



Focus Group Study on Minority Women's Access to Prenatal Health Care in the City of Manchester, New Hampshire

EXECUTIVE SUMMARY

The New Hampshire Minority Coalition conducted a focus group study on behalf of the Manchester Public Health Department and the Bureau of Maternal and Child Health to examine issues related to minority access to prenatal health care in Manchester.

The objectives of this study were:

1. To identify the barriers that minority women face in gaining access to prenatal care and in utilizing the existing prenatal care services of in Manchester.
2. To understand how cultural practices may affect access to care as well as prenatal behavior.
3. To understand how social, financial, and environmental conditions may impact the access and utilization of prenatal care services for minority women living in Manchester.
4. To recommend changes, suggested by the comments and explicit suggestions of focus group participants, to Manchester's health infrastructure in order to facilitate improved access to prenatal health care.

Latino, African, and African women aged 19 years and over and who had a baby within the past two years or who were currently pregnant were recruited to be participants for the study. Six focus groups (three Latinos, one African, and two African-American) were conducted in the period from May, 2002 to August, 2002. A total of thirty-nine (39) women including 20 Latinos, 9 African Americans, and 10 Africans participated in the focus groups.

Findings from the focus group study are organized into nine major themes:

- A. Qualities of good prenatal care
- B. Perception of clinic and hospital care
- C. Barriers to prenatal care
- D. Knowledge of healthy prenatal practice
- E. Cultural practices affecting prenatal care
- F. Perceptions of differential treatment when receiving care
- G. Different expectations between patient and provider in the delivery of care
- H. Social determinants of health
- I. Social support

Qualities of good prenatal care: The most important quality of prenatal care agreed by a majority of women in every focus group was good communication between patient and provider. Participants stressed the importance of:

- Being able to understand how their pregnancy was progressing,
- Knowing available options during pregnancy,
- Understanding safe practice during pregnancy,
- Being able to approach the provider to ask questions, and
- Having the doctor listen to their concerns.

Other qualities of good prenatal care mentioned by some participants were:

- Availability of staff people who could speak their language
- Prompt service with a minimal wait
- Transportation services to a doctor's appointment
- Privacy with no interruptions
- Prior experience of doctor having gone through a pregnancy
- Efficient and clean appearance of health care facility
- Respect from clinic and hospital doctors and staff.

Perception of clinic and hospital care: Although African and Latino participants were in general more positive than African American participants about the clinic and hospital care they received, most participants were satisfied with the level of care they received. The results of a post focus group survey showed that over 80% of participants felt their clinic service was either good or excellent and only about 5% felt their clinic service to have been poor or unacceptable. Participants had similar perceptions for hospital service. However, although most focus group participants were satisfied with the clinic and hospital care they received when pregnant, many participants voiced problems they encountered in the process of receiving care. Most of these problems are discussed in the section *A. Qualities of good prenatal care* and section *F. Perceptions of differential treatment when receiving care*. One of the reasons why the perception of care among the African and Latino participants and the African American participants may have been so different is because of the context in which their opinions were formed. Many of the Latino and African participants, being recent immigrants, described the health care service they received in Manchester as very positive relative to the service they received in their country of origin. A few African American women, however, described the service they received as inferior relative to non-minority women.

Barriers to prenatal care: Focus group participants identified a number of barriers that restricted their ability to receive prenatal care. These barriers included:

- Lack of insurance: One of the main reasons for not having medical insurance discussed by the participants was the lack of proper documentation for their citizenship status. Lack of knowledge on the Medicaid, public assistance and sliding-fee-scale programs was another reason mentioned by the participants.
- Language difficulties: Language barriers were a critical concern for many Latino participants when receiving care.

- Conflicts with work: Although participants largely understood the importance of prenatal care, the costs resulting from missing work in order to go to doctor's appointments, including lost income and the possibility of losing their jobs, were often considered to be too high to attend appointments.
- Inability to secure the provision of child care: The inability of participants to find child care for their children was noted as a reason why women could not attend doctor's appointments.
- Transportation difficulties: Difficulties securing transportation to appointments were stressed, primarily by Latino participants, as a factor restricting participants' ability to receive health care. Problems communicating with the taxi drivers and navigating Manchester's bus system were emphasized as factors contributing to participants' inability to attend doctor's appointments.

Knowledge of healthy prenatal practice: In general, focus group participants were knowledgeable about healthy prenatal practice. Participants knew that they should see a doctor during their first trimester, break bad habits (including smoking and drinking alcohol), and should engage in light-to-moderate exercise during pregnancy. Lack of knowledge was not a reason for some participants to not see a doctor during the first trimester. Lack of insurance was the main cause for delaying care.

Cultural practices affecting care: While most participants shared similar knowledge of healthy prenatal practice, many were influenced uniquely by cultural traditions. For example, although most women would agree that light-to-moderate exercise was recommended, many Latinos and African women believed that a woman should avoid exercise entirely including doing household chores such as sweeping, mopping, cleaning, and vacuuming. Also, many Latino and African women expressed the need to eat certain foods to produce more breast milk such as corn muffins, bread, oatmeal, crackers, hot porridge or cereal. In addition, many Latino and some African women believed that women should keep themselves covered during pregnancy and after delivery in order to avoid sickness which they could pass on to their babies. A number of African participants mentioned that it is a custom to bathe babies immediately after birth to avoid the development of eczema and dandruff. Some of these women claimed that their babies contracted eczema and dandruff as a result of following the doctor's instructions to not bathe their babies right away. Finally, several African women mentioned that they normally do not like to announce to the public that they are pregnant, whereas in the U.S., it is generally accepted to do so.

Perceptions of differential treatment when receiving care: A number of women in the focus groups felt that they received differential treatment as a result of their:

- Language: Raised only among Latino participants, a few women felt that they were treated differently by doctors and medical staff because they did not speak English.
- Insurance status: While differences of opinion existed regarding the causal factors leading to differential treatment, a number of participants felt as though they

received inferior treatment when receiving medical care because they did not have insurance or because they had Medicaid.

- **Race:** Although sensed by some Latino and African women, differential treatment resulting from racial discrimination was emphasized to a great extent by a few African American participants. African American participants discussed instances where they were felt a lack of respect by doctors as a result of their race.

Different expectations between a patient and a provider in the delivery of care: In some cases, what participants perceived as differential treatment was likely a result of the difference in expectations between patients and providers. An example of this possible misperception of differential treatment is the case of a participant who expected to be seen by the order of her arrival in the emergency room instead of the order of urgency. When she had to wait for her son to be treated for an ear infection (while other patients who arrived after them were treated first), she felt as though she was a victim of discrimination. Another participant expected the doctor to be able to treat her after office hours for a breast infection and also questioned the way the doctor dismissed her pain and told her that she either had to wait until the office reopens or go to an emergency room to treat her pain. In these cases, the patients felt their treatment to be discriminatory while the treatment they received was likely in line with common medical practice, of which they were unfamiliar.

Social determinants of health: Many women raised various concerns about the environment (housing quality, neighborhood safety, lack of transportation) in which they were pregnant or raised their children. Other participants voiced concerns about their ability to make ends meet in light of the financial burden of pregnancy and child rearing. Concerns about the social conditions surrounding their pregnancy including participants' unfamiliarity with a new culture, language difficulties, child care problems, and the problem of their children being labeled as "bad" kids by teachers, school administrators, and other parents were also expressed by focus group participants.

