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Issues in Latino Women's Health: *Myths and Challenges*

SUSAN C. M. SCRIMSHAW, RUTH E. ZAMBRANA, AND CHRISTINE DUNKEL-SCHETTER

These scholars' qualitative research on pregnancy behaviors of Puerto Rican women in New York City and Mexican American and Mexican immigrant women in Los Angeles illustrates how cultural misconceptions held by hospital personnel can negatively influence the quality of medical care provided. Their recommendations for how to offer more culturally appropriate care provide a model of how qualitative research can be used to reshape the behavior of health workers, not just that of patients.

Historically, the medical and public health communities have largely ignored ethnic and class differences among populations they served. The underlying assumptions guiding these professional communities have been that the technology of biomedicine is applicable to all consumers of health services, irrespective of individual social, cultural, and class variations. Although the last twenty years have witnessed an increased awareness of ethnic and class differences, particularly in the areas of reproductive health, there is still limited recognition and knowledge among health care providers of the influence of sociocultural behaviors on doctor-patient relationships, the use of health services, and health status. Researchers and health care providers can make incorrect assumptions about these different subgroups. They may fail to understand why people do not seek medical care, why medical advice is not followed, and why treatments don't work. Among Latino women, particularly with respect to reproductive health issues, misconceptions regarding culturally shaped behaviors are common and often negatively influence the quality of the delivery of health care services. Thus it is essential to challenge existing assumptions and to clarify the meaning of health behaviors to improve the existing delivery of services in our pluralistic society.

The purpose of this chapter is threefold: to present and discuss some

common behaviors related to pregnancy among Latino women, to address a set of misconceptions held by health care providers regarding these cultural behaviors, and to offer some recommendations regarding the provision of appropriate health services to Latino women. The data presented here are based on systematic observations and on empirical studies conducted in obstetrical facilities in New York City with Puerto Rican women and in Los Angeles with Mexican American and Mexican immigrant women.

Background

There is a lack of empirical work on the particular health needs of Latino women and their families. It has only been during the decade of the 1980s that specific systems for identifying members of the Latino subgroups have been put into operation in national data collection systems. In fact, there is an ongoing controversy over whether *Hispanic* or *Latino* should be the national umbrella term (Hayes-Bautista 1980; Trevino 1987). *Hispanic* is more acceptable among national government organizations and in the eastern and southern United States, whereas *Latino* is preferred in the West and Southwest. Unless we are citing published work that uses the word *Hispanics*, we will use the term *Latino* in this chapter.

At present, there are about 20 million Latinos living in the United States, of which 60 percent are Mexican American, 14 percent Puerto Rican, 6 percent Cuban, and 20 percent other Hispanics, mainly Central Americans. It is projected that Latinos will constitute the largest minority population in this country by the year 2000 (Bean and Tienda 1987). In California, it has been projected that Latinos will constitute 50 percent of the population by the year 2010 (Hayes-Bautista, Shink, and Chapa 1988). There are distinct differences between Latino subgroups with respect to country of origin, geographic concentration, English language proficiency, years in the United States, socioeconomic status, and health risk factors. Despite these variations, Latino families tend to be younger, poorer, and less educated than the norms for the U.S. population, which reflect a much higher proportion of individuals born and raised in this country. Youth, poverty, and lower levels of education correlate with less access to health care for Latinos (U.S. Dept. of Commerce 1993). This lack of access is exacerbated by low levels of health insurance. McCarthy and Valdez (1986) estimate that one-third of the Latino population lack health insurance. These characteristics influence the health of women, children, and their families.

Current data are not adequate to identify the most significant health problems for Latinos, although a few government reports, such as the Black and Minority Health Volumes (U.S. Department of Health and Human Services 1986) and Children's Defense Budget (1986), have begun to identify specific health needs of Hispanic subpopulation groups. Two major questions need to be addressed: How do Latino subgroups (as defined above) relate to overall health indicators? And how do their health profiles and needs compare with the services available in the existing structure of the health system? These questions are most critical in the areas of maternal, child, and adolescent health, because the Latino population tends to be young with a high number of women of childbearing age and a high fertility rate (Bean and Tienda 1987; Molina and Aguirre-Molina 1994; Wingard, chapter 2, this volume).

