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Mexican-Born Women's Experiences of Perinatal Care in the United States

Lauren Trainor, CNM, IBCLC, MS[1,2], Ellen Frickberg-Middleton, PhD, RN, NP[3], Monica McLemore, PhD, MPH, RN[2], and Linda Franck, RN, PhD, FAAN[2]

Abstract

Mexican-born women represent a significant proportion of the obstetric patient population in California and have higher incidence of adverse obstetric outcomes than white women, including maternal postpartum hemorrhage and perinatal depression. Little is known, however, about Mexican-born women's experiences of maternity care in the United States. Qualitative methods were used to conduct a secondary analysis of interview transcripts, field notes, original photographs, and analytic memos from a study of 7 Mexican-born women's birth experiences. Participants reported social isolation influenced their expectations of maternity care. Disconnection, characterized by unmet physical and relational needs, yielded negative experiences of maternity care, while positive experiences were the result of attentive care wherein they felt providers cared about them as individuals.

Keywords

maternity care, Latina, Mexican, immigrant, obstetric care, birth experiences

Introduction

An estimated 11.2 million people in the United States are Mexican by birth, the largest single county of origin among immigrants to the United States (1). Studies demonstrate that Hispanic (term used in the study reports) women in the United States were more likely to experience severe postpartum hemorrhage, peripartum infection, and perinatal depression compared to non-Hispanic white women, despite controlling for patient characteristics and care facility (2–4). Although the cause of these disparities is unknown, some authors posit that life stressors such as economic insecurity, fear of deportation, and societal exclusion generate a significant psychological burden that impacts health (4–6). In addition, barriers to health care access such as poverty, language differences, insurance status, and physical location may contribute to poorer outcomes (7). Finally, for those who do access care, cultural norms, mental health stigma, and provider biases may contribute to provider–patient challenges that disrupt screening and treatment strategies (8,9).

To date, very limited data are available regarding the experiences of Mexican-born women accessing maternity care in the United States (10–12). Therefore, the aims of this study were to describe Mexican-born women's experiences of maternity care and identify common themes.

Methods

This study is a secondary qualitative analysis of qualitative data that were collected as part of a study exploring the relationship between life-course adversity and obstetric trauma in Mexican-born women (5). The quantity and depth of the data acquired in the original interviews accommodated a deep, focused investigation of descriptions of participants' perspectives on maternity care received.

Sample

The study was approved by a university institutional review board (IRB). Recruitment occurred at a family-health clinic between 2011 and 2014. Inclusion criteria were self-described experience of a difficult birth, age greater than

[1] May Grant Obstetrics & Gynecology, Lancaster, PA, USA
[2] Department of Family Health Care Nursing, School of Nursing, UCSF, San Francisco, CA, USA
[3] Department of Obstetrics & Gynecology, UCSF Fresno, Fresno, CA, USA

Corresponding Author:
Lauren Trainor, May Grant Obstetrics & Gynecology, 694 Good Dr, Lancaster, PA 17603, USA.
Email: leftrainor@gmail.com

18 years, Mexican-born, and fluency in either English or Spanish. In addition, the IRB required 6 months to have elapsed since the difficult birth to mitigate possible retraumatization by discussing the event (6). Exclusion criteria included active receipt of mental health care. In order to prevent potential breach of anonymity with respect to immigration status, informed consent was conducted verbally upon participant enrollment in the study.

Data Collection

Data were collected in 3, hour-long, semistructured interviews with each participant at the location and in the language of the participant's choosing. A certified Spanish-language interpreter/translator facilitated interviews and translation of written transcripts. For this secondary data analysis, data were provided in the form of English-language transcripts from the audio-recorded interviews, field notes, and photographs of the participants' homes.

Data Analysis

Data analysis was conducted using a modified grounded-theory approach in the tradition of Charmaz (13). Each participant's interview transcripts were read and line-by-line coded before engaging with the next participant's interview transcripts. Memo-writing and journaling were utilized to observe for personal reactions and interactions with the participants as they were represented in the data. Axial coding and further memo-writing helped to identify emerging themes.

Analytic rigor was enhanced by application of constant-comparison through simulated chronology, open coding, and an iterative process that remained grounded in the data at every new level of abstraction. Special care was paid to keep emerging themes grounded in the participants' own words to guard against erasure of the voices of the women themselves.

Results

The sample consisted of 7 women residing in and around Fresno, CA (Table 1). Although no participant formally withdrew, 5 additional participants who originally enrolled were lost to follow-up due to migratory work patterns.

The multisession interviews yielded strikingly candid personal accounts. Most participants reported sharing thoughts and emotions with another person for the first time. Themes of invisible burdens, feeling unheard, and attentive care emerged from the descriptions of maternity care encounters. Each theme is presented with verbatim exemplar quotes under pseudonyms (Table 2) and discussed in further detail below.