Social support: A major theme that emerged from the focus group study was the desire for women to receive more social support during and after their pregnancies. Women expressed the need to:

- Have someone to mentor them through their pregnancy.
- Have someone who can verify if something they experienced is normal.
- Have someone to help with household chores and to care for their baby.
- Have someone to interpret for them.
- Have a support group to discuss pregnancy and parenting issues.
- Have a single parent support group.
- Have someone to advise them about financial issues.

Latino participants were generally more aware than the African and African American participants about the community social support programs available for pregnant women. Community services used by Latino participants were programs provided through the Women Infant and Children's program, Healthy Families (a program of the New Hampshire

Minority Coalition), the Latin American Center, and Child and Family Services. African participants used Head Start and NH Healthy Kids while African American participants only used the state's assistance program for child care.

Submitted by

Phuong T. Hoang
Principal Investigator of the Focus Group Study and
Director of Monitoring & Evaluation
New Hampshire Minority Health Coalition (NHMHC)

Andrew Ryan
Research Analyst
NHMHC

Libing Shi
Statistician & SAS Database Programmer
NHMHC

Sponsored by the Bureau of Maternal & Child Health of the Department of Health and Human Services (NHDHHS) and the City of Manchester Department of Health

Recommendations for Action

Improve patients' understanding of health care system:

To help patients understand common practices within the U.S. health care system (particularly those who are new to the U.S. culture) and to reduce misunderstanding between a provider and a patient, we recommend that health care facilities do the following:

- Further patient education on the typical emergency room procedure in order to explain common practice and protocol in the emergency room.
- Help women to understand how their pregnancy will be different in the United States and to plan how accordingly.
- Prenatal patients should be warned that on some occasions, the labor may not go as smoothly as expected. As such, they should be advised to discuss with their prenatal care doctor early about how they want their pain and labor to be handled. Prenatal care doctors may want to encourage women to think of a birth plan which outlines the woman's wishes of how she wants her pain and labor to be managed when she is in the labor and delivery room. By discussing the birth plan early on in the pregnancy, the woman will not only be more in control of her prenatal and labor care but she will be given more opportunity to ask any questions that she may not understand about her pregnancy, labor, and delivery.
- These issues could be discussed in an introductory session about the medical system, for all new patients, outlining the basics of care, answering questions patients may have about receiving care, and addressing health care topics that are commonly misunderstood by patients.

Facilitate access to care

To improve access to care and the relationship with the patient, below are some extra steps suggested by our cultural competency trainer that the clinic can provide to minority patients:

- Have the person scheduling appointments ask the patient about their timeframe needs for appointments. Make appointments for times that work for the patient.
- Have the person scheduling appointments ask the patient about logistics for transportation. Help the client figure out how they will arrive back at the next appointment. (Providers should know that transportation is a huge barrier for patients, due to income and language factors.) Set appointments for times that work given the transportation logistics of the patient.
- Have support staff call patients to remind them of appointments a day or so prior to appointment. Ask in this conversation or voice message if they need any help with transportation (support staff could possibly arrange for taxi pick up if the patient asks for this assistance and acknowledges their personal financial responsibility for the taxi).
- Refer pregnant women and children to NH Healthy Kids (income-based NH program for insuring children), WIC, Healthy Families, and other care programs.

- Make application forms available and enlist bilingual support staff to help women fill out the forms.
- Work with the employers of minorities and immigrants to encourage these employers to offer health friendly policies, including time-off to attend doctor's appointments, to their employees. In the long-run, the increased productivity from healthy workers is likely to increase the efficiency of their work force.
 - Work with insurance companies to provide transportation vouchers for patients who are not able to attend doctor's appointments due to transportation barriers. Educate insurance companies on the benefits of transportation vouchers relative to the cost of expensive emergency care visits. Also, educate patients about the availability of transportation reimbursement through Medicaid.
 - Educate minority women about the Medicaid program and its requirements. A number of focus group participants qualified for Medicaid but did not understand how to apply for Medicaid insurance.
 - Educate women about discount programs that are offered by health care centers and clinics.

Expand hospital and clinic prenatal service

- By popular demand, hospitals should consider having Lamaze classes available in Spanish, African dialects and languages, as well as in other popular foreign languages including Bosnian to meet the changing needs of the Manchester diverse population base. These classes should be run by members who are from the target minority communities who can share their knowledge of their own culture to tailor the classes to the needs of participants.
- Prenatal care providers who normally do not schedule the first office visit with a new patient until 12 weeks into term should consider scheduling the initial visit earlier, especially for high-risk patients including minorities and patients with a history of pregnancy-related problems. During this initial period, the doctors could spend time discussing issues related to prenatal care, birth plan, and answer any questions that the patient may have. This time can also be used to familiarize pregnant women with the existing social services that are available in the community. This extra service will be particularly helpful for first-time mothers, young mothers, and minority women with language difficulty who need further attention and mentoring about their pregnancy.

Build social support

To respond to a number of concerns that minority women had with their environmental conditions, we suggest that health care facilities and other community organizations help to create social support networks to:

- Disseminate information about interventions such as the Fair Housing Project (part of New Hampshire Legal Assistance) which could help renters address poor housing conditions.

- Spread information about organizations like the Manchester Housing Authority which help to improve access to home ownership for low income families. Have pamphlets readily available in multiple languages so that information could be transferred to minorities easily.
- Establish localized interventions such as neighborhood crime watch groups to improve the safety of residents' neighborhoods.
- Identify channels through which complaints related to racial or other forms of discrimination could be addressed.

Health infrastructure

The following organizations could improve minority access to optimal prenatal care:

- WIC: Should consider providing ethnic foods that are nutritious and culturally appropriate to the minority women and children they serve.
- Manchester Transit Authority should:
 - Extend fare discounts to Medicaid recipients
 - Conduct an outreach campaign aimed at increasing minority ridership. The campaign should involve the inclusion of foreign language bus service in places easily accessible to minority communities

Enhance providers' relationships with patients

To increase provider's awareness and sensitivity to the issue of differential treatment that can be experienced by a patient from a different culture or race, our cultural competency trainer suggests the following practices which providers should consider in order to increase patients' receptiveness to care and long-term positive outcomes:

- Show respect for the patient.
- Ask questions, seek information.
- Listen carefully to the concerns of the patient (ask her why she is concerned, take the concern seriously, listen to why, do not merely dismiss fears.)
- Use a trained medical interpreter if communication is difficult due to language.
- Help a patient feel their accent and culture are something you appreciate as important parts of their person.
- Demonstrate understanding of how tough learning new systems in a new culture and a new language can be. Small comments build trust.
- Do not assume the health system is free of racial bias.
- Do not be too quick to pass judgment on your patients. As individuals are socialized differently, the inferences drawn in the context of their own culture may be used and applied in the context of the patients' culture, causing a prejudgement of the patient's beliefs, values and interpretations of health.
- Respond out loud to the concerns of the patient.
- Explain why service is being denied or a referral is being made. Providers should be aware that patients will draw their own conclusions if a satisfactory explanation is not provided.