These questions about health profiles and their relationship to services take on a new complexity in the context of both class and culture. Culture includes norms, behaviors, and their meanings, and these may vary with the Latino subgroups but still make up a pattern distinct from other cultures in this country. Class refers primarily to socioeconomic status. Often, it is difficult to tell whether a behavior such as low utilization of health services is due to socioeconomic obstacles or cultural beliefs about the degree of need for health care. It is important to understand how the role of culture for United States Latinos is interrelated with socioeconomic status and other attributes. Specifically, among Mexican origin and Puerto Rican groups, these attributes consist of lower educational levels, less knowledge of health care services and health promotion activities, less experience with large bureaucratic health care systems, more reliance on extended family support, and more traditional beliefs regarding gender roles (Perales and Young 1987; Zambrana 1987; Zambrana and Ellis 1995).

Our research at UCLA on Latino pregnancy and childbirth addresses some of these questions. The data emphasize the importance of challenging the assumptions that guide health care programs and practices in the United States.

Origins of the Research Projects on Latino Women's Reproductive Health

The authors have had a long-standing history of work on the reproductive health needs of Latino women. Two of the authors began working in New

York City in the 1970s with Puerto Rican and other minority groups. Some issues discussed here were raised first when the first author was observing obstetrical residents in a New York hospital in order to understand the socialization of physicians. The obstetrical patients in that hospital were low-income women, predominantly from three ethnic groups: Puerto Rican, Haitian, and American blacks. It was very clear from observations that women in the three groups coped with labor differently and evoked different reactions from hospital staff. For example, the Haitian women made rhythmic sounds, even in early labor. This was regarded as a bid for attention by the staff, who were scornful: "She's only in early labor." In fact, labor chants are a part of labor management in Haiti and might be seen as the Haitian equivalent of Lamaze. Certain sounds are made (such as ooo . . . ooo), whereas others are considered cowardly (such as ow). The sounds may vary with the stage of labor. When this was pointed out to the medical staff, resentment toward "hypochondriacal" Haitians dissipated and was replaced by fascination. Staff tried to guess a woman's stage of labor by her chanting patterns. The most frustration expressed by obstetrical staff, however, was not with the Haitian women but with the Puerto Rican women, who were viewed as excessively noisy and bothersome during labor. Seeing the change in attitude toward the Haitian women when the cultural meaning of the sounds they made was understood raised questions about the need for similar information on Latinos.

Hurst and Zambrana (1980) found that these low-income Puerto Rican women had negative obstetrical experiences with providers and that they were viewed as noncompliant patients. Their study suggests that, for these women, the lack of familiarity with the health care system and their poor treatment by providers was a result of providers' lack of understanding of the women's needs and sociocultural behaviors. The next opportunity to examine issues surrounding birth for Latina women emerged in Los Angeles.

Pilot Research on Myths and Stereotypes about Pregnancy and Birth in Latinos

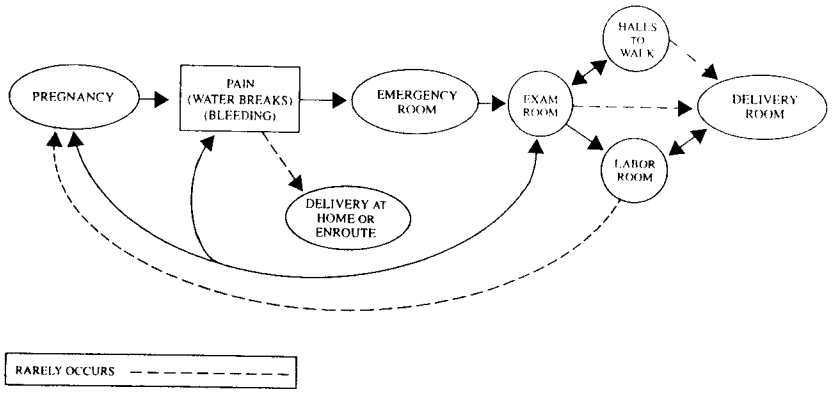
In 1977, the first author began to explore the opportunities to increase medical professionals' understanding of birth in Latino women in the Los Angeles area. The first myth about Latino women was identified when several departments of obstetrics and gynecology were approached about

the possibility of research on Latino women and childbirth. Staff at UCLA agreed to allow a pilot study with the expectation that they would receive help in solving a problem. Latino women, they said, came to the hospital in early labor or not in labor at all (but merely having experienced some of the uterine contractions that often occur in late pregnancy). When told that labor had not yet begun, or that true labor was hours or days away, and that they needed to go home, these women were described by staff as reacting tearfully and argumentatively. The staff asked for help in facilitating an understanding by patients and their families regarding the need to return home. In response to this request, we gathered ethnographic data by observing and interviewing fifty women during labor and delivery and the postpartum hospital stay. This work quickly revealed that women's views of the birth process and their definitions of labor differed greatly from those of the physicians and nurses. Because there is no word for labor in Spanish, only the word for pain, the concept of a long process with distinct stages was absent (Scrimshaw and Souza 1982).

To improve communication between staff and patients regarding the onset of labor, a booklet entitled *Understanding Labor* was developed on the basis of the ethnographic data, supplemented by interviews and discussion groups with additional prenatal patients. This booklet was tested through postpartum interviews with women who had not received the booklet and a comparable number of women who had received it during the last month of pregnancy. All women were asked how many trips they made to the hospital before they were able to stay and deliver. The myth that Latino women were the most likely to come to the hospital repeatedly before true labor was disproved. In fact, it was the Caucasian women having their first babies who were the most frequent early visitors to the hospital because they thought they were in labor. The staff had thought the Latinos came more often because their interactions with them were more salient and memorable. However, the Caucasians were more likely to understand and accept the concepts of false and early labor (due to higher rates of prenatal education and a common language with staff) whereas the Latinos were more likely to protest the decision that it was not yet time to be admitted to the hospital (Scrimshaw and Souza 1982).

Other views of labor based on the pilot study revealed a second set of issues. Latino women experiencing their first birth discovered that their expectations regarding the onset of labor and the subsequent sequence of events differed from the actual process. Figure 13.1 shows a typical example

Figure 13.1 Actual Places, Events and Their Interrelationships in Intended Hospital Births

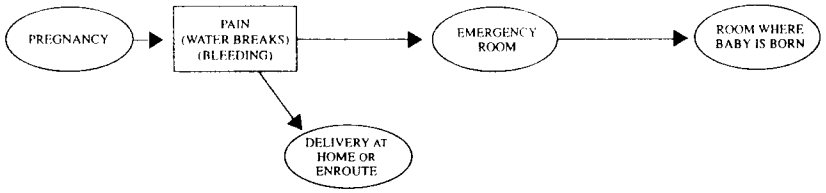


of locations and events in most intended hospital births. A pregnant woman gets some sign, usually pain, that the birth is imminent. She goes to the emergency room of a local hospital, where she is examined for signs of labor. From there, she may be sent home because it is too early, sent to a labor room, or sent to walk the halls because labor has begun and walking will help it along. Once she is ten centimeters dilated and the baby has been pushed through the birth canal until its head is visible (crowning), she goes from the labor room to the delivery room. Very rarely, labor moves quickly and the woman delivers at home or on her way to the hospital (as indicated by the dotted lines). It is possible for a woman to suspect labor and make the trip to the hospital several times before she is actually admitted.

Figure 13.2 shows the perceptions of this process held by many of the Latino women studied in the pilot research. Rather than the feedback loops in figure 13.1, where the process of going to the hospital may occur repeatedly, the process is seen as linear. A woman is pregnant, has pains, goes to the emergency room and then to the room where the baby is born. Delivery at home or on the way to the hospital is seen as a likely and frightening prospect. The idea of going to the hospital and being told it is too early is not present. Given these varied perceptions of the process, it is not surprising that the staff and patients had difficulties.

Figure 13.3 shows how some of these concepts translate into a woman's perceptions of her "job" during labor. Many of the Latino women

Figure 13.2 Common Perceptions Held by Primiparous Latino Women of the Sequence of Places and Events in Intended Hospital Births



studied felt that their task was to get to the hospital and to have the baby. Getting to the hospital was complicated for most by not having a car. Because most felt the baby would come soon after pains started, the concept of a long labor with various stages was absent. Meanwhile staff members (dotted line) were already at the hospital and not necessarily aware of the effort it took to get there. They saw the woman's "job" as "being a good lady" during the early stages of labor and then later to push. Because the doctor "performed" the delivery, the woman's main effort was

Figure 13.3 Comparison of Primiparous Latino Women's and Provider's Perception of Woman's Effort in the Birth Process

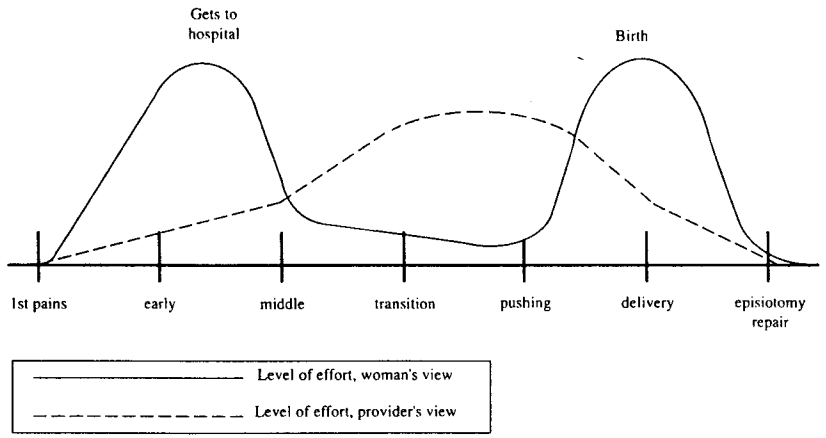
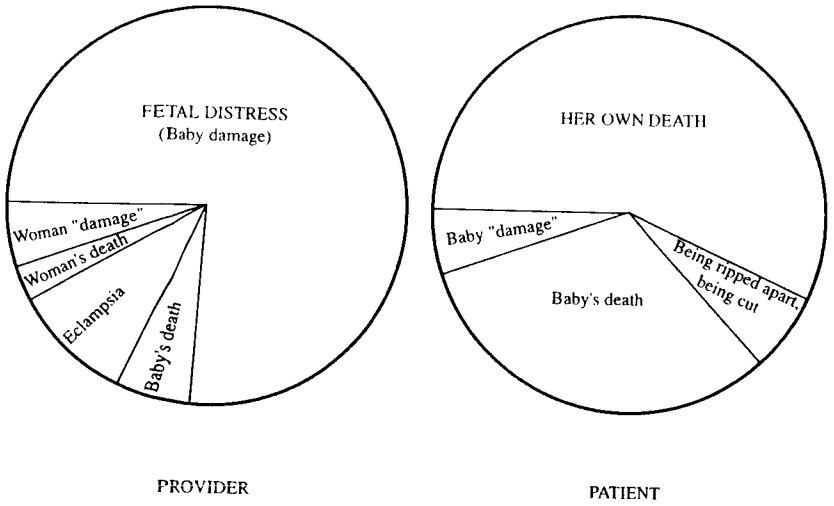


Figure 13.4 Provider versus Patient Perceptions of Danger during Childbirth



seen as the pushing. Again, staff and patient views of the process diverged with the potential for misunderstanding.

Finally, health care providers and patients differed in their perceptions of danger (figure 13.4). Hospital staff, who were aware of the relatively low risks of childbirth in a tertiary care center in the United States, are most concerned with a delivery process and a baby free of any complications, however minor. Latino women, who often come from rural villages where they knew someone who died in childbirth, are most afraid that they will die and leave their babies motherless. Their second concern is that their baby will die, which is not so far-fetched, because many babies who are saved with dramatic modern medical techniques would not survive in rural Latin America. The women's fear of childbirth and particularly of the possibility of her own death was not fully appreciated or understood by staff in general.

Following the pilot project that identified key issues, these figures, along with classification systems contrasting provider and patient breakdowns of the word *birth* (Scrimshaw and Souza 1982), were developed and presented to staff. They reacted with fascination and increased appreciation of their patients' experiences and needs.

The UCLA Birth Project

From July 1980 through September 1982 we studied cultural and medical aspects of birth in primiparous women of Mexican origin and descent who were delivering in two Los Angeles hospitals.[1] We interviewed 291 low-risk primiparous women once in the last six weeks of pregnancy and again during their postpartum stay in the hospital.[2] This group is referred to as the *longitudinal sample*. Another 227 women who met the study criteria were interviewed only postpartum, although a few relevant questions from the prepartum questionnaire were also asked. These latter women were not located in the prenatal clinics serving the two hospitals, although, as will be seen, most had received prenatal care of some kind. This group is referred to as the *postpartum sample*. We collected data on the medical course of their labor and delivery for both samples from the women's medical charts for the total sample of 518 women. In addition, a subsample of forty-five women were observed throughout labor and delivery for a total of 273 hours of observation.

Fifty physicians and forty-four nurses affiliated with the labor and delivery services of the two study hospitals answered questions about their attitudes toward patients (Zambrana, Mogel, and Scrimshaw 1987). In particular, we asked them to describe and compare the women in the different ethnic groups they served.

The primary research questions addressed by the study were these: What beliefs, behaviors, and expectations do women bring to the birth process? Do these vary by levels of acculturation? How do these interact with the biological realities of childbirth? This project produced data that challenged other myths and stereotypes regarding Latino women. Before discussing these, the women studied are briefly described below.

Ninety-five percent (N = 518) of the total sample were born in Mexico. Eighty-nine percent of the women had been in the United States seven years or less, and 25 percent had been in the United States one year or less. Eighty-five percent of the women declared a preference for receiving explanations in Spanish. Forty-three percent of the sample were under twenty years of age (range thirteen to thirty-eight years, mean age twenty-one). Most of the women in the study were married (64 percent). Most (82 percent) of the unmarried women stated that the baby's father was planning to help support the baby. The mean years of schooling was eight (range birth to eighteen years). Forty-seven percent of the women described themselves as housewives with no personal income. The others

had worked in factories, offices, and stores or had cleaned homes and cared for children. Only 3 percent had professional skills. Both occupation and level of education indicate that most were of low socioeconomic status, in keeping with our selection criterion of clinic patients only.

Confronting Additional Myths and Stereotypes

Prenatal Care. Staff at the hospitals involved as well as other health professionals in the Los Angeles area frequently stated that many women of Mexican origin in Los Angeles did not obtain prenatal care at all or sought it late in pregnancy and made relatively few prenatal visits (Norris and Williams 1984; Williams and Chen 1981). We found, however, that 76 percent of the entire sample reported being in their first trimester at the time of their first prenatal visit. By the fourth month of pregnancy, 86 percent had initiated some prenatal care. Only 4 percent initiated care in the third trimester, and only four women, less than 1 percent of the sample, did not seek prenatal care. These data are biased in that all the women studied had delivered in a hospital, so that women in the community who did not have a delivery in one of the two hospitals studied would not be picked up in our sample. Still, the proportion of women receiving prenatal care is high even for a sample of women delivering in hospitals. Also, the staff who felt many Latino women received no prenatal care were talking about these same women, the ones delivering in their hospitals. The mean number of visits (8.7 for the longitudinal sample and 7.4 for the postpartum-only sample) was also adequate by medical standards.

It seems likely that the staff perceptions of late or no prenatal care for Latinos were incorrect in part because of their methods for obtaining information about prenatal care. Staff tend to look for medical records of prenatal care. If a woman received care in Mexico or in another part of California or in another state, as some did, this would not show up in the records. Also, if women's records from Los Angeles County or the study hospital clinics were not immediately available, they might be labeled incorrectly as women who had not obtained prenatal care. Often, the women are not asked about prenatal care in other settings or their replies are not trusted. The possibility that prenatal care use is often underreported for this population should be considered.

We also must point out that this sample consisted of women having their *first* births, who are more likely to seek prenatal care than women who have already had a successful pregnancy. Nevertheless, many Latinos do appear to make a strong effort to obtain prenatal care. In a culture that highly values pregnancy and children and that places a strong emphasis on self-care in pregnancy, this is not surprising. The figures reported by Wingard (chapter 2) and other researchers (e.g., Norris and Williams 1984) indicate that there may be an important gap between trying to obtain prenatal care and actually obtaining it in an effective, consistent manner. Given some of these divergent findings on prenatal care for Latino women, it is hard even to identify the magnitude of the problem. A better tracking system is needed so that women's records are available to labor and delivery staffs during labor when they are needed to provide appropriate care during the birth process. In addition, researchers would do well to triangulate their results by collecting information from the women as well as from the medical and birth records to obtain more accurate data.

Because most of the 518 women in the sample were recent immigrants, it was important to explore whether concerns about citizenship status were an obstacle to prenatal care for these women in particular. To keep anxiety to a minimum, we asked an indirect question: "Based on your citizenship, are you concerned about your ability to receive health care?" Forty-five percent expressed some degree of concern. Those who did were asked *how* they felt their citizenship affected their ability to receive health care. Women responded with concerns about their immigration status ("They treat you as a noncitizen"), their ability to communicate in English, and their ability to pay. Twelve percent (60) said they had no money for health care and could not get public assistance because they were not citizens.

Social Support. Another stereotype about pregnancy is that social support for pregnancy and delivery comes primarily from the baby's father. This belief by staff is based on middle-class Caucasian ideas about family structure, social support, and childbirth education. Birth project results showed that social support from the baby's father and from the woman's family were both important and had different correlates. Support from the baby's father was significantly related to the time of initiation of prenatal care and the number of prenatal visits (Engle et al. 1990) and duration of breast-feeding (Scrimshaw et al. 1987). During prenatal visits the baby's father sometimes accompanied the woman, making it easier for her to make the trip. In the case of breast-feeding, father support was correlated

with when a woman returned to work, which in turn was related to the duration of breast-feeding. Financial support from a man meant she could delay the return to work longer.

On the other hand, family social support was correlated with lower levels of anxiety, a higher degree of acculturation, less desire for pain medication during labor, expectations for a more active role during labor, and greater knowledge of childbirth. In addition, the women observed during labor often preferred to have their mother or sister in the labor and delivery room with them rather than the baby's father. Staff assumptions that the baby's father is the most important led, for example, to the rule in one of the study hospitals that only the father could accompany the woman in labor. The other hospital let the woman choose her source of support and even permitted family members to take turns in the labor room.

Breast-feeding. The hospital staff also believed that Latino women are not very interested in breast-feeding. In our population 74 percent initiated breast-feeding while still in the hospital; 26 percent planned to breast-feed at least three months, and 44 percent planned to nurse at least four to six months whereas 30 percent planned to nurse more than six months. There was a difference between the two hospitals in the percentage who initiated breast-feeding postpartum, although prepartum women's intentions were the same irrespective of where they planned to deliver. The hospital with a higher proportion of women nursing in the recovery room and with a chance for mother and baby to share a room had the highest rate of initiation of breast-feeding. If given the opportunity, many women will breast-feed. This is probably due in part to the high value placed on breast-feeding in Mexico and the fact that so many of our sample were recent immigrants (Scrimshaw et al. 1987).

Medication and Control during Labor and Delivery. An additional stereotype encountered was that Latino women do not want natural childbirth but instead want to be medicated. This belief was enhanced by the fact that most (over 90 percent) of these women did not receive childbirth education, where the management of labor pain is taught. This appeared to result from language differences between patient and childbirth educator, difficulty in going out in the evenings when most classes are held, and fear of the birth process. In the latter instance, women appeared to prefer not to think about the birth process before it happened and to rely on hospital staff to look after them once labor had begun.

These women might fear delivery, but 63 percent said they did not want pain medication. Childbirth, including some pain, was seen as a woman's right and an honorable duty. Medication was viewed as bad for the baby. Our observations of labor showed that, although women sometimes requested pain medication, more often the staff suggested it. In fact, during both the pilot phase and the main study, women commented that they would have refused medication offered near the end of the cervical dilation stage of labor if they had known this is usually the most painful period and that pushing, which follows, is more comfortable. A typical comment was: "I knew I could handle the pain I had, but I didn't think I could handle more. Since I thought the worst pain was when the baby's head came out, I took the medicine."

Another stereotype, frequently mentioned by staff, is that Latino women are likely to scream during labor. Observation notations included a seven-point scale of noise level completed by the observer for a sample contraction in every five-minute period. When those data were compiled, it was clear that most Latino women made low or moderate sounds and only a few were very loud. It is likely that a few were influencing the way the group as a whole was perceived. It would be interesting to repeat these observations with other ethnic groups to compare actual and perceived noise made during labor.

Interviews with the fifty obstetricians serving the study hospitals in Los Angeles obtained data on these physicians' views of the ideal patient and the difficult patient. Physicians revealed that their ideal patient was one who was informed, knowledgeable, and compliant during the labor and delivery process. Their perception of Latino patients clearly showed that they were stereotypically viewed as nice but "out of control" (noisy and loud) and uninformed. The data revealed that only 13 percent of the providers viewed Mexican Americans as compliant (Zambrana, Mogel, and Scrimshaw 1987).

Cesarean Birth. A search did not uncover any literature on ethnic differences in attitude toward cesarean birth before the publication of results from this project, but it is well known that women in general fear and dislike this method of birth. Contrary to this, the Latino women in this study tended to regard cesareans as "normal," and 6 of the 57 women who underwent cesarean sections (of the 518 women we interviewed) thought they provided advantages over vaginal births. Most of the women in the sample who gave birth by cesarean did not regard it as an unsatisfying, psychologically negative experience. In fact, some reported feeling lucky

to have avoided labor (Cummins, Engle, and Scrimshaw 1988). Latino women apparently suffer greater anxiety about childbirth than other American women.

Patient-Provider Communication. Another impression held by staff was that they had to speak Spanish to effectively communicate with their Latino patients. Many staff members berated themselves for their poor Spanish. In fact, when the patients were polled about staff qualities, Spanish ability was tied for fifth in the list of desired attributes. Ninety percent of the patients said that providing explanations was very important, 89 percent said it was important to know a lot about medicine, 73 percent valued friendliness, 76 percent wanted staff to be understanding and sympathetic, 63 percent wanted them to be polite, and an equal proportion wanted them to speak Spanish. Essentially, Mexican and Mexican American women wanted what most patients want from medical staff: information, professional competence, and courtesy. During the labor and delivery observations, there were many instances of staff who communicated with smiles, a few words of fractured Spanish, gestures, and touch, and these were greatly appreciated by patients. Given the choice, women appeared to prefer an empathic non-Spanish speaker to a less supportive Spanish speaker.

Preferences for Sex of Children. Another commonly held myth was that Latino women prefer male children, especially for their firstborn. A detailed look at sex preferences for this sample revealed that sons and daughters were equally desired by the mother except when she was in a poor relationship with the baby's father. In that case, she had a slight preference for a boy. We attributed this to her feeling that the baby's father would prefer a son and that having one would help improve the relationship (Engle, Scrimshaw, and Smidt 1984).

Summary

The research described here revealed some misleading conceptions about Latino women. Our conclusions regarding common behaviors relating to pregnancy among Latino women are as follows:

1. Latino women do not come to the hospital before the onset of true labor more often than other women.
2. Latino women hold concepts of the labor and delivery process unlike those of labor and delivery staff.

3. Latino women do not understand the low risks of labor in a modern U.S. hospital and are very worried about birth.
4. The primary source of social support for a pregnant woman is not necessarily the baby's father. The woman's family is also very important during pregnancy and birth.
5. Latino women, unlike most women in the United States, do not all feel negatively about a cesarean section. Some women regard it as an advantageous method of delivery.
6. Latino women are interested in breast-feeding, and most will breast-feed, especially if given opportunity and encouragement during the postpartum period.
7. Many Latino women want to avoid medication in labor and want to be in control during labor and delivery.
8. Latino women are not all noisy in labor.
9. It is highly desirable, but not essential, to speak Spanish to work well with Latino women. Other aspects of communication such as nonverbal empathy and support are important substitutes for Spanish skills and should be employed as much as possible.
10. Latino women want a healthy child of either sex for their firstborn, and they value both daughters and sons.
11. Assertions about late or no prenatal care or relatively few visits for Latino women must be interpreted with caution. The primiparous Latino women in this sample obtained appropriate prenatal care in terms of the trimester they began the care and the total number of visits. These rates are higher than others reported for Latino women and may reflect extra attention to prenatal care in the first pregnancy. All the women we studied had hospital deliveries, and several sources (women's statements and clinic records) were used to establish prenatal care use. Other studies may underreport prenatal care use because records on care sought from multiple sources may not have been obtained.

The fact that the women we studied tended to differ from these stereotypes indicates that research on women and health must look at ethnicity and sociocultural behaviors that influence women's health in addition to biomedical and other behavioral variables. Generalizations that ignore ethnicity and socioeconomic status cannot and should not be made (Molina and Zambrana 1994).

Challenges and Directions for Future Research

The myths in the public health community regarding Latino women and complex realities displayed by the UCLA Birth Project and the studies that led to it point to the need for further description and analysis of cultural and socioeconomic variations relevant to women's health. Following the UCLA Birth Project, the Stress in Pregnancy Study[3] looked at high- and low-risk women having either first or subsequent births and representing a variety of ethnic groups. It examines issues of perceived stress, coping, and social support in relation to pregnancy risk status and pregnancy outcome. Ethnicity, class, and cultural factors are considered along with the biomedical and psychological variables. The Birth Mediators Study (1987–90)[4] examined determinants of pregnancy outcome in newly arrived Mexicans, women of Mexican descent, blacks, and a small sample of Caucasians. This project attempts to explain variations in pregnancy outcome as measured in weeks of gestation, birthweight, and complications of childbirth. These outcomes are better for some ethnic groups (particularly Latinos) than others, even when all women studied are of a similarly low socioeconomic status and could be expected to have similar rates of adverse outcomes. Cultural factors may be influencing behaviors such as prenatal care use, alcohol, tobacco and drug use, and perceived stress and social support. Understanding sociocultural factors may provide the keys to differences in birth outcomes and the bases for pregnancy interventions to improve outcomes for women in all ethnic groups (Zambrana, Scrimshaw, and Dunkel-Schetter, forthcoming).

It is essential that women be seen as individuals and as members of their cultures and not just as a uniform group of patients or, worse, as behaving in strange ways that often cause them to be incorrectly labeled as "difficult." We tread a fine line when we say that reproductive health research must record, analyze, and discuss diversity, yet must avoid labeling and stereotyping. The effort must be made to provide information for health professionals that will allow them to provide more appropriate programs and to understand the women they serve as they really are. More cross-cultural, interdisciplinary research is needed that combines cultural, socioeconomic, biomedical, behavioral, and psychological information. In addition, health care providers must begin with an appreciation for cultural diversity and the willingness to learn from the people they seek to serve. By considering the whole woman, rather than a part of her anatomy or a biological process such as pregnancy, caring, humanistic, and more effective health care can be achieved.

NOTES

This chapter, which summarizes many of the results of the UCLA Birth Project, carries with it our gratitude to Dr. Charles Brinkman and Ms. Lauren Kartozian. As head of obstetrics at UCLA and head of the obstetrical nurses, Charlie and Lauren stepped outside of conventional medical boundaries and let an anthropologist, a psychologist, and public health students into the labor and delivery rooms. Then they listened to and implemented many of our findings. We also wish to acknowledge the multiple contributions made by Patricia Lee Engle, co-principal investigator of the UCLA Birth Project and coauthor of many of the articles discussed in this chapter.

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2. Between twenty-four and forty-eight hours postpartum for vaginal deliveries and between forty-eight and seventy-two hours postpartum for cesarean section deliveries.

3. Psychosocial Mediators of Stress in Pregnancy in Relation to Pregnancy Outcome. Christine Dunkel-Schetter, P.I., Susan Scrimshaw, Co-P.I. March 1984–February 1986. March of Dimes Foundation.

4. Mediators of Birth Outcome among Three Low-Income Ethnic Groups. Ruth E. Zambrana, P.I., Susan Scrimshaw, Co-P.I., Christine Dunkel-Schetter, Co-Investigator. 1987–1990. National Institute for Health Services Research.

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