi-structured interviews with a non-proportional quota sampling of ten Latina women, five with and five without health insurance. Most women reported a positive global experience; the birth of a healthy child was the most important factor influencing birth experiences for all of them. Locus of control and support from medical providers and loved ones also shaped experiences. Uninsured women reported lower levels of perceived control and support, which did impact their birthing experience. These differences could be influenced by social status and position. Medical provider, hospital, and policy recommendations are made which could lead to improvements in uninsured Latinas' childbirth experiences.

Keywords Childbirth · Pregnancy · Latino · Insurance · Uninsured · Labor and delivery

Introduction

As demographic trends have shifted throughout the past decades, Latinos are currently the largest minority group in the USA [1]. New immigrants have started moving to areas with traditionally lower numbers of Latinos instead of historically high immigration areas [2, 3]. These new growth areas (NGA) have experienced much faster growth than traditional immigrant communities; the number of Latinos living in these areas doubled between 1996 and 2003 [4]. NGA 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 residents [4]. Like many NGA, the Latino population of Allegheny County, Southwestern Pennsylvania, has increased significantly. Between 2000 and 2010, the Latino population expanded 71 %, comprising 1.6 % of the general population [5]. The number of births to Latina mothers has also expanded by 68 %, from 148 to 248, during this time [6].

Increased attention has been focused on factors associated with Latino mental and physical health. Unfamiliarity with the US health care system, communication barriers, and social isolation negatively impact Latino health in NGA, leading to conditions which could foster poor physical and mental well-being [2, 7–10]. Additionally, insurance status impacts the health of Latinos, as Latinos have the highest uninsured rates of any other racial or ethnic group in the USA [11]. Although making up approximately 17 % of the US population, Latinos account for one third of the uninsured [11], which can be attributed to low-paying jobs, limited access to employer-sponsored plans, limiting regulations on Medicaid for adults, and eligibility restrictions for public and private insurance plans based upon citizenship status [11]. Insurance coverage leads to stronger health outcomes for adults by increasing access to care providers and appropriate use of medical services, resulting in improved preventative and screening behaviors, and more effective management of chronic illnesses and acute conditions [12]. Conversely, uninsured individuals report feelings of stigmatization and poor treatment from

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Published online: 29 August 2015

medical providers due to their insurance status [13]. These disparities may be even more prevalent for immigrant Latinos living in NGA, as research has shown that misinformation, loneliness, and lower social support leads to depression within the Allegheny County Latino population [14].

Although previous research has focused on factors which influence Latino health, less is known about the importance of childbirth experiences on the well-being of new Latina mothers and their babies. The birth of a child is an intense experience and can have an enormous impact throughout a mother's life [15]. Studies have found that positive birth experiences can promote a sense of empowerment, achievement, increased personal strength, and self-esteem after delivery [16, 17]. In contrast, women who perceive their birth experience as traumatic often experience ongoing and acute symptoms, including social withdrawal, anxiety, depression, posttraumatic stress disorder (PTSD), flashbacks [18], or decreased rates of breastfeeding [19]. Women who report a negative experience cite lacking a sense of control, uncontrolled pain, a feeling of powerlessness, increased medical interventions, feeling alone and without support, and inadequate birth information [18].

Although some factors which precipitate a negative childbirth experience are sometimes unavoidable, such as induction of labor or infant transfer to the NICU [20, 21], locus of control and emotional support are often reported as two of the more influential factors in childbirth experience [16]. Locus of control includes external control (having decision-making capabilities and self-determination) and internal control (one's ability to manage one's own behavior, thoughts, and actions) [22]. Women who report a negative birth experience claim that they felt ignored, faceless [19], powerless, and that they lacked control over decisions that were made throughout their child's delivery [17]. Research suggests that individuals desire different levels of control [23], and that balance between patient autonomy and medical provider direction throughout the birth process both contribute to a positive locus of control. Effective communication between women and their medical providers is also a major influence in perception of control [23].