Increase institutional awareness about race and racism

To increase long-term positive cross-cultural interactions between students/parents and school employees, below is list of recommendations suggested by our cultural competency trainer:

- Cultural competency trainers should conduct some basic race and class literacy workshops for school staff, to look significantly at how race and class stereotypes function and how to not perpetuate them.
- Cultural competency trainers should conduct awareness and skills workshops for working with parents with low English proficiency.
- Cultural competency trainers should conduct workshops on general cultural knowledge, to increase the cultural literacy of educators, support staff, administrators, school board members and students. Specific cultural topics such as parenting norms, communication patterns, adolescent behaviors, expectations of teachers, schools, and students by culture could be covered in these workshops.

I. Problem Statement

Access to prenatal health care is a major issue facing modern public health. Prenatal care received in the first trimester of pregnancy has been demonstrated to significantly improve health outcomes for both the mother and child. Early prenatal care has been shown to decrease rates of infant mortality and rates of babies born with low birth weights as well as improving other health outcomes for children (CDC, MMWR, December 23, 1994/43(50); 939-942.) However, despite an overall increase in the rate at which early prenatal is received in the general population, disparities still remain in the rates at which minority and non-minority women receive early prenatal care (National Vital Statistics Report, 1999). Confronting the disparities in early access to prenatal care is both a challenge to public health, as well as a priority, as demonstrated by its inclusion as a health priority in the Healthy People 2010 Objective initiative.

In an effort to address the issue of disparities in prenatal health care, the NHMHC, on behalf of Manchester Public Health, conducted a series of focus groups in an attempt to better understand why minority women are not receiving early prenatal care at rates similar to those of non-minority women. This issue is particularly relevant to Manchester in the face of Manchester's demographic, socioeconomic, and cultural transformation. Over the last decade, Manchester has seen dramatic changes in the composition of its populace. From 1990 to 2000, the total White population decreased by 3.4% (from 96,550 to 93,388) while the total Black population in Manchester increased by 149% (from 968 to 2,410). Over the same period, Manchester's total Hispanic population increased by 121% (from 2,121 to 4,679) (Census 1990 and 2000). According to Census Bureau, these trends are likely to continue. Census projections show New Hampshire's Black population increasing by 56% up to 14,000 by 2025 and New Hampshire's Latino population increasing 100% to 34,000 by 2025 (Census Population Projections.) The vast majority of these increases are likely to occur in Nashua and Manchester due to these cities' proximity to Massachusetts as well as their current minority presence. These projected minority population increases are fuelled partly by the differential birth rate between racial and ethnic groups (Whites (12.2), African Americans/Blacks (18.1), and Latinos (25.1))¹ (National Vital Statistics Report, Feb. 2002). These high minority birth rates not only indicate that more minorities will end up living in Manchester, but also that prenatal care and access to prenatal care will be particularly important among minorities who are having more children.

Reflecting Manchester's demographic development are changes in the level of English proficiency reported by Manchester residents. According to the Census Bureau, the number of Manchester residents over the age of 17 who reported being able to speak English "not well" or "not at all" increased by 63% (from 1,421 to 2,322) from 1990 to 2000.

Also accompanying, and likely resulting from, the demographic and linguistic changes in Manchester are marked changes in socioeconomic status of Manchester residents. Contrary to the national decline in poverty status, Manchester has seen an increase in

¹ Birth rates are nationally calculated live births per 1,000 people in the specified group

poverty among Whites (8.2% to 8.7%), Blacks (25.5% to 29.3%), and Latinos (19.1% to 30.6%). Rates of insurance coverage have been falling along with this decline in socioeconomic status for both minorities and non-minorities. Nationally, the rate of uninsured persons rose among White Non-Hispanics (9.6% to 10%), African American/Black (18.8% to 19.0%), and Latino (32.9% to 33.2%) racial and ethnic groups (National Vital Statistics Report, Feb. 2002). In New Hampshire, the rate of those who are uninsured rose from 8.7% in 1999-2000 to 8.9% in 2000-2001 (National Vital Statistics Report, Feb. 2002). New Hampshire minorities' significant decline in socioeconomic status and insurance coverage further jeopardize minority access to prenatal health care. In short, the importance of addressing the issue of prenatal health care access is undeniable in light of Manchester's demographic, socioeconomic and linguistic changes.

The data reported above (which are also included in Appendix A) suggest that a plan of action is necessary to respond to the prenatal health needs of an increasingly diverse Manchester population. An initial step in this plan of action, a detailed enquiry into the barriers that minority women may face in receiving prenatal health care as well as the cultural and linguistic forces which affect the utilization and quality of care that minority women receive, has been fulfilled by the focus group study conducted by the NHMHC on behalf of Manchester Public Health (MPH) and the Bureau of Maternal and Child Health (BMCH) of the Department of Health and Human Services (DHHS). Hopefully, this study will mark the beginning of a citywide initiative to expand minority access to prenatal care and to improve the pregnancy-related health outcomes for minority women and children in Manchester.

II. Goals and Objectives

The purpose of our focus group study is fourfold:

1. To identify the barriers that minority women face in gaining access to prenatal care and in utilizing the existing prenatal care services of in Manchester.
2. To understand how cultural practices may affect access to care as well as prenatal behavior.
3. To understand how social dynamics, financial conditions, and the physical environment confronted by pregnant minority women may impact their prenatal behavior as well as their access to and utilization of prenatal care services.
4. To recommend changes, suggested by the comments and explicit suggestions of focus group participants, to Manchester's health infrastructure in order to facilitate improved access to prenatal care.

A similar study conducted in Nashua will help to create a more complete assessment of minority access to prenatal care in southern New Hampshire. Hopefully, the focus group studies in Manchester and Nashua will not only provide a clearer picture of minority access to prenatal care and allow comparison between two very similar cities in southern New Hampshire for city and state officials, but will fuel collaboration between the cities to jointly combat the threat to public health posed by disparities in the access to prenatal care.

III. Methodology

The MPH Department hired Ms. Phuong T. Hoang, who has more than 12 years of quantitative and qualitative research experience, to act as the principal investigator for the study. Ms. Hoang is currently the Director of the Monitoring and Evaluation for the New Hampshire Minority Health Coalition (NHMHC). Ms. Hoang's responsibilities were to train moderators and observers how to conduct the focus groups, to oversee the focus group activities including recruiting participants, reimbursing the participants, and transcribing tapes. Data coding and analysis were conducted by Ms. Hoang and Mr. Andrew Ryan, a Research Analyst of the NHMHC. Ms. Libing Shi, a Statistician for the NHMHC, also assisted with the data analysis.

The study design and selection criteria for participants for the focus groups were pre-specified by the MPH Department in conjunction with the BMCH of the DHHS. The guidelines included five criteria:

1. Six focus groups must be conducted with approximately 10 to 12 women per group.
2. Focus groups should be divided according to the race and ethnicity of the participants.
3. Focus group participants must be over the age of 19.
4. Foreign born and U.S. born women should be equally represented in the focus groups.
5. Focus group participants must be either currently pregnant or have had a child born in Manchester within the last two years.
6. Focus group participants must either be Black/African American or Latino.

Focus group participants were recruited by flyers and word of mouth. Flyers were distributed in Spanish and English at places including WIC (Women Infants and Children's Program), the Human Resources Office at DHHS, Manchester Community Health Center, the Elliot Hospital's maternity ward, the Caribbean Spice restaurant, Fuel Assistance, and cultural advisors of the NHMHC. Flyers for recruiting participants in Spanish and English are included in Appendix B.

A total of 39 female participants (20 Latinos, 10 Africans, and 9 African Americans) were recruited for the six focus groups - three Latino, one African, and two African/African American). We chose to include African participants along with African American participants because of the relatively large number of Africans in the Manchester area as well as due to the idea that these Africans face many of the same barriers to health care as both African Americans and Latinos. Also, because of the limited number of African American participants signing up for the focus groups, African American participants were included in the same group as African participants. Thus, there was no single group of African Americans. However, the interaction between African American women and African women in the focus groups yielded interesting results, particularly on the issue of perception of differential treatment.

In each focus group, there was a moderator as well as an observer. The role of the moderator was to facilitate the focus groups by asking a set of questions suggested by a focus group consultant for the BMCH and revised by Ms. Hoang (the revised focus group questions can be found in Appendix C). The role of the observer was to take notes and to ensure that the tape recorder was operating properly. All three Latino focus groups were facilitated in Spanish and observed by Ms. Sonia Para and Ms. Saby Briones. Ms. Wanda Diaz also acted as an observer for one Latino focus group. The one African and two African/African-American focus groups were facilitated in English by Ms. Hoang with Ms. Samba Halkose and Ms. Glinda Allen acting as observers in the African and African/African-American focus groups, respectively. All the focus group moderators and observers are employees of the NHMHC.

In preparation for data analysis, Ms. Hoang also trained Ms. Elizabeth Pena and Ms. Glinda Allen (who are native speakers in Spanish and English, respectively) to transcribe the tapes of the focus groups. The transcribed data were then coded by Ms. Hoang and Mr. Ryan by key points which were then grouped into major themes. To protect the participant's confidentiality, each participant was assigned a number which was then used instead of the participant's name in tape transcriptions and data analysis. All names were also removed from the participant's quotes to protect the confidentiality of individuals and health care settings.

Nine major themes or patterns emerged from the data of the six focus groups. They are:

- A. Qualities of good prenatal care
- B. Perception of clinic and hospital care
- C. Barriers to prenatal care
- D. Knowledge of healthy prenatal practice
- E. Cultural practices affecting prenatal care
- F. Perceptions of differential treatment when receiving care
- G. Different expectations between patient and provider in the delivery of care
- H. Social determinants of health
- I. Social support

IV. Data Collection

In addition to the focus group itself, a short, written survey was distributed to the focus group participants after the completion of focus group. The survey contained questions about participants' socioeconomic attributes and insurance status. This section contains the results from this survey. A copy of this survey is included in Appendix D and the complete data collected from this survey is included in Appendix E.

Table 1 below describes the country of birth of the participants. The African focus group consisted of women from Congo, Democratic Republic of Congo (formerly Zaire), Ghana, Jamaica, and Sudan. The two African and African-American focus groups contained

women from United States, Haiti, and Nigeria. The three Latino focus groups included women who were born in Mexico, Puerto Rico, and the United States.

Table 1: Focus Group Participants and Country of Origin

Group (No. of Group)	Frequency	Percentage (%)	Country of Birth	
			Country	No.
African (1)	10	25.64	Congo	1
			Ghana	1
			Jamaica	1
			DR of Congo	3
			Sudan	4
African-American & African (2)	9	23.08	USA	6
			Haiti	2
			Nigeria	1
Latino (3)	20	51.28	Mexico	16
			Puerto Rico	2
			USA	1
			Missing	1

Table 2 below outlines the dates of the six focus groups, the number of participants in each group, the participant's age range and the length of time that the participants lived in Manchester.

Table 2: Manchester Prenatal Focus Groups and Participants

Date	Ethnic Identity of Participants	Number of Female Participants	Age Range of Participants	Range of Time Lived in Manchester
5/13/02	Latino	7	18-34	9 Months - 5 years
5/31/02	Latino	8	16-35	1 - 9 years
6/10/02	Latino	5	21-27	2 months - 2 years
6/15/02	African	7	24-44	2 - 9 years
6/22/02	African/ African-American	7	21-40	1.5 - 9 years
8/10/02	African/ African-American	5	24-37	1- 8 years

The six focus groups were held between May and August of 2002. The size of the focus groups ranged from 5 participants to 8 participants. The age of the participants ranged from

16 years old to 44 years old, and the length of time that the participants lived in Manchester varied from 2 months to 9 years.

Table 3 below illustrates the distribution of the participants by age group.

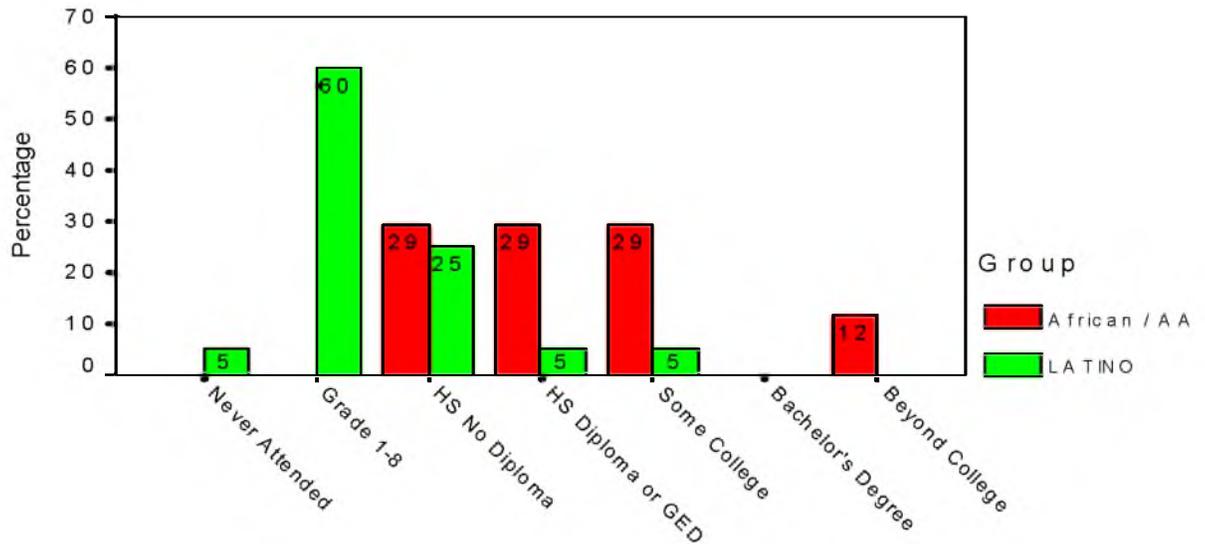
Table 3: Age Distribution of Participants

Age Group	Frequency	Percentage (%)
16-18	2	5.13
19-24	12	30.77
25-34	18	46.15
35-44	7	17.95

The minimum age requirement for the participants was 19 years old. All but two of the participants were 19 years old and over. Exemptions were made for the two participants who were under 19 years old because they showed up on the day of the focus group and they were interested in participating in the discussion.

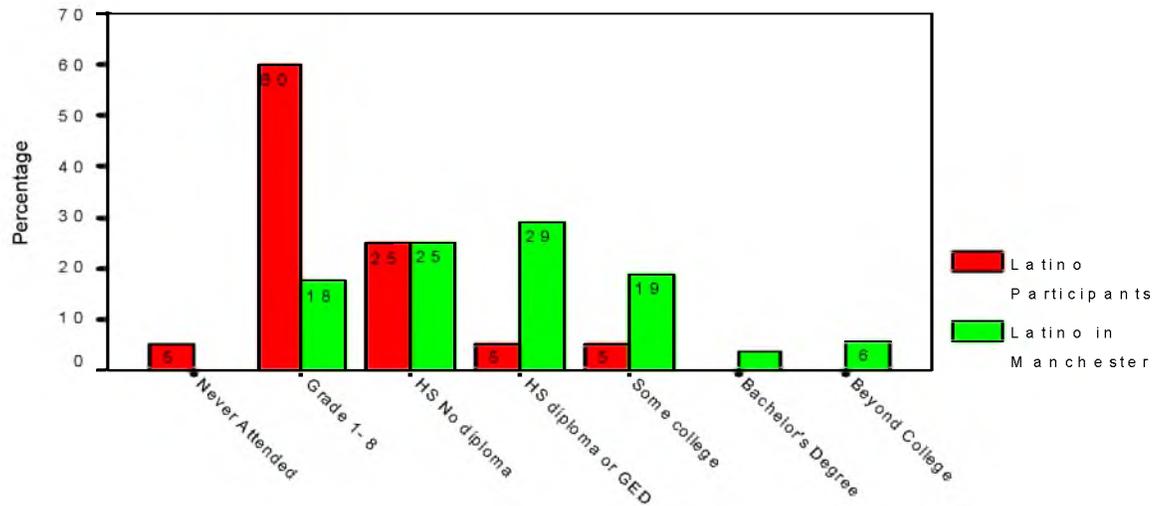
Graph 1 below illustrates the highest educational attainment of the focus group participants. About 65% of the Latino participants had an education level of less than a 9th grade, whereas 70% of the African and African American participants had at least a High School diploma.

Graph 1: Highest Educational Attainment of Participants

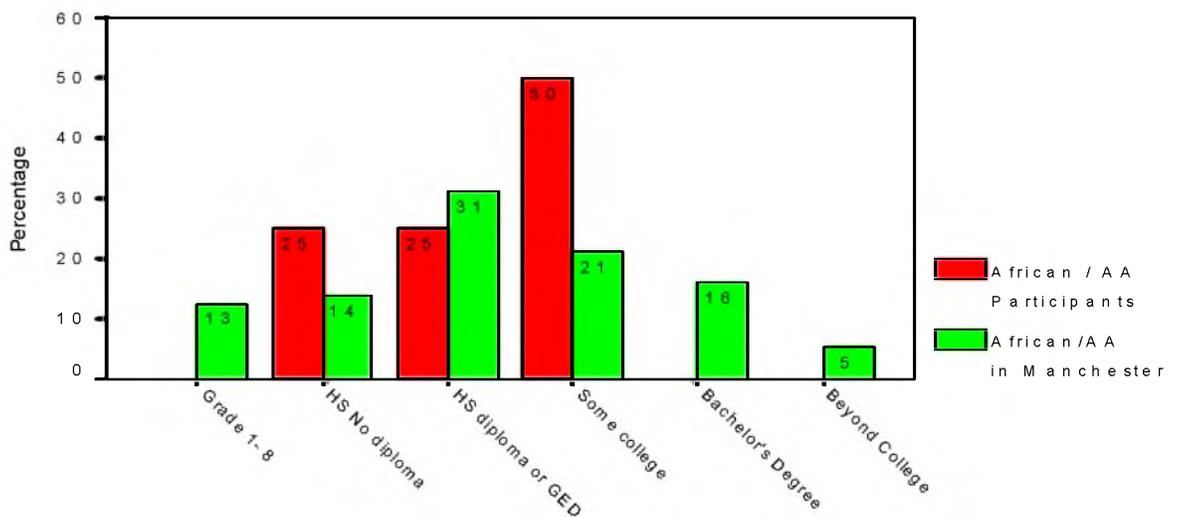


The distribution of the Latino participants' educational attainment was not representative of that of the Latino population living in Manchester. According to the Census 2000, only 18 percent of the Manchester Latino population reported having less than a 9th grade education compared to the 65% of Latino focus group participants in this category (Graph 2). Similarly, the educational distribution of the African-American and African participants was also not representative of that of the counterparts living in Manchester (Graph 3). There were no African American and African representatives with a college degree in the focus groups, whereas about 20 percent of the Manchester counterparts had at least a college degree (Census, 2000)

Graph 2: Distribution of Highest Educational Attainment of Latino Participants vs. that of Manchester Latino Population

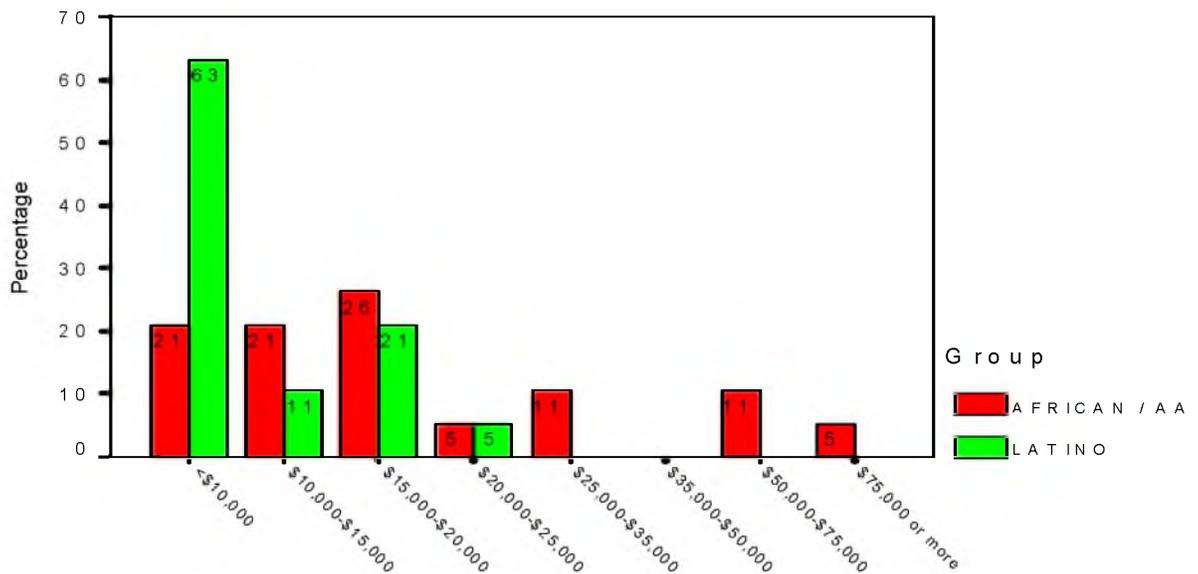


Graph 3: Distribution of Highest Educational Attainment of African & AA Participants vs. that of the Manchester Population