"Here It Is Different:" Invisible Burdens

Despite direct interview questions on maternity care experiences, all participants shifted the conversation toward discussion of their experiences of isolation and exclusion. Physical distance from important family members as well as cultural and relational distance from those around them in their new environment dominated participant's experiences of pregnancy. Pregnancy heightened the contrast and highlighted the distance between "here" and "there."

In addition, 5 of the 7 participants shared personal experiences of deportation or the deportation of a loved one. The fear of permanent separation from their children contributed to a desire to remain unobtrusive. Participants were reticent to critique the care they received or to ask for additional services for fear of causing a disturbance that could draw further attention upon themselves. These invisible mental and emotional burdens accompanied participants into their maternity care encounters.

"Maybe If You Scream, They Will Come:" Unheard

Each of the 7 participants reported difficult birth experiences. Perinatal loss and emergency cesarean delivery were the most common causes. Four of 7 described negative encounters with a health care provider. They related experiences of both physical and relational needs being left unmet. Many participants described a deep desire to be heard and to be able to express their fears and feelings, yet they were left feeling unheard, unseen, and uncared for. This contributed to a sense of deepening isolation.

"Someone Was Worried About Me:" Attentive Care

Six of 7 participants reflected positively on their maternity care as a whole despite some negative individual health care encounters, stating that they preferred the care in the United States to that of their home communities in Mexico. These participants cited the frequent appointments and physical examination techniques, such as blood pressure monitoring, as evidence of attentive care that aligned with their expectation of pregnancy as a time for special attention and care.

Four of 7 participants specifically described positive encounters with a health care provider despite difficult birth experiences. Relational connections were highlighted by these women, using the language of "worry" or "concern" (in Spanish, *preocupado*) to describe positive encounters with maternity care providers. Knowing that someone was "worried" about you served as a metric for being seen by and having a close connection with their health care providers.

Discussion

This study is one of only several studies (10–12) to provide descriptions of maternity care experiences of Mexican-born women in the United States. The women who participated in this study described similar experiences of both positive and negative maternity care encounters. Common themes of

Table 1. Demographic Characteristics of Mexican-Born Women Participants.[a]

Demographic characteristic	Participant data
Age range (mean)	19-47 years (31)
Marital status	
Married	5
Partnered	1
Single	1
Number of children	1-5
Ages of children	6 months-21 years
Employment	
Currently working outside the home	3
Not currently working outside the home	4
Current/prior types of employment	Field work, packing house, babysitting, party rentals
Education, highest grade achieved (mean)	2nd-11th grade (6th)
Languages spoken fluently, by participant report	Spanish (7), Nahuatl (1), Mixteca Alta (1), Zapoteca (1), English (0)
Years in the United States, cumulative[b]	
At time of interview (mean)	4-26 years (13.3)
At time of difficult birth event (mean)	3-16 years (8.4)
Home states in Mexico	Guadalajara, Michoacán, Oaxaca, Guerrero
Nature of self-defined difficult birth reported (number of participants)	Unplanned or emergency cesarean (3), stillbirth (second trimester to term) (2), prolonged labor with resultant obstetric injury (1), child with long-term disability (1)
Time elapsed since difficult birth event (mean)	0.5-16 years (6.2)

[a] $N = 7$.

[b] Inclusion criteria specified that participants have been in the United States for 5 years or less. All participants met inclusion criteria. However, several participants reported moving across the US-Mexico border several times, resulting in a cumulative time in the United States greater than 5 years.

Table 2. Summary of Themes With Exemplar Quotes From Participants.

Theme	Exemplar quotes
"Here it is different:" Invisible Burdens	In my town, my mom—when a baby is born—my grandma [a community *partera* (midwife)] takes good care of them, and she doesn't let them get up, and they bring food to the bed. They wash your hands with warm water. They change you, comb your hair, everything. But here, who is going to help me? Nobody but myself. (Diana)
	I was sad . . . there was nobody taking care of me. I had to cook and clean. Over there [in Mexico] my mother and my mother-in-law would take care of me, but here it is different. (Valentina)
	Everything is so different, and you come and you don't know anybody, and then you are "Oh my gosh, where am I at?!" . . . I felt like a stranger. (Ana)
"Maybe if you scream, they will come:" Unheard	"I had so much pain . . . I told my husband that I thought my daughter will die . . . My husband told me to scream, because maybe if you scream they will come." (Elena)
	In the hospital they don't do anything, but finally we went to the hospital, and they didn't do anything . . . they told me to go see my regular doctor. (Ana)
	Nobody asked me about it [perinatal loss]. When it happened—nobody . . . When I came to the clinic they thought I was still pregnant, and I said I lost my baby. So they said, "Oh, sorry. We didn't know." When they didn't know, I felt bad because this is the place that they were taking care of me. I feel the clinic should have had the record of what was happening . . . This is the place where I came so you could check my baby and listen to the heart. We are like living together at this point. (Sara)
"Someone was worried about me:" Attentive care	It is very special here because they give you a lot of attention. They take your blood pressure. They ask you how you are feeling, and they see you often. (Ana)
	The best thing is to talk to them [women] and hug them. I was in a lot of pain. I didn't have my mother here. It is nice when somebody comes and hugs you. I felt very grateful for the nurse who hugged me that day when everything happened. I felt like someone was worried about me . . . I think you feel well when someone is worried about you and they feel the pain that you are having. (Sara)
	I had a nurse for 12 hours that would come and make me comfortable. She would tell me, "Lay this way. Lay this other way." (Alma)

invisible burdens and feeling unheard contrasted with themes of attentive care described as "knowing someone worried about them."

Participants described accessing maternity care amid a backdrop of invisible burdens including social isolation. Social isolation is a common immigrant experience and has been reported

to be common for Mexican-born women residing in the United States (12,14,15). Consistent with other studies (9,11,15), participants described a lack of familiarity with systems and access to information due to limited support networks augmenting difficulties accessing care in their destination communities. Additional factors such as lack of insurance, language differences, and lack of education have been found to diminish Mexican-born women's sense of ownership, agency, and rights to the benefits of society (9,10). The common experience of unmet physical and relational needs leading to feelings of deepening isolation is consistent with previous research examining the health care experiences of Mexican-born women (9-12). Those women described how having needs unrecognized by providers yielded feelings of being invisible and unvalued (9,10,12).

Despite the difficulties and negative experiences, the participants noticed and valued attentive care, particularly against the backdrop of social isolation. Their characterization of attentive care as "someone being worried about me" has not previously been reported. If validated in future research, this finding could lead to greater understanding by health care providers of the affective salience of their communication with Mexican-born women and how to convey caring in health care encounters.

This study has several limitations. These data had been previously collected for a study to explore the relationship between life course trauma and perceived difficult birth. The mobile work patterns of the community of interest significantly limited enrollment and yielded a small sample size with a wide range in time elapsed from the birth to the time of interview. Despite this, participants vividly recalled their health care experiences during pregnancy and childbirth, yielding common themes. The interview transcripts were analyzed in their English translation version as the lack of Spanish-language fluency of the researcher prevented the use of the Spanish-language transcripts. While a certified, bilingual interpreter/translator was used during the interviews and to validate the English-language transcripts, it is possible that mistranslations occurred, impacting the data and subsequent analysis. Finally, women receiving concurrent mental health services were excluded and may have had different experiences of pregnancy care. Despite these limitations, this study adds new knowledge regarding maternity care experienced by this underserved population and provides novel insights to guide future research and practice.

In summary, Mexican-born women residing in the United States seeking maternity care may be carrying invisible burdens of profound social isolation with them into health care encounters. Disconnected care that leaves physical and relational needs unmet contributes to negative experiences. However, personalized and attentive care by the provider communicating attention and worry can affirm the inherent dignity of the pregnant person.

Authors' Note

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Declaration of Conflicting Interests

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ORCID iD

Linda Franck, RN, PhD, FAAN https://orcid.org/0000-0003-4291-9181

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Author Biographies

Lauren Trainor is a practicing nurse-midwife, currently in Lancaster, PA and previously affiliated with the University of California, San Francisco School of Nursing. Her research interests include physiologic birth, cultural birth practices, experiences of birth trauma, and equity in maternity care.

Ellen Frickberg-Middleton is a clinician and faculty researcher with emphasis on maternal physical/mental health, immigrant health/disparities and perinatal mood/anxiety disorders. She has had the privilege of working her entire career with the underserved communities of Califorina's Central Valley and holds a faculty position with University of California San Francisco, Fresno.

Monica McLemore is a tenured associate professor in the Family Health Care Nursing Department, at the University of California, San Francisco. she is an affiliated scientist with Advancing New Standards in Reproductive Health, and a member of the Bixby Center for Global Reproductive Health. Her program of research is grounded in reproductive justice, a lens she uses to understand reproductive health and rights for people with the capacity for pregnancy.

Linda Franck holds the Jack and Elaine Koehn Endowed Chair in Pediatric Nursing at the University of California, San Francisco, School of Nursing and co-directs the ACTIONS Fellowship program. She has extensive clinical, research and academic experience in maternal, newborn, child and adolescent health care, with an emphasis on patient, family and community partnership in healthcare delivery and research. In 2020, she was inducted into the Sigma Nursing Researcher Hall of Fame and named the UCSF School of Nursing Research Mentor of the Year.