In addition to locus of control, support from loved ones and the relationship between patient and medical providers can also greatly impact women's childbirth experiences [17]. Many immigrant Latina women depend on their partner or husband as their strongest source of support throughout the pregnancy and delivery [24]. The cultural influence of *familismo* (strong supportive ties among the extended family) makes positive emotional and physical support from husbands, partners, family, and friends particularly important during childbirth experiences and the postpartum period [25]. However, receiving positive support and respect from caregivers (including doctors, nurses, and hospital staff) has also been associated with a better birth experience [17, 21, 23]. Latinas, in particular, have mentioned the importance of having doctors and nurses who are friendly and respectful throughout childbirth experiences [26]. Many Latinos place a stronger emphasis on the importance of reciprocal politeness, and most highly value a provider who demonstrates concern and courtesy throughout the visit, pointing to the importance of *personalismo* (positive personal relationships) and *respeto* (respect) in Latino culture [25]. 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 [17].

Healthy People 2020 goals of achieving health equity and decreasing health disparities [27] point to the growing importance of understanding immigrant Latina women's childbirth experiences to ensure positive postpartum mental and physical well-being, and ensure equitable rates of postpartum depression, anxiety, and social isolation. However, the majority of studies on childbirth experience have been conducted with middle-class, educated, Caucasian women, and thus may be difficult to conclude that these findings are generalizable to the immigrant Latino community in NGA. Furthermore, little is known between the connection that insurance status may have on childbirth experiences for Latina women, including its influence on locus of control, communication, and patient-provider relationship.

For this study, we explore the following: (1) how Latina women in a new-growth community perceive their birth experiences, (2) factors most important in creating positive or negative birth experiences, and (3) the role insurance status plays in the birth experience. For our purpose, birth experience applies to the time during labor and childbirth when women were at the hospital, including early and active labor, and postpartum period.

Methods

Population and Sample Allegheny County, PA, has a population of just over 1.2 million, including over 20,000 Latinos. From January to March 2011, we recruited a nonproportional quota sample of ten women, ensuring five women with health insurance during the last childbirth and five women without. All participants were recruited by face to face contact from *Salud Para Niños*, the only bilingual-bicultural pediatric clinic in the region. This clinic was chosen due to the large number of Latino newborn patients seen here, and because of the availability of both insured and uninsured Latina mothers who bring their children for medical care at this site. Eligible participants had to self-identified as Latina, be over 18 years, had immigrated from a Spanish-speaking country and had given birth at a hospital in Allegheny County in the previous 12 months. Before a child's appointment, the pediatrician introduced the mother to the first author in the waiting room. The first author then sat with potential participants and explained the study in either English or Spanish. Eleven women

were approached to participate to reach the ten participant quota; however, one did not return phone calls to schedule an interview. Interested participants gave oral informed consent and received a small gift of baked goods for their time. The University of Pittsburgh Institutional Review Board reviewed and approved the study protocol.

Data Collection In-depth semi-structured interviews were conducted among participants using an interview guide developed by the authors and reviewed by key leaders from the Latino community to ensure cultural sensitivity and appropriateness. Questions addressed perceptions of birth experiences and included prompts related to experiences in the hospital, interactions with care providers, and locus of control throughout the labor, delivery, and postpartum periods. We scheduled interviews in advance; interviews lasted about an hour and took place at participants' homes. All interviews were voluntary and confidential. After informed consent was obtained, the first author conducted all interviews giving participants the option of completing the interview in English or Spanish.

Data Analysis A study representative transcribed all interviews and read transcriptions multiple times in order to find common responses. If two or more participants mentioned the same response, that theme was noted, and theme definitions were developed [28]. Analytic memos [29] were written during coding to identify broader categories and links connecting themes together and with previous research. All authors discussed the results and agreed on the main themes.

Results

All five participants who had insurance during childbirth self-reported higher English proficiency and education. Table 1 shows participant information by insurance status. Nine of ten participants delivered past 38 weeks gestation; one participant delivered prematurely. Participants gave birth at three different hospitals in Allegheny County. Throughout the different narratives, themes which emerged included: birth outcome, locus of control, support from husband/partners and medical provider, communication and language barriers, prior expectations of childbirth, and postpartum recovery. Upon completion of the analytic memos, the three major themes which encompassed overall childbirth experience for these participants were as follows: birth outcome, locus of control, and support. Illustrative quotes are presented in Table 2.

The Birth Outcome: "vale la pena" An overarching theme shared by all participants was the importance of the birth outcome itself. They said that seeing, touching, and holding their baby for the first time was the most important aspect of the childbirth experience. In this instant, participants reported forgetting everything they had been through; seeing their baby made the pregnancy, labor and delivery "*vale la pena*," (worth all the difficulties). Many narrated feeling overwhelmed with indescribable emotion after hearing their baby cry. Even though six of the pregnancies were unplanned, all participants reported being extremely happy when they discovered they were pregnant, and both unplanned and planned births were greeted with elation.

Table 1 Participant demographics

	Number of participants
Country of origin	Mexico, 7
	Guatemala, 1
	Puerto Rico, 1
	Costa Rica, 1
Years living in Allegheny County	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
	Bachelor's degree or above, 4
Number of children	One, 7
	More than one, 3
Type of birth	Vaginal, 7
	C-section, 3

Locus of Control Although participants felt that childbirth was a wonderful experience, insured and uninsured participants had different views on the level of personal control they had throughout labor and delivery. Participants discussed topics of control that can be classified as external and internal control, as defined earlier.

External Control Four of five insured participants reported having full external control over decisions made throughout labor and delivery. These participants said they felt as if they could impact their own childbirth experience and play a role in the decision-making processes along with their medical provider. The five participants who did not have insurance reported more difficulty talking about the amount of external control they had during labor and delivery. None of them reported the ability to direct their medical providers throughout labor and delivery.

Internal Control The five uninsured participants discussed how they were able to control childbirth through internal,

Table 2 Perceptions of experience

Respondent perceptions of labor and delivery experience
Insured participants
Locus of control
• "I think I had pretty much full control. Even the time when I was tired of pushing, 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." (Participant 7, insured)
• "I wanted to get out of bed to walk a bit…but the nurse told me that I can't because they were monitoring the baby…We also wanted to use the red ball [birthing 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…I had no say over anything else." (Participant 10, insured)
Relationships and support—from husband, family, or friends
• "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 [us] a lot." (Participant 7, insured)
• "Two of my friends helped me a lot because I was 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" (Participant 1, insured)
Relationships and communication with medical providers
• "They were very patient with me because my English isn't very good…But the communication was good. A few times they spoke with my husband, because my husband speaks English very well. So he almost was like an interpreter for the things I didn't understand." (Participant 1, insured)
• "The nurse… was with me the whole time. Even the three hours and a half plus [I was pushing]…she was with me the whole time. She was awesome…Of course my husband and my mom [provided encouragement], but I think the nurses knew more of the processes." (Participant 7, insured)
• "The only thing that I didn't like was all of the medical residents. During the exams…they came in groups of 4 or 5, and it wasn't like only one practiced, but three or four practice…I understand that they need to practice…but not all at the same time! This made me very nervous." (Participant 1, insured)
Uninsured participants
Locus of Control
• "Since I was four months pregnant until today, I was learning to have control [remain calm] so that my baby would be born…I had to have control, take good care of myself more than anything." (Participant 4, non-insured)
• "Fear doesn't help at all. Fear is like a shadow and it doesn't do anything. She [childbearing women] should be brave, and have faith. Bravery and faith." (Participant 6, noninsured)
Relationships and support—from husband, family, or friends
• "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…My husband was in charge of feeding him, taking care of him, honestly he was a huge help." (Participant 4, uninsured)
• "I was so scared, and I said to my husband, what are we going to do? And he also started to cry and he didn't know what to do because nobody else is here [in Allegheny County], just him and I… Just imagine being without family! I was so scared and I said to myself, how am I going to do this by myself? How am I going to care for this baby?" (Participant 6, uninsured)
Relationships and communication with medical providers
• "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 [pain]. Because of the [language], but husband wasn't able to explain…So, unfortunately, our request didn't work." (Participant 4, noninsured)
• "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 [to complete the paperwork]." (Participant 5, non-insured)
• "When I arrived…they [the medical providers] started to do a lot of things to him [the baby], and I thought how are they going to do that [induce labor]? They started to explain to me. They were telling me a lot of things, but I didn't understand." (Participant 6, noninsured)
• "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…Honestly, the treatment that I received from some hospital employees made me very unhappy." (Participant 4, uninsured)

emotional processes. Some participants used positive self-thought to remain calm throughout labor and delivery. Insured participants did not report how they controlled childbirth internally. However, all uninsured and two insured participants spoke about having faith in God, and praying throughout labor and delivery for their health and their babies' well-being.

Support All participants, regardless of insurance status, stated they felt supported by a loved one or that a medical provider helped to encourage them throughout labor and delivery.

Husband, Family, or Friends All participants reported being accompanied by the child's father during childbirth and that these men were their main source of encouragement and support

while giving birth and throughout the postpartum period. Six participants explicitly said they depended upon these men to make decisions during labor and delivery, such as whether or not to receive an epidural. Six participants reported additional support from extended family members and/or during childbirth and into the postpartum period. Four of the five insured participants had mothers who traveled to Allegheny County and stayed with them after the delivery. None of the uninsured participants reported family members travelling to the area to provide postpartum support. Four of these participants expressed difficulty in giving birth far away from their extended families. Fifty percent of participants had a doula present for childbirth. These participants expressed that having a doula improved their childbirth experience due to the continuous mental, emotional, and physical support provided by the doula.

Medical Providers Medical providers played a major role in participant's childbirth experiences. All participants reported most of their medical providers being attentive and treating them well. Several mentioned specific medical staff, such as nurses, who were by their sides and provided reassurance throughout the labor and delivery process. All participants also spoke about the importance of trusting their providers and feeling comfortable with their physicians. Eight of the participants reported problems with at least one medical provider while they were in the hospital. These problems included feeling ignored, being left with questions or concerns, feeling used as a mere case study for medical residents, or feeling discriminated due to insurance status. Women with lower English proficiency reported more communication problems with hospital staff. Although the majority of participants were pleased with the care they received, one felt discriminated due to insurance status.

Discussion

The purpose of this study was to understand birth experiences of immigrant Latina women living in a NGA and to investigate if insurance status impacted childbirth experience for these women. Perceptions were largely shaped as a spiritual and emotional process through which they were able to meet their babies and become mothers, in addition to the medical care they received during childbirth. Overwhelmingly, all women agreed that childbirth was an indescribably positive time because it was the process through which they met their children. Indeed, for these participants, and as one woman quoted, childbirth was "*vale la pena*," or "it's worth it all." Women forgot everything else they had been through, including difficult pregnancies and painful labors, and saw them as necessary steps toward beginning a new life with their children. Although participants saw childbirth as a positive experience, perceived locus of control, support from loved ones and, relationships and communication with medical providers also played important roles in shaping childbirth experience. Furthermore, differences in experience between uninsured and insured women suggest that childbirth experiences are shaped by their health insurance status.

Our data suggests that the relationship of insurance status with perception of care was closely related to education and English proficiency. Past research has shown that educational achievement and English proficiency both play a role in improving an individual's economic and social position [30, 31]. In this study, insured participants had higher levels of English proficiency, educational achievement, and support, as compared to uninsured participants. In the USA, these factors—English proficiency and educational achievement—are associated with access to and quality of health care [9, 32]. These factors suggest that insured participants have higher social status than uninsured participants. Previous research suggests that "most of the variability in health status we find in the United States and other developed countries has little to do with healthcare and everything to do with one's position in the social hierarchy" ([32], p.1). This could become even more salient for immigrant Latina women, who also are reporting increased discrimination in medical environments [33]. Indeed, one uninsured participant who described being treated poorly by hospital staff described feelings of dehumanization and disempowerment, which ultimately negatively impacted her childbirth experience.

From this data, we can pose several hypotheses. Lower social status could contribute to some of the differences perceived in this study of the level of external control and in the availability and quality of support from loved ones and medical providers. Moreover, language-related barriers may decrease quality of care by making it difficult for women to ask questions, to be informed, and to voice concerns and needs throughout labor and delivery. Language discordance may therefore lead to increased confusion and decreased sense of being informed. Due to language barriers, and perhaps a sense of hierarchy, uninsured women may have felt they had less decision-making capacity, less self-determination, and less power to direct their labor and delivery, which previous research often associate with negative childbirth experiences [16]. Language barriers and gender or societal roles could also have prompted women to lean on their husbands or partners as decision-makers, where some may have had higher capacity to understand and respond to different choices. These hypotheses require further research.

The reliance on family support and cooperative networks during the postpartum period affirms the importance of *familismo* for Latina participants [34]. While all participants had at least one support person with them during delivery, none of the uninsured women had a support person that was there continuously for the labor and delivery, or had extended family support during the postpartum time. This lack of support is further enhanced by the existing social isolation in NGA, where social and support networks are not as well developed, as compared to non-NGA [2, 8].

Encouragement from medical providers along with respectful, amicable doctor-patient relationships have been reported to improve childbirth experiences. English proficiency and patient-provider relationships seemed to be independent factors—all participants reported 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, instead of being predominately shaped by medical practice [26]. The concepts of feeling respected and having friendly interactions with care providers, or *respeto* and *personalismo* [25], were discussed by all participants throughout the interviews—participants felt they were receiving high quality care when their medical providers were attentive, respectful, informative, and patient.

There are some limitations with this study. The sample was small and was recruited from the same pediatric clinic, therefore not reaching saturation within this population. Women who attend other clinics may be demographically different and may have different experiences. For example, they may be more connected to the Latino community, which may impact the support they receive, their levels of English proficiency, and their ability to navigate the health care system. However, this clinic was chosen because it is one of the most attended bilingual and bicultural clinics in Southwestern Pennsylvania. And, as with most studies among Latinos with diverse countries of origin, there may be varying sociocultural expectations of childbirth, which may have shaped experiences during labor and delivery. However, this is one of the few studies that have been conducted on birth experiences in NGA, particular in this region. Lastly, this study found that these themes were pertinent to Latina women; however, they may apply to other cultural and ethnic groups. This study simply did not study anybody else outside the Latina community.

Conclusion

This study adds to the growing body of knowledge on Latino health in NGA [2–4, 8, 14] and expands upon the limited number of studies on factors impacting Latina childbirth experience [16, 18]. Further, the study adds to the evidence that social status, including health insurance status, educational achievement, and English proficiency, may influence different health outcomes. While several women reported satisfaction with their childbirth experiences, there remain numerous opportunities for improvement.

Medical providers, hospitals, and policy makers can take steps to ensure all women have positive perceptions of childbirth. For medical providers, increasing culturally sensitive care in health care settings has been shown to improve outcomes, quality, costs, and patient satisfaction [9]. As this study demonstrates, culturally sensitive care during childbirth—regardless of a woman's social status—can influence her labor and delivery experience and impact postpartum health. An important aspect in culturally sensitive care, particularly in the Latino community, is the need for language concordance between patient and provider [35]. This could increase the external control felt by women who typically may not feel empowered to have a voice in medical situations or able to navigate within the healthcare system. However, the cultural emphasis on *respeto* and *personalismo* indicate that individual medical personnel can improve Latina experiences by providing respectful treatment toward her and her family, and promoting warm and friendly interpersonal relations, regardless of language concordance.

Hospitals can set policies in place to ensure a culturally proficient interpreter is available to Spanish-speaking women; provide space for women to exert self-determination and collaborate with medical providers in dictating their care as opposed to having stringent medical policies dictating birth practices; and increase support throughout labor and delivery by modifying visitation policies which limit the number of support persons a laboring woman can have present. Additional training on bias awareness for hospital staff, including nurses, physicians, and hospital administration, can help decrease stigma associated with uninsured patients. Additionally, hospitals and medical providers can provide free or low-cost childbirth education classes which are bilingual and bicultural, taking into account the specific context that immigrant women are giving birth in.

Policy makers can advocate for legislation which would decrease insurance regulations so that women have access to health insurance to ensure access to care throughout the prenatal, birth, and postnatal periods. Increasing insurance may lead to positive maternal and fetal outcomes, decrease costs associated with uninsured labor and delivery, and reduce perceived stigma, thereby leading to positive childbirth perceptions. Certainly, insurance is crucial in facilitating Latinas use of health services [36]. However, for effective use of services, it may be not enough. Modifications in health services, such as providing interpreters, reduction, and reminder systems [37] can be extremely helpful. Additionally, enabling insurance coverage and reimbursement of Doula services could also positively impact childbirth experiences and birth outcomes [38].

This study brought to the forefront gaps related to Latina childbirth experience. More research is needed to further understand specific factors that influence the labor and delivery process, particularly characteristics associated with insurance status and how insurance status is related to communication, control, support, and social status. Moreover, mechanisms related to what extent language, education, and insurance contribute to available support and perceived control are needed. The themes that emerged in this study can inform the design of questions for a future quantitative study to test the mentioned research questions. As the Latino population expands in NGA, understanding the social, cultural, and economic contexts are important in improving care and access to high quality care.

Compliance with Ethical Standards Meagan Niebler, Patricia Documét, Diego Chaves-Gnecco, and Thomas Guadamuz declare that they have no conflict of interest. This article does not contain any studies with animals performed by any of the authors. Informed consent was obtained from all individual participants included in the study. The University of Pittsburgh Institutional Review Board reviewed and approved the study protocol.

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