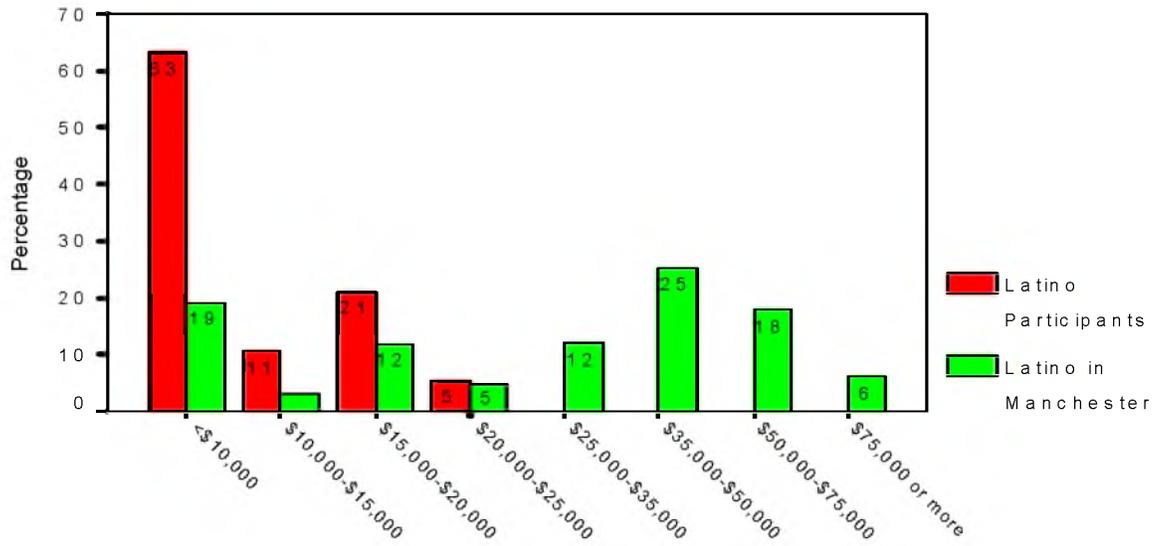
In general, the Latino women participants were less affluent than the African and African American participants. Graph 4 below shows that 74% of Latino participants reported having incomes less than \$15,000, whereas only 42% of the African and African-American participants reported that they were in this range. Also, all of the Latino participants reported having a household income of less than \$25,000. Almost 84% of African and African American participants reported having an income of less than \$35,000 while a small percentage (16%) reported that they had an income of greater than \$50,000.

Graph 4: Household Income Distribution of Participants



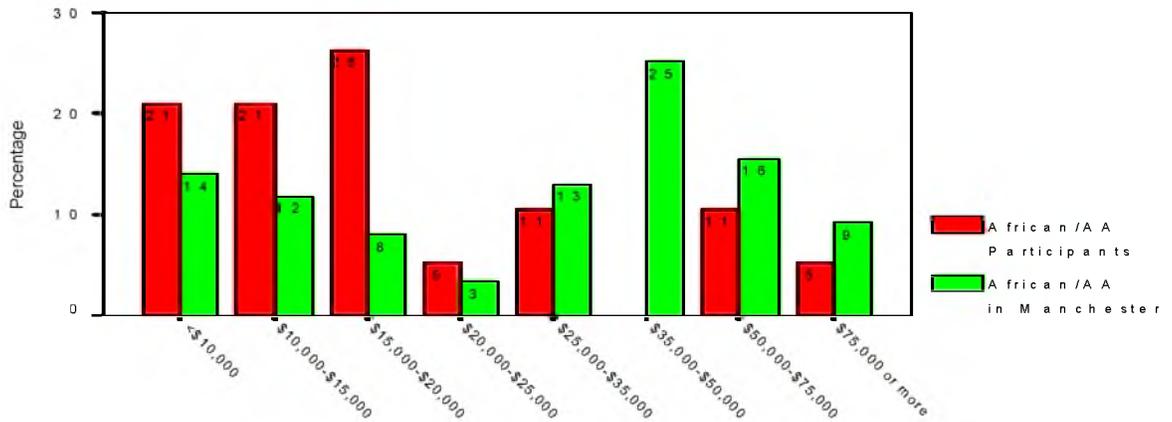
Graph 5 below compares the household income distribution Latino participants to that of the Latinos living in Manchester. The comparison suggests that a much greater percentage of the Latino participants fell in the income range of less than \$15,000 than that of the Manchester Latino population (74% vs. 22.2%). Thus, the income distribution of Latino participants in the focus group is skewed towards the lower end of the Latino income distribution in Manchester. In general, according to the Census data, Latino residents living in Manchester were less affluent than their White counterparts. The median income for the Manchester Latino households was \$34,511 in comparison to the higher median income of the Manchester White households of \$41,403 (Census 2000)

Graph 5: Household Income Distribution of Latino Participants vs. that of Latino Population in Manchester



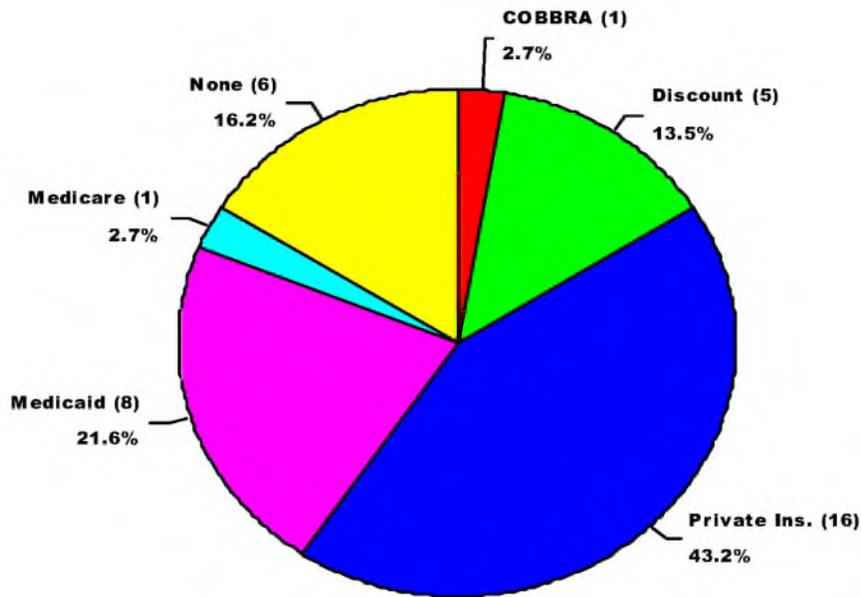
Similarly, the household income distribution of the African and African American participants is skewed to the lower end of the income distribution of African and African-Americans living in Manchester. Graph 6 below shows that 84 percent of the African and African American participants had an income range of \$35,000 and below, whereas only 50% of Manchester’s Africans and African Americans lived within this income range. Comparing the median household income of African/African American residents of Manchester (\$34,919) with White residents of Manchester (\$41,403) shows a substantial difference between the two groups.

Graph 6: Household Income Distribution of African & African-American Participants vs. that of Manchester Population Counterparts



The pie graph below (Graph 7) depicts the insurance status of the focus group participants. Over 43% (16/39) participants reported having private insurance, 24.3% (9/39) of the participants claimed that they had either Medicaid or Medicare insurance, 13.5% percent (5/39) of the participants have used discount method of payment, one participant (2.7%) reported having insurance through COBBRA, and 16.2% (6/39) participants did not have any medical insurance. In short, more than half of the participants in the focus group used either public insurance, discount, or had no insurance.

Graph 7: Insurance Status of Participants



N=39; Missing=2

It is widely understood that people in lower socioeconomic strata are faced with greater barriers to health care. The fact that these groups were well represented by focus group participants ensures that the voices of those most affected by barriers to health care were heard in our focus group study.

V. Findings and Interpretation

In the course of carrying out the focus group study, a wide range of similarities and dissimilarities emerged among and within the African, African American, and Latino focus group participants. Overall, the participating groups expressed many of the same concerns, problems, and perceptions regarding access to prenatal care. However, the groups differed in the extent to which these concerns, problems, and perceptions were emphasized. This section is an attempt to synthesize the data collected from the six focus groups into a number of themes that highlight the most important issues raised by focus group participants when discussing access to prenatal health care.

The findings of the six focus groups will be grouped into nine major themes:

- A. Qualities of good prenatal care
- B. Perception of clinic and hospital care
- C. Barriers to prenatal care
- D. Knowledge of healthy prenatal practice
- E. Cultural practices affecting prenatal care
- F. Perceptions of differential treatment when receiving care
- G. Different expectations between patient and provider in the delivery of care
- H. Social determinants of health
- I. Social support

These themes will facilitate the analysis of the wide range of issues raised by focus group participants.

A. Qualities of good prenatal care

Findings

To have women identify the qualities of best prenatal care, we asked the following question:

What would you like to see in the best prenatal care service?

In answering this question, participants reflected upon their prenatal care experiences and expressed what they liked and disliked about the prenatal care service they received. A dominant concern raised by the majority of women in every focus group was the need for better communication to exist between patient and provider. Women stressed the importance of:

- **Being able to understand how their pregnancy was progressing**

¹ "One of the things that was very useful to me was to have someone to talk to and ask very basic questions. In my case, it was the first child. I had so many questions in terms of how I was feeling; how I should go about

things; how I should deal with sickness and feeling uncomfortable and things like that and have someone to call to ask very simple basic questions and have understanding." (African)

² "...Back when I had him, I was pretty young you know, just 18. I was pregnant with him and you know from the time like, I learned a lot from then but as particularly younger woman having babies, I felt that they could have been more, more you know, just explained more about what was happening to your body or just being really supportive to, if a problem arises, explain it thoroughly, explain better about the changes that are going on..." (African American)

³ "Like, I had a c-section, I would like more information and I'm scared of having another child, I could die. I don't know what is going happen to me." (Latino)

⁴ "...When I had this pregnancy, I went to ____; they said I was going to have the baby that night. I suffered a lot trying to have it normal and then after they said I was going to have it by c-section. They never told me that was going to happen. I always asked them and the doctor always said that I was going to be fine; that I had enough space to deliver; but when I got there they did the c-section. They never told me this could have happened, and the doctors at the ____ told me they should have warned me about it..." (Latino)

- **Knowing available options during pregnancy**

⁵ "He (the doctor) gave me options to choose...they gave me people to call, specific to specific needs." (African)

⁶ "...Lucky for me my experiences weren't so bad. I don't know, like giving us all the options, putting it out there. (We're not aware of the) things that are out there. The options that we have..." (Haitian)

- **Understanding safe practice during pregnancy**

⁷ "Yeah...the doctor say you have another somebody inside you and it's normal. Because when I have a headache, I suppose to take Tylenol, but I scared you know that something will happen to me." (African)

- **Being able to approach the provider to ask questions**

⁸ "The best prenatal is like you know is when you get good service...Somebody's always there to attend to you and talk to you if you're not aware of certain things..." (Jamaican)

⁹ "Basically, I would say good prenatal care, basically being there as well you know, as far as office hours go, after office hours for problem. Definitely making sure you get in touch with your doctor. Answer questions when you need them." (African American)

- **Having the doctor listen to concerns**

¹⁰ "It's my first time having a baby here so I mean the doctor that I had he was very nice; you know because he always wanted to know if I had any problems, never afraid to say to him anything happen, just call him. The experience I had was great... What I'm saying is that he was always there for me and that the part when he said if I have any problem (to call him). I feel he was interested in my pregnancy and all of that. Anytime, any problem, even right now I still call him up and say whatever. It's just good, it's my first time having a baby here." (Jamaican)

¹¹ "Just basically like some doctors to basically listen to you. A lot of the times, doctors think they know everything possible, like if you ask them, some doctors are more likely to give an ultrasound; others like if you have concerns, to listen more; if you request an ultrasound or concern or if you request certain tests or things like that, for them to be more aware. Take it into consideration." (African American)

An African American woman described a situation where she wanted her doctor to excuse her from work due to her sickness during pregnancy. The woman did not need the doctor's validation for missing work for any reason other than to make her feel justified in missing work. She described this circumstance saying:

¹² "I needed for him to say "I understand where you're coming from, you're very sick."

Other qualities of good prenatal care mentioned by a few of the women in the focus groups were:

- **Availability of staff people who could speak their language**

¹³ "... We need always an interpreter. We speak Spanish and you understand us, but they don't. They (should) always have an interpreter to follow you around."

¹⁴ "We don't understand what they are saying."

¹⁵ "You wait too long and without an interpreter."

- **Prompt service with a minimal wait**

¹⁶ "I asked the doctor one question--if my baby was big? And he said that I should know, and they have you waiting a for a long time." (Latino)

¹⁷ "Great service, good attention. It's just that we have to wait too long with the gown." (Latino)

¹⁸ "I got there at 11:00 AM from work and they told me they couldn't see me right away (and) that I have to go back home and come back at 1:00 PM and they have me waiting for two hours." (Latino)

- **Transportation services to doctor's appointment**

¹⁹ "Transportation and somebody that speaks our language." (Latino)

²⁰ "I say the same, transportation." (Latino)

²¹ "More convenient transportation." (Latino)

- **Privacy with no interruptions other than the doctor**

²² "Mine would be my privacy... Like um when you go to the doctor and um you (are) in the room, exam room with the doctor, you'd like to not be (interrupted) by nobody, no mess. (Haitian)

- **Prior experience of doctor having gone through a pregnancy**

²³ "Ah mine (ideal care) would be (to be treated by) someone who's been pregnant. I find that two of my doctors you know are men and they've never been pregnant and so there was a lot of things that I went through that I felt like how can you possibly understand this? I mean even as a thirty year old woman you know it's hard for me to say you don't know but it was hard for me to believe that he, that these doctors could know how I feel physically or any other way so I think just somebody who knows what it's like to be pregnant and to have a difficult pregnancy...." (African American)

- **Efficient and clean appearance.**

²⁴ "... When I go to a doctor, I like to see basically a nice clean place, which this center was. This clinic was basically clean. It looked like the doctors and the nurses practice good precautions as far as washing hands and you know, the bathrooms were clean and everything looked pretty clean and up to par..." (African American)

- **Respect**

²⁵ "Mine would be to be a respected patient. Basically to be a respected patient and have the doctors listen to my concerns about my pregnancy instead of just brushing me aside." (African American)

²⁶ "I would eliminate everything (about prenatal care). I was treated like absolute dirt and I can say growing up in New Hampshire ... that I don't remember being treated that bad. I've been treated bad. I found that it's not just the OB doctors that do this. It's a lot of the doctors out there, not all the doctors, but a lot of the doctors and a lot of the nurses are confused. And I would change everything. And I would be treated like a person... I don't really care for a male doctor what so ever. I think they're chauvinistic pigs. That's my opinion, they're chauvinistic pigs, never been pregnant and they never will and they'll never understand, and they lack emotion." (African American)

Interpretation

The fact that women in every focus group stressed that communication with their provider is an ultimate quality in prenatal care suggests that women yearn for more information regarding their pregnancy. By not obtaining the adequate information during pregnancy, women are at a greater risk of having unhealthy pregnancy. Without an adequate base of knowledge, women do not know where to begin asking questions and are therefore put them at a disadvantage of achieving healthy pregnancy and having a successful birth.

B. Perception of clinic and hospital care

Findings

The perception of the quality of care pregnant women received in the clinic setting and the hospital setting varied widely among the African, African American, and Latino groups. In general, participants were positive about the quality of care they received in both settings. Over 80% of participants felt that their prenatal clinic service was excellent or good while only about 5% felt their clinic service to have been poor or unacceptable (as determined by the post focus group survey). Perceptions of quality of service in the hospital setting, as documented in the survey, were similar to perceptions of clinical care. However, there was a contrast among Africans, African Americans, and Latinos in their perception of care as well as the extent to which the survey results represent the comments made in the focus groups. Certain participants described their hospital and or clinic service as good/excellent in the survey while expressing substantial discontent with their service in the focus group. Possible reasons why survey results did not always reflect focus group comments will be discussed in section F. *Perception of differential treatment when receiving care.*

Clinic Care

Although not represented in the survey results, clinic service was perceived by both the Latino and African American groups (but not the African group) as far less positive than hospital care. Both the Latino and African American groups had a series of issues and complaints with how they were treated in their clinic service. As discussed in Section A, a number of focus group participants felt as though they did not receive enough information about their pregnancy, had to wait too long, and were not treated with the respect they felt they deserved. In addition, many women from both groups objected to the quality of care in the clinics. A Latino woman spoke about her dissatisfaction with clinical care saying:

²⁷ "They (the clinic) said they were going to give me some help, but I never saw again the lady I talked to ____, who is in charge of that and she said she was going to have an answer for me, they told me I had to pay but we couldn't we make too little and we didn't have the possibility to pay.... They never told me that (charity care exists), the lady that works there she's always mad because she has a lot of people to attend."

Another Latino woman said:

²⁸ "To me they did the PAP, and she was rude, she put inside me her fingers very hard, I thought she was going to provoke me an abortion, when you are pregnant they should be gentle with you, I don't know what was wrong with her."

A number of Latino women had complaints about a particular provider (the same one in each quote) saying:

²⁹ "I don't like ____. I like the ____, I like their service... I go to the ____ because someone told me they give good services, and you could get a discount, I never knew about doctors, I was very healthy. When I used to go to ____, he would only open my legs, and my cousin 15 days before she was due he broke her amniotic sac and he force the birth of the baby, because he decided it was time."

³⁰ "____ checks too much, more than normal, I've heard that he inserts his hand too much."

³¹ "____ never gives you the results, we never know how we're doing, if we have an infection or not."

These comments must be qualified in that they refer to a specific provider and are therefore unrepresentative of the health care provider community as a whole.

The African American focus group participants had a number of poignant stories related to the poor quality of care that they felt they received from the clinic setting. One African

American woman described the difficulties she experienced when trying to schedule prenatal visit earlier than 12 weeks into her pregnancy. Typically, OB-GYN doctors schedule the initial prenatal visit when a pregnant woman is about 12 weeks into term. However, because this woman had a previous history of miscarriages, she wanted to see her OB-GYN doctor on a date earlier than this. The woman described making several attempts to push up the date of her initial visit date but was unable to convince the clinical staff of the need to do so. Her mother, who is a nurse, had to call on her daughter's behalf and demand that her daughter be able to see a doctor sooner than the date scheduled. Only after her mother's persuasion was the woman able to change her initial visit to a time earlier than her previously scheduled appointment. Her description of these events is depicted below:

³² “...My mother had to call. My mother is a very pushy woman. I had called a couple of times. I couldn't take it anymore, cause I was scared from the beginning. I had my twins; my twins were 3 and a half and 4 pounds. They had...ultra uterine growth retardation. One with a clef butt. Numerous, numerous problems and I was very concerned that my pregnancy just didn't feel right and I had had a miscarriage. It felt like my last miscarriage from the beginning...I guess their theory is, well there's nothing we can do anyway, if you're gonna miscarry, you're gonna miscarry. There is something you can do. You can find out what is going on before that point so I'm not walking around feeling miserable, when you can make things a lot easier by doing a DNC (an abortion) and it's done...”

When asked by the moderator if she had tried to make an appointment as soon as she found out she was pregnant, the woman answered:

³³ “Immediately. (But) they won't see you until like...12 weeks along...My mother said (who is a nurse) that this is ridiculous. You know you have a history of spontaneous abortion...And my husband was born with mild spinal bifida. You can't tell, but all of his siblings were the genes and so we were concerned with that also....If I had seen the doctor, they could have tracked my HCG levels from the beginning.”

Another African American woman, suffering from a breast infection, felt as though her problem was not taken seriously which resulted in her condition deteriorating before she was cared for. She describes how she was uncomfortable calling her doctor to ask for help saying:

³⁴ “I was trying to just let it ride and think that it was going to get better, not only that, I know I was uncomfortable, I was very uncomfortable calling my doctors office after hours, calling them when they had just seen me. They didn't make me feel like, just call, you might need to. I was uncomfortable to call. I didn't want to call. I wanted to just take their word for it, that the medication was gonna knock the pain out.”

The stories of this woman and the previous woman quoted will be discussed in more depth in sections F. *Perceptions of Differential Care when Receiving Care* and G. *Different Expectations between Patient and Provider in the Delivery of Care*.

Another problem raised by the African American and African groups is that many women object to being treated by different doctors every time they receive care. Responding to a question about how she feels about being treated by multiple doctors an African American woman said:

³⁵ “I don’t like it. I do not like it. I think in particular, people who are at high risk. However, they don’t seem to take high risk very seriously. I don’t like it at all!”

A Haitian woman had mixed feelings regarding this issue saying:

³⁶ “I don’t like either, but sometimes you can make your own choice because that’s when I (used) to go to ____ and they have several doctors there. They not all the same... So when you call or whatever they give you, an appointment and depend on the nurse or who the person who give, who schedule the appointment for you, sometime they do ask you, who do you want to see? And they find out about your preference, cause that was my case... But the one that I like to see the best, that’s the one who had my baby. Eight month and a half, I couldn’t take it anymore and he was the only one see that. So by your preference and you get to see the doctor that you like the most. Sometimes it works like that because they not all different, really sometimes you get to the doctor and either you call, you want to see a doctor you feel bad or something they just concerned about seