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BARRIERS TO PREGNANCY HEALTHCARE AS PERCEIVED BY HISPANIC WOMEN IN THE NORTHERN MIDWEST

Anna O. King

ACKNOWLEDGMENTS

I would like to thank my mentor, Professor Cathy Dillinger for supporting and encouraging me throughout this process. Thank you Dr. Schurman for encouraging me, helping me create a project about which I am passionate and interested, and working with me through the process. Thank you to Dr. Sharda, Dr. Stipp, and Dr. Case along with the honors faculty and program for helping us find a place in our communities and world. Thank you to the Honors Program for providing the funds and tools to conduct research. Thank you to the other honors students for their insight, support, and friendship. A big thank you to my translator and friend, Sam Lopez and all the work she did with me on this project.

ABSTRACT

BACKGROUND: This study explored the barriers to pregnancy health care experienced by Hispanic women. Research has shown that Hispanic patients are less likely to have adequate health insurance coverage compared to the white population in the United States and frequently face communication barriers in health care, as interpretive services are underutilized. These barriers may cause the Hispanic population to delay seeking health care and can lead to poor health outcomes. This is especially a problem in pregnancy health care, where prompt prenatal care is essential in ensuring a healthy pregnancy and positive health outcomes in both mother and baby.

METHODS: This was a qualitative study consisting of 12 Hispanic mothers from Illinois and Iowa with children ages eight months to 37 years old. Semi-structured focus group interviews were conducted using questions based off the Pregnancy Risk Assessment Monitoring System (PRAMS). Data was transcribed and coded manually using Microsoft Word and a descriptive coding process.

RESULTS: Communication barriers emerged as the most significant among participants during pregnancy health care, as the majority utilized family or friend translators or their own understanding of English. Participants referenced not being provided sufficient patient education during health care, leading to inaccurate or inadequate information. Half of the participants mentioned that insurance impacted where they sought pregnancy health care, which occasionally delayed care.

CONCLUSION: Only one woman utilized interpretive services, and the others reported that they would have felt more comfortable if they were provided professional translation. The misinformation found in the data could be the result of miscommunication or lack of patient education during health care. Regardless of barriers reported, participants expressed satisfaction with health care.

Keywords: Hispanic, pregnancy health care, barriers, language, insurance, patient education.

LITERATURE REVIEW

Introduction

Health care providers are tasked with consistently providing attentive, empathetic, and quality care. Individualized patient care has the ability to directly influence health outcomes. Health care professionals have the responsibility of individualizing care and advocating for minority patients by providing translation services, ensuring the patient has access to appointments and pharmacies, and minimizing bias in health care. Blair et al. (2013) found that often in providing care for minority patients, nurses and physicians overlook the barriers they face in accessing and utilizing health care. Providing individual, culturally competent care can increase patient satisfaction, which is often used as a measure of quality of care (Johansson, Oléni, & Fridlund, 2002).

A growing and often under-served minority population in the United States is the Hispanic population. First and second-generation Hispanic patients tend to speak primarily Spanish and have limited access to insurance (Hawks et al., 2018). Studies show that Hispanic patients are less likely to have adequate insurance coverage, which often prevents them from receiving preventative and adequate health care (Cristancho, Garces, & Peters, 2008; Gresenz, Rogowski, & Escarce, 2009; Law & VanDerslice, 2011). Additionally, Hispanic patients frequently face communication barriers when interpretive services are unavailable or under-utilized, leading to confusion, poor health outcomes, and dissatisfaction in health care (Jacobs, Shepard, & Suaya, 2004; Nápoles et al., 2009). These disparities are especially pronounced in areas with low Hispanic populations and when patients are primarily Spanish-speaking or undocumented (Gresenz et al., 2009). Bias is one way in which patient-centered care and therapeutic interpersonal communication between healthcare providers and patients can be interrupted.

Implicit bias

Although bias should not affect how health care professionals interact with patients, research has found that both explicit and implicit bias does impact health care perception in minority populations. Studies show that health care providers are not likely to explicitly express bias towards minority patients (Blair et al., 2013). However, implicit bias typically presents in subtle and unrecognized ways, and for this reason can be hard to measure in a quantitative study. Even though health care providers strive for equal treatment for patients of all racial and ethnic backgrounds, bias is subconsciously endorsed (Chapman, Kaatz, & Carnes, 2013). Blair et al. (2013) conducted one of the first studies to evaluate implicit bias and communication in clinical relationships, using Implicit Association Tests (IAT) to measure physician bias against black and Hispanic minorities. The IAT tests implicit bias by measuring the time it takes for an individual to respond in a positive or negative way to a group. After obtaining data from 134 physicians in the Denver area, they found that although no physician reported explicit bias, the IAT found about two thirds of them to have implicit bias towards black and Hispanic patients (Blair et al., 2013). Blair et al. also administered a patient survey to 2,908 adults to compare to the IAT, finding that overall Hispanic and Latino patients report being less satisfied with health care providers, but these results did not correlate with implicit bias in physicians. More research needs to be conducted on how Hispanic patients perceive their health care.

Chapman et al. (2013) conducted a literature review to explore implicit bias in health care and the ways in which it affects health outcomes. This study found that the interaction between patient and physician is affected by implicit bias, and this often leads to patient nonadherence and decreases in follow-up care. Not only does implicit bias in health care affect the relationship with the patient, but it also affects health outcomes. Hispanic patients are significantly less likely to receive adequate pain management compared to white patients; even though the physicians reported being able to judge severity of pain regardless of ethnicity, they provided less analgesia to Hispanic patients than to white patients with the same severity of injury (Chapman et al., 2013). This study also found that these racial disparities may lead to increases in morbidity. Bias is subconsciously endorsed in ways that negatively impact the patient's health outcomes.

Insurance

Although physician bias may play a role in the Hispanic patients' satisfaction with care received, it does not seem to be a primary barrier to accessing quality health care. Avila and Bramlett (2013) found that the most profound disparity to accessing adequate health care for the Hispanic population is lack of insurance. Cristancho et al. (2008) conducted a series of semi-structured focus groups with a total of 80 Hispanic adult participants in Illinois, finding that main barriers to accessing and utilizing health care include lack of health insurance, communication and transportation issues, and lack of documentation. Hispanic people are much less likely to be insured, especially if they are undocumented (Cristancho, et al., 2008). Avila and Bramlett (2013) utilized the National Survey of Children's Health (NSCH) to survey 91,642 adults through random-digit-dial and found that even Hispanic children who live in English-speaking households have lower health outcomes than white children. This could be partly because Hispanic people are less likely to be insured than their white counterparts.

Especially with Hispanics along the border and those without documentation, there is a complex relationship between socio-demographic factors and access to health care. A study conducted in El Paso County, Texas by Law and VanDerslice (2011) used the Behavioral Risk Factor Surveillance System (BRFSS) to survey 653 adults through random-digit dialing. The results of this study showed that 32% of Hispanics reported not being able to see a doctor because of cost, a percentage that is almost double that reported from non-Hispanics in the same region. Without insurance, a lot of the Hispanic population is unable to afford health care, which likely contributes to differences in health status between the racial groups. Employment status is the biggest determinant of insurance, with those who receive government-aided insurance policies such as Medicaid and retirement funds more likely to be adequately insured (Law & VanDerslice, 2011).

Communication and language

In order to provide high quality health care for their patients, health care providers must be able to adequately communicate. With patients in the United States for whom English is not their primary language, this entails providing professional medical interpreters or translation services, rather than relying on broken translations or family translators who lack training in medical translation. Hospitals are required to provide translations for consent forms and legal documentation, but often times these resources are underutilized in routine care and interaction with health care providers (Guo et al., 2018).

Hispanic patients may speak basic English or none at all, making it difficult to communicate with health care providers untrained in medical translation. Many Hispanic patients resort to bringing along a family member or friend as a translator to medical appointments, but this often leads to misinterpretations and omissions that could have serious clinical consequences (Cristancho, et al., 2008). Interpretation services are often unavailable or underutilized in health care. In all focus groups conducted, Cristancho et al. (2008) found communication issues listed as a main barrier encountered by Hispanic patients when accessing and utilizing health care. Improper communication can often be interpreted as uninterest or disrespect to the patient, which is associated with a decrease in satisfaction (Cristancho et al., 2008; Nápoles et al., 2009). In these studies, participants

reported physicians rushing through interactions, not taking the time to explain results or interventions, saying they are more satisfied when health care providers involve them in the process of deciding a course of action.

Studies have showed that interpretive services of any capacity improve patient satisfaction, and in turn, patient health outcomes. However, for Hispanic patients, especially those with subpar or no insurance, it can be costly. There is a significant increase in cost for health care for patients who utilize translation services, and typical insurances do not cover this cost (Jacobs et al., 2004). This could pay off, as patients who choose to pay for interpretive services on the front end typically spend less on health care in the long run. This study conducted by Jacobs et al. (2004) sampled a total of 4,499 adult patients separated into two groups enrolled in a health maintenance organization before and after interpreter services were implemented. They found that though interpretive services increased the immediate cost of health care, the patients who utilize translators receive more preventative services, physician visits, and prescription drugs, all of which could reduce cost of health care in the long term (Jacobs et al., 2004).

These studies all suggest that language and communication are primary barriers to adequate health care, and poor health outcomes can result from misinterpretations or inadequate translation services. These disparities are especially pronounced in rural communities, whereas living in areas with more Spanish speakers increases access to care (Cristancho et al., 2008; Gresenz et al., 2009). Hispanic people living in communities with a higher Hispanic population are less likely to experience barriers to receiving needed care. This could be the result of a greater availability of Spanish-speaking physicians or simply the social networks within the community that facilitate the transmission of information for which doctors and hospitals provide the most culturally competent care or who has bilingual staff (Gresenz et al., 2009).

Pregnancy health care in hispanic women

Though several studies suggest that barriers such as bias, insurance, and language exist to providing health care in the Hispanic community, these studies have not focused specifically on how these barriers to healthcare manifest in the female Hispanic population. A study conducted by Butler, Kim-Godwin, and Fox (2008) began to explore the female demographic by conducting semi-structured interviews with eight Hispanic adult women in Bladen County, North Carolina. The participants of this qualitative study indicated that they often learned medical practices through traditions passed down through generations, asking the older generations for advice when needed. This is part of Hispanic culture but may also be due to the fact that many exclusively Spanish-speaking women have less access to healthcare and may be unable to afford primary care. Additionally, these women reported difficulty arranging and keeping appointments due to transportation issues (Butler et al., 2008). Interpreters were not always utilized, in which case one woman and her husband had difficulty explaining symptoms and understanding treatments described to them by the physician.

Women's health is important when exploring health care during and after pregnancy. A study conducted by Bromley, Nunes, and Phipps (2012) began to look at pregnancy care

for Hispanic women through a retrospective cohort study with 9,906 participants using the Rhode Island Pregnancy Risk Assessment Monitoring System (PRAMS). They found that although Medicaid provides insurance to pregnant and postpartum women with low incomes, income still plays a significant role in the disparities to receiving prenatal care. Already Hispanic women are typically younger, less educated, and have lower insurance rates prior to pregnancy and are at risk of delayed or inadequate prenatal care (Bromley et al., 2012). Recently, there has been more research conducted regarding the barriers to pregnancy health care, but there is still much to learn.

Lack of education.

Many Hispanic women, especially the undereducated, have not received adequate preconception education, which can lead to postponed prenatal care and poor health outcomes for mother and baby. Hawks, McGinn, Bernstein, and Tobin (2018) utilized data from the Pregnancy Risk Assessment Monitoring System (PRAMS), finding that Hispanic and black women have a higher rate of unintended pregnancies but not a lower rate of contraception use. They assume that Hispanic and black women either have less access to higher quality contraceptives because of cost or are less educated than their white counterparts on how to accurately use contraceptive devices (Hawks, et al., 2018). Hispanic women with insurance were more likely to receive preconception and prenatal care; however frequently the insurance these women utilize is Medicaid, under which the rates of preterm and low birthweight rates are higher (Parekh, Jarlenski, & Kelley, 2018).

Pregnancy health care is imperative to proper prenatal nutrition and positive pregnancy outcomes. Unfortunately, Hispanic patients typically have below-basic health literacy compared to white patients and are less likely to receive adequate care throughout the pregnancy period (Guo et al., 2018). Guo's (2018) study conducted surveys and focus groups on 26 women in Orange County, California, finding that the participants were generally dissatisfied with the care they received postpartum. The women reported barriers to communication, including complicated medical jargon that went unexplained and doctors who were too rushed to answer questions and spend time with the patients. They reported bringing their children to help translate as they were unable to understand the doctors and would have appreciated access to their health records to help them understand what was going on.

Recently more studies have been conducted to analyze the barriers Hispanic women face to obtaining pregnancy health care, but a research deficit still exists as to how Hispanic women perceive their own health care. Researchers can measure patient outcomes that correlate to barriers in health care, but if patients perceive a problem or disparity in their health care, then a problem exists somewhere in the system. Statistical data is important in measuring patient outcomes, but ultimately the best way to see the extent to which race impacts access to adequate health care is to ask the patients about their perceptions and experiences through qualitative research (Johansson et al., 2002).

Previous research shows that factors such as implicit bias, lack of transportation and insurance, and language barriers lead to disparities in health care in the Hispanic population. This research picks up where other studies left off to answer the question: how

do Hispanic women in the northern Midwest perceive their pregnancy health care? This study seeks to answer this question through a qualitative approach by conducting focus group interviews with 12 Hispanic women throughout the northern Midwest.

METHODS

Participants

Participants included eight women from two towns in Illinois and four from Iowa. Participants were identified through the pastor of a local church, a compassion center, and a peer. The participants were mothers of children aged eight months to 37 years. Four of the mothers had their children outside of the United States the rest had their children between Iowa, Illinois, Georgia, and Wisconsin. One participant was native to the United States, whereas the rest were native to Mexico (five), Puerto Rico (three), Guatemala (one), Peru (one), and Honduras (one). See Table One for participants and the location of where they had their children.

Table 1
Participant Pseudonyms and The Location of Childbirth

Name	County
Adriana	Mexico
Anita	U.S.
Carla	U.S.
Carmen	Costa Rica & Peru
Eva	U.S.
Cynthia	U.S.
Andrea	U.S.
Brenda	Honduras
Sofia	U.S.
Rosa	Puerto Rico
Daniela	U.S.
Dariana	U.S.

Interviews

Data collection began upon approval from the Institutional Review Board. Participants signed a letter of informed consent before initiating the interviews, and participants were assigned pseudonyms. Focus groups were conducted in the participants' primary language through translation and lasted from 30 minutes to one hour. Interviews were recorded and transcribed by the interviewer. Both the interviewer and translator were present in all interviews. Two focus groups were conducted in Illinois and two in Iowa. Interviews were semi-structured and based off questions from the Pregnancy Risk Assessment Monitoring System (PRAMS). See Appendix A for the list of interview questions. All participants were rewarded a 10-dollar gift card for their participation.

Coding

The interviews were transcribed manually in English. Transcriptions were coded manually using Microsoft Word through the process of descriptive coding, with second-cycle coding as needed. There was a total of 13 codes between the four focus groups. For example, the code "misinformation" included instances in which the participant expressed either inaccurate information or lack of information, such as "I just heard it was abnormal", and "I thought it was normal."

RESULTS AND DISCUSSION

Below is a table detailing the codes encountered in the data, the number of times they appeared, and the number of participants by which they were cited.

Table 2
Codes and Code Frequency

Code	Number of Citations	Number of Participants
Misinformation	5	4
Education*	5	3
Educational Resources*	8	4
Satisfaction: Provider Relationship	24	9
Satisfaction: Bad Experience	7	6
Insurance	18	11
Transportation	15	8
Translation Services and Translators	26	10
Family and Friend Translators	9	4
Frustrated/Intimidated	6	5
Pre-conception Care	6	2
Breastfeeding	4	2
Domestic Abuse	3	1

**Secondary Codes*

Misinformation

The code “misinformation” was mentioned five times between four participants who reported instances of lack of patient education or inaccurate information that occurred during the prenatal and postpartum periods. Anita was experiencing complications during her prenatal period, including hyperemesis, saying, “For three months I was just throwing up and throwing up. Everything made me sick.” When asked if she received medical attention for this condition she responded, “I didn’t tell my doctor because I thought it was normal. My doctor just told me I was decreasing in weight rather than increasing and I needed to do something about that.” Similarly, Carla was discussing her prenatal care and mentioned a risk for miscarriage. She said she was not educated as to why she was at risk for miscarriage or on bed rest, stating, “I rested a lot, but they didn’t tell me why.” Another participant, Adriana, was told of an abnormal pap smear during her pregnancy but nobody followed up or explained what that meant she just “heard it was abnormal.” These women all experienced a complication to their pregnancy but were not informed of the extent of their condition.

One postpartum story of misinformation came from Adriana. She had a large birth weight child and gave birth vaginally, after which she recalled, “I had some bleeding, so they had to like every half an hour try to push my stomach all the way through to make it stronger or something, I don’t know.” Health care providers in the postpartum unit provide fundal massage and examinations to decrease the risk of hemorrhage, which is what Adriana is

describing here. Adriana was unaware of the rationale behind this procedure and even listed it as a reason to avoid postpartum check-ups, saying “So I think I just didn’t want to go... I didn’t want to deal with that for a while.” Hispanic women typically have below-basic health literacy and report being dissatisfied with postpartum care, which can be related to medical jargon or just inadequate education from health care providers. Guo et al. (2018) found similar results, that Hispanic women could not understand medical terminology, even when translated to Spanish, often saying that the doctor did not take the time to explain things to them.

In another instance, Carla and Carmen were discussing misinformation regarding prenatal nutritional needs and their pregnancy eating habits. Carmen stated “At that time they say, ‘you have to eat double for you and the baby,’” whereas Carla responded that her doctor said “‘you’re not eating for two, just add enough calories to make sure the baby has enough to sustain itself.’” This discrepancy between misinformation and accurate information could be due to the country of pregnancy care, Carmen having her children in Costa Rica and Peru, and Carla in the United States, or the fact that Carmen had her children about 30 years before Carla did. Another difference between the participants who had their children in the United States and those who gave birth in Latin America was noted in Rosa from Puerto Rico. Rosa had a unique case during pregnancy, as she had been fighting breast cancer when she got pregnant. She emphasized a close relationship with the health care providers during her pregnancy wherein they provided a lot of patient education, saying “they always explained everything really well.”

Education.

Misinformation can come from lack of appropriate guidance from health care providers, inaccurate information from secondary sources, or lack of education. A large part of health care is patient education, which should be present throughout the duration of care. A secondary code from the code misinformation is “education,” referring to the education received specifically from health care providers, or the lack of education provided in the health care setting for these women.

When specifically asked about patient education, the code “education” was referenced five times by three participants. When asked about preparedness for the first birth and taking care of a newborn, Adriana stated that she was not ready and the conception of their first child was much earlier than they had planned, as she and her husband did not use contraceptives. She said they were aware of contraceptives but “didn’t really pay attention to it.” Hispanic women tend to receive less education on contraceptive use, with statistically higher rates of unintended pregnancies compared to other races with the same rates of contraceptive use (Hawks, et al., 2018). The rate of contraceptive use is lower in under developed countries, in part because of lack of education and resources, which could explain why Adrianna, who had her children in Mexico, did not utilize contraceptive devices (de Vargas Nunes Coll, Ewerling, Hellwig, & de Barros 2019).

Comparing the code “education” referenced in participants who had their children in the United States to those who had their children in Latin America, it seems that those in Latin America received less prenatal education than those in the United States. Various studies

indicate that women in Latin America are not receiving adequate education regarding women's health, but little research exists to examine the quality of patient education these women receive prenatally or in the hospital (Dongarwar & Salihu, 2019; Liebermann et al., 2018). Carmen referenced lack of education regarding prenatal care during a conversation about prenatal education, saying, "I didn't have much education," and later saying she only got basic information about how to take care of a baby. Differing slightly, Adriana said the nurses after her first child "gave me information about vaccines, milk, attention for mothers" but did not follow up with education after the second child. Carla recounted her experience with the doctor in Georgia: "Dr. Johnson was very thorough with everything and I was very well educated on what needed to be done," and Cynthia said in reference to prenatal vitamins and education "usually when you go to normal check-ups, the nurses and people in charge explain to you what the vitamins are for." These examples could indicate a difference between the education received in the hospital from women having their children in Latin America and Hispanic women having children in the United States.

Educational resources.

There is more than one way for patients to learn about pregnancy, the birth process, and postpartum care. Various educational resources exist for patients to learn about their health outside of the health care settings, which can be especially beneficial for patients to receive education in their primary language. Another secondary code to misinformation was "educational resources," which references the additional resources the participants utilized during their pregnancy health care experience.

Some health care providers may not be providing adequate information or education for Hispanic patients before, during, and after pregnancy, but there are more resources to educate women during the pregnancy and birth process than just health care providers. Carmen described this, saying, "I did have my doctors and it was all just general information. It's not just what my doctor said but also what my mom and other family members said that helped me throughout my pregnancy because all the doctor's information was very general." People in Hispanic cultures tend to support each other and rely on familial and community help, sharing helpful information with each other (Gresenz et al., 2009). This was evident in the data, as the code "educational resources" appeared eight times among four participants. Carmen mentioned multiple times relying on the information her mother provided when navigating pregnancy through statements like, "my main nutrition education came from my mom," "the only care I received was from my mom," and "my mom was the book" in reference to a conversation about books, classes, and videos provided to Carla throughout her pregnancy. Cynthia echoed this in another interview, "A lot of times too when you are around people, your friends, they start talking, so part of [education] is society." However, this could lead to inaccurate information, such as it did in Anita's case with hyperemesis. She was told by her mother that throwing up during pregnancy was normal, and nobody told her otherwise, so she delayed care when she was going through that experience.

Other participants mentioned utilizing books and video resources, which Carmen referenced as a newer form of education. Carla and Cynthia have children who are under

15, whereas Carmen has children over 30, so it is possible that these discrepancies are due generational differences and the evolution of media. Carla mentioned feeling alone with her husband after moving and switching doctors and turning to other resources for prenatal education, stating, “we didn’t have a lot of outside help, and I think that’s why we looked for those resources and that’s why we did all the books and videos and all that stuff.” Cynthia also spoke about receiving books during her pregnancy about prenatal care and what to expect during pregnancy and after and reported that she “usually got more information from the book than anything else.”

Satisfaction: Provider relationship

“Satisfaction” as a code was mentioned 24 times between nine women and included instances where the women were satisfied with their health care providers and when they were not. Carla started her pregnancy health care in Georgia at a clinic and had a good OB/GYN there. She mentioned in her interview five times that she was very satisfied with her doctor in Georgia. Examples of this include, “the prenatal care I had when I was in Georgia was phenomenal,” and “I had a lot of support from her and it made me feel a lot more confident.” When she moved to Illinois, she stayed in contact with her doctor in Georgia for the duration of her pregnancy, since she was “not confident with the OB here.” She recounted a story from one of her friend’s which was parallel to how she felt with an OB in Illinois. Her friend said to her, “My doctor does nothing. She just goes, checks, makes sure the baby’s fine, and on your way.” When women feel that their doctor is rushed, they may feel more intimidated to ask for education or clarification. In contrast, Carla felt as though she could discuss anything with her doctor, which increased her confidence in caring for herself during pregnancy and her child.

Other participants echoed Carla’s experience in Georgia. Cynthia said “Everything was good. I had good experiences with the doctors and nurses,” and Sofia said, “I thought it was good because they always ask if you’re in pain and help you get into a more comfortable position if you needed it.” Rosa stated that she “thought it was good, obviously I had a unique case because I was always in the hospital,” meaning she already had a relationship with health care providers in the area because she spent a lot of time in the health care system while battling breast cancer. Anita had children at two separate hospitals and discussed the satisfaction she felt after having children in both, saying she felt better at one hospital than the other.

Daniela noted a difference between experiences at different hospitals, but overall said, “they were very good, yes, I had a good experience.” The participants generally responded with a better relationship with their nurses than their primary providers and physicians, saying the care the nurses provided was more personal than the doctor’s. Anita said, “The nurses are a bit more involved. The doctor just comes, checks in, and leaves,” which was a sentiment echoed in several other participants. Adriana said she “felt like I received more personal attention from the nurses” and “The doctor was worried with other things... I felt more of a relationship with the nurse.” Additionally, Brenda stated that “the nurse is the one who does the hard job.” Dariana even mentioned that the nurse working during her second birth helped name her daughter. Participants in a study conducted Crisanchio et al. (2008) expressed similar dissatisfaction with doctors in the United States, saying that the

doctors did not care about the patient relationship or take time to educate the patient during care. As medicine advances, the physician-patient relationship loses emphasis, and patients are left with shallow interactions and less focus on their individual needs (Aoun, Al Hayek, & El Jabbour, 2018). In turn, nurses and other health care staff often provide this relationship for the patient.

Participants generally reported satisfaction with those involved in their pregnancy health care. A few of the women who had their children in other countries and have received care in the United States talked about feeling better cared for in the United States than in their home country. Dariana said “I felt like I got better attention and care than in Puerto Rico.” Sofia said, “I got better care in the United States than in Guatemala,” and Brenda from Honduras said “It’s totally different in every aspect. There, people die in the hall waiting a long time.” Even if the primary language is different and communication is impaired in the United States with these Hispanic women, they felt like the care they received was higher quality.

Satisfaction: Bad experience

Though most participants expressed satisfaction with health care providers, there were five participants who shared a bad experience with health care providers during their prenatal and delivery periods. Carmen shared a story from Peru with a night shift nurse, saying, “after my c-section, the nurse was sleeping during the night shift.” Anita said that during her delivery, “my doctor told me that I needed to give birth before seven because she needed to go see the Chicago Bears game.” There were a couple similar accounts of situations in which these women felt as though they were not being listened to or heard. One of these was Andrea, who recalled a bad experience where she went to the doctor for bad contractions but was told to return home and wait even though it was already past her due date, at which point her baby was too big and she had to have a c-section. She said after her procedure, “They put staples instead of stitches and when it was time to let me go two days later, they made me walk the baby in the car seat by myself.”

Another bad experience regarding undermedication was when Eva had her child in Wisconsin. She was in a lot of pain, but whenever she would go to the doctor, they would send her back home with “sleeping pills.” At one point, they kept her in the hospital due to pain and after giving her these sleeping pills, and she recalled, “I was hallucinating, and the nurses were laughing to death because... I didn’t know where I was, and I thought I was a bug crawling on the floor.” After a few days of this pain, her husband took her to the hospital and insisted they admit her. She had a similar experience in Iowa too, where the nurse told her she could not come to the hospital because it was not her due date. She said “I got my husband at like four in the morning and said, you know we’re leaving. And when I was there... I was almost 9cm dilated.” Eva felt disappointed in her health care providers for not listening to her and helping her when she was in pain. Aoun et al. (2018) found that minority patients, including Hispanics, are less likely than whites to receive adequate pain management in a hospital setting. In this study conducted by Chapman et al. (2013), the physician detected the same amount of pain in a white and Hispanic patient yet prescribed less pain medication to the Hispanic patient. This finding is echoed in a study conducted

by Janakiram et al. (2018) who found that Hispanic patients were half as likely to receive opioid pain medication following dental procedures as white patients.

Insurance

Out of all 12 participants, two of them had no insurance during their pregnancies, both of whom had their children in Latin America. Some women had insurance through their place of work, three used Medicaid, and the rest had various insurances. Six women mentioned eight times that insurance or lack of insurance impacted where they sought pregnancy care. Those without insurance mentioned not being able to receive adequate care compared to those with health insurance. Carla said her insurance was accepted and approved everywhere she went, and Daniela said the same was true of those who had Medicaid. Some had to seek care where their insurance permitted. Sofia said, “with my insurance, they almost recommend a place for you to go and get the best place that’s closest to you, but with [my insurance] they’ll send you to like... a hospital that’s not as convenient.” Rosa echoed this experience, saying that her insurance told her where to go, and Dariana was unable to find a doctor or gynecologist when she was pregnant because they did not take her insurance. When these women are told where to seek health care, they may not be able to get to their appointments, which could cause a negative impact to their health and the health of their developing child.

Transportation

Two out of the 12 participants reported their first prenatal appointment as being not as early as they would have liked it to be. Adriana did not state a reason for this, and Carmen had problems with insurance, but for many women this could be a result of limited transportation (Cristancho, et al., 2008). The code transportation was mentioned 15 times among eight participants. Sofia, Rosa, and Adriana reported no problems with transportation; they had cars and getting to appointments and the pharmacy was not a problem for them. Carla said her insurance would offer rides to the gynecologist and the pharmacy when she needed transportation, however, she had her husband take her where she needed to go, so they did not utilize this service. Brenda said in Honduras she had to walk everywhere.

Anita shared in detail about relying on her sister-in-law to transport her to the doctor as needed. She said it was not very reliable, and since she was so dependent on her sister-in-law, if her sister-in-law needed to cancel for any reason, Anita would not be able to get to the appointment that day. She said she did not know how to use public transportation and her hospital did not arrange transportation. She also shared a story of a friend, saying, “I know somebody that was driving people; she would charge like 20 dollars to drive people. She would schedule all the appointments in the same day within the same hour, so she would drive like four or five people up at the same time.”

Transportation services through hospitals or insurance companies are available for patients to utilize, as is public transportation, but often patients are unaware of the availability of these or how to use them. Underutilization of transportation services or limited access to transportation can lead to delayed treatment, missed appointments, and inability to access prescriptions (Cristancho, et al., 2008). In a study conducted by Butler et al. (2008), all participants reported difficulty keeping appointments due to lack of transportation. With

pregnancy, limited access to transportation could lead to detrimental delays in prenatal and delivery care.

Translation services and translators

One resource available to hospitals is a language line, and though this terminology may differ from hospital to hospital, the concept is the same. With a language line, the health care provider can speak into a telephone in English, where it is translated to whatever language is needed and the patient listening on the other end can understand in their language. This resource is becoming increasingly available and is important to utilize, even in routine care. When asked about language lines, four participants reported being offered translation services during delivery, whereas four said they were not offered at all. Of those who were offered translation services; only one reported utilizing these services, many of the others said they had friends or family with them to translate.

One aspect of providing translation services is ensuring resources for patient education are available in their primary language. Six participants were offered prenatal classes in Spanish in the United States. Some of these women chose to participate in the English classes, like Carla, and others did not attend prenatal courses, like Anita. After delivery, neither Carla nor Anita were offered resources in Spanish for how to care for a baby. Anita said she had a hard time understanding postpartum education, and her husband “told me whatever he understood.” She said it would have been nice throughout this process to be provided with written copies of patient education in Spanish so she could follow along.

During health care, especially in the hospital during delivery it is beneficial to have translation services so the patient can understand what’s going on. Anita was not offered a language line or interpreter during delivery, but her husband was with her and he knows English. When asked whether or not her husband would have been qualified to translate medical jargon and terminology, she said he has a high school education and was not able to translate the “medical stuff” very well. Sometimes health care providers assume a patient understands English or is able to translate. Carmen told of this also, saying, “I go by myself and I try so hard to understand them,” and when asked if she is ever offered a language line, “no, because they think I speak English. Generally, I understand the doctors. But if I don’t understand, I ask questions or ask them to write it down so I can ask other people.” Other participants spoke of relying on friends and family rather than the provided translators, like Cynthia, who said, “sometimes they offered, but since I had my friends, I just asked them.”

There were several women who reported being offered translation services consistently, including Andrea who said, “everyone was talking Spanish to me [at the hospital].” Sofia said, “If you ask, there is always someone who will go,” and Dariana said, “I was always offered translations, I didn’t always need it... but I was always offered translation with any medication. I was... offered an explanation for it and they would break it down and tell me everything.” Additionally, Rosa said, “thankfully they always had translators or someone to help.” The women who reported being offered translation services, or being treated by Spanish-speakers in Andrea’s case, had their children within the past five years, whereas all the other women had their children over 25 years ago. This could explain the

discrepancy, as states began requiring facilities to provide translation services in the early 2000s (Foden-Vencil, 2014). Eva even said that when she would go with her friends, sometimes the hospitals will not allow nonprofessional translators and provide their own professional translation services. Professional translators are trained in medical terminology and are to remain in accordance of privacy laws. With untrained or non-professional translators, this privacy and competence cannot be ensured

Family and friend translators

Though health care providers are encouraged to utilize the translation services and professional translators during care to avoid miscommunication errors and ensure privacy, they often still rely on family and friend translators out of convenience and availability. Participants were asked whether they have relied on friends or family for translation, provided a friend or family member with translation, and how those experiences went. Four participants mentioned family and friend translators nine times. Carla shared that she translated for her mother at 13 years old when her mother was pregnant. She would accompany her at doctor appointments, but was in school when her brother was born, so her aunt helped translate during delivery. This was almost 15 years ago, and Carla's mother was not provided translation services through the hospital and had to rely on her daughter to translate. When asked whether or not she felt she could adequately translate for her mother, she responded:

I was probably not adequately conveying, I was translating what I knew how to translate, and what I didn't know how to translate, I kind of filled in the blanks. I feel like if someone was there to translate appropriately, she could have asked more questions... I feel like I did the best I could at the time.

Carla continued to say later that she felt like her mother had more questions for the doctor but "she was just like, okay, it's fine then" and moved on.

This is a similar experience to what Anita went through when she was pregnant with her children. She brought her sister-in-law or her husband with her to doctor appointments and the hospital. She said she felt more comfortable with her husband than her sister-in-law, but she usually had to go with her sister-in-law, who would control the situation by saying what she wanted to say or not asking what Anita wanted her to ask the doctor. Anita's sister-in-law would answer the questions for Anita without asking the doctor, which Anita elaborated on by saying, "Before the doctor had even answered the question, my sister-in-law had already answered it for the doctor." For several reasons, she said that she would have preferred to have a medical translator with her, one of which being, "I would have had answers for all my questions the way I wanted them to be answered." Additionally, she said:

I think that I would have felt more comfortable and trusting of somebody that was there professionally to translate because with my sister-in-law and my husband, I just had to trust whatever they were saying, and they could've translated it in whatever way they wanted... and sometimes with a family member or someone you know, you feel less comfortable sharing some things because you feel like they're listening in on what you have to say.

Anita did say she was glad to have her sister-in-law and husband with her, because it was better than having no translator present, but she would have felt more comfortable and satisfied with a professional translator.

For these women, a personal translator was the only option if they wanted to be able to communicate with their health care providers. However, to provide comprehensive care to people who speak a different language, it is important for the health care providers to provide professional translators or interpretive services. A study conducted by Foden-Vencil (2014) found that the rate of error in interpretation was 12% with professional translators, as opposed to 22% for non-professionals, a margin of error that dropped to 2% when utilizing experienced medical translators. These translation errors can cause clinical consequences. According to Ku and Flores (2005), if the patient can understand their care and ask the questions they need to, there are less likely to be negative health outcomes and the patients are more likely to be satisfied with care.

Frustrated/ Intimidated

The code “frustrated/ intimidated” was found six times with five participants regarding communication and language. Some women like Carmen said they have no problem asking for clarification with the doctor and asking questions when they do not understand. Other people, like Carla’s mother and Anita stopped asking questions when relying on a family or friend translator and could not adequately express their concerns. When asked whether they felt intimidated or discouraged to ask for clarification, Brenda originally said no, but after Eva expressed her embarrassment on occasion, agreed with Eva. Eva answered by saying, “I was embarrassed that I didn’t understand” so she would just nod her head and answer yes to whatever the doctor was saying, even though she had no idea what they were saying or asking her. A health care provider might see this response and assume the patient is understanding the education, when actually, the patient is too intimidated to ask for clarification. In response to Eva, Cynthia said, “sometimes if they ask or talk too fast, I don’t understand what they’re saying.” In this instance, the focus group setting opened a dialogue about the frustrations of not being able to understand a doctor and gave these women an outlet to express that sometimes they feel embarrassed.

Anita was talking about how she emphasizes to her children the importance of learning both Spanish and English so they can help people like herself. She said, “I knew how frustrating it was for me sometimes when I had to go by myself, and I just felt incompetent because I couldn’t understand or just couldn’t do anything to understand or help when I was by myself.” Adriana said something similar about telling her kids to learn both languages, especially since the Hispanic community is growing. She said more people are going to need help with translation and “more people that feel intimidated by not being able to speak English and wanting translation.” Anita said recently she has been seeing more help in terms of translation since she had her children and more people know Spanish, which is encouraging.

Pre-conception care

Only two participants discussed pre-conception care and complications. Adriana got pregnant a month after she got married because she and her husband did not receive or use

any contraceptives. When asked whether or not they had contraceptive education, she responded, “I just didn’t really pay attention to it. We kind of regret it and to this day we always talk about it.” Hispanic women have similar rates of use of contraceptives, but a significantly higher rate of unintended pregnancies, and thus it may be due to lack of education about use of contraceptives, which was seen with Adriana’s story (Hawks et al., 2018). On the other side, Anita experienced fertility issues. She did not receive much education as to why this was occurring, but she said, “I had some sort of infection that was killing the sperm so that’s why I wasn’t getting pregnant.” The doctor gave her vaginal suppositories and she got pregnant a few months later. When asked whether her husband accompanied her to the fertility doctor or got tested at all, she simply said she went by herself.

Breastfeeding

In one interview, the participants discussed breastfeeding trends and their own experiences. The code “breastfeeding” appeared four times between two participants. Adriana said she felt that people were less likely to breastfeed in the United States than in Mexico and she speculated that it was “just because of lack of encouragement and the lack of push for moms to breastfeed and teach moms that breastfeeding is a better option.” She spoke about Mexico and how there are “less resources to buy formula and they encouraged you to breastfeed more” than they do in the United States. Anita said she and her other friends had trouble producing milk, so they had to switch to formula after her first child. Adriana had her children in Mexico, whereas Anita had her children in the United States. Garrett et al. (2018) found that 81% of non-Hispanic mothers compared to 57% of Hispanic mothers report exclusively breastfeeding, which is not what the women from this study seemed to think. In Latin America, women often use both formula and breastfeeding in a practice called “las dos cosas.”

Domestic abuse

One unexpected finding was a story from Eva about her experience with domestic abuse from her first husband. She said, “he was very violent, we were fighting every single day of my pregnancy... I tried to leave him several times, but every time I tried, he would try to kill me.” When asked whether she confided in anyone about her situation or talked to her doctors or nurses about it, she said:

I never told them... I tried to call the cops. I ran out of the house trying to find a pay phone because I didn’t have a phone at all. And I never could find a pay phone and I was hoping to see people in the street because it was late at night, but nobody was there to help me, so I had to go back again, walking home alone in the dark because I had nobody to ask for help.

She said she wishes the health care providers had asked if everything was okay or would have at least been able to recognize the signs that somebody was going through a situation like she was. She said, “I was more afraid because I wanted my son to have a father, and I felt that I had no help... because I had no communication or sources to get information.” She was never informed of a domestic abuse hotline or any resources that could have helped her get out of that situation. Since then, she has escaped that situation and remarried, but at the time had nobody to turn to who understood her nor could adequately communicate with her.

CONCLUSION

Hispanic patients in pregnancy health care perceived barriers to health care in terms of language and communication, insurance, and education. Participants reported satisfaction in spite of such barriers, especially with their nurses during pregnancy care and delivery. Only one participant used professional translation services during her stay in the hospital, the others relying on family or friends or their own understanding of English. When utilizing family and friends, participants admitted that they were not qualified to translate medical terminology or knowledgeable of healthcare in a capacity sufficient for medical interpretation. These women said they would have felt more comfortable asking questions with a professional translator present than somebody they knew personally, but ultimately this did not impact their reported satisfaction with health care.

Half of the participants mentioned that insurance or lack of insurance impacted where they sought care and occasionally had to postpone seeking health care due to insurance-related issues. Insurance companies in some instances provided transportation services, but other women who could not drive or could not access public transportation had to rely on friends or family to get to appointments and the hospital as needed.

Participants reported several instances of misinformation, or times where they were not provided sufficient patient education or educational resources during their pregnancy period. Phrases such as “nobody told me” and “I thought it was normal” occurred five times in the data, lending to the question of whether or not Hispanic women are getting health education during care. This lack of health literacy could be due to a communication barrier and women who are intimidated to ask for clarification, or a misunderstanding between health care provider and patient, or simply a lack of explanation and patient education.

This study was limited by sample size due to the nature of qualitative research. Future studies could sample a larger population across the northern Midwest and compare community demographics to qualitative data. Data collection could have been influenced by focus group environment where some participants were required to bring their children and other distractions were present. Future studies could use statistical data about patient health outcomes to compare to perceptions for more depth. There is still a deficiency in information regarding patient education, especially during pregnancy health care in Latin American countries. Future research could study pregnancy health care in Latin America compared to the United States, and health outcomes in patients who utilize professional translators in comparison to those who use family or friends as translators.

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APPENDIX A

Interview Questions

- Regarding prenatal care
 - Describe your level of satisfaction with your prenatal care
 - How would you describe your prenatal nutrition? Did you regularly consume prenatal vitamins and folic acid? Did you get education on this?
 - How many weeks or months pregnant were you when you had your first visit for prenatal care? Was that as early as you wanted? Where did you go for prenatal visits?
 - How well did you feel prepared in understanding prenatal care?
 - How well did you feel prepared and informed for your first birth and caring for a newborn? Were you offered prenatal classes in your primary language?
- Regarding birth
 - Describe your level of satisfaction with the care provided during your stay at the hospital during delivery.
 - Was an interpreter or language line needed and utilized?
 - Describe your level of satisfaction with your relationship with the physician during delivery.
 - Describe your level of satisfaction with your relationship with the nurses and other health care staff during delivery
- Regarding postpartum
 - Tell me about your postpartum care and education.
 - Since your baby was born, did you have a postpartum checkup for yourself? If not, why not? If so, where did you go? How long after birth?
 - After your delivery, did the hospital send a survey about your hospital stay, and was it in your primary language?
 - Did you fill out and return the survey? If not, why not?
- Did you face any complications to your pregnancy prior, during, or after birth?
- What kind of health insurance did you have prior to your pregnancy, or each of your pregnancies? Did health insurance or lack thereof impact how or where you sought prenatal and pregnancy care, and how so?
 - If you did not have health insurance, why not? How did you pay for prenatal care and delivery?
- If you have had multiple children, were there significant differences between the care you received with each one?
- Did you receive care from different providers or hospitals?
- Were you able to get to appointments, pharmacies, and the hospital as needed for pregnancy care? (transportation, location)
- Were you able to adequately communicate with health care providers during any prenatal, delivery, and postnatal care?
 - Were you provided with translation services if needed? If so, did that impact your perception of care or ability to communicate with health care staff?

- Did you ever bring a friend or relative as a translator to a prenatal or postnatal appointment? Have you been a translator for a friend? Can you describe these experiences?
- Have you ever felt intimidated or discouraged to ask for translator or clarification?

Demographic questions:

- Where did you have your children?
- Are you native to the United States?
- What is your primary language?
 - Do you speak English as a secondary language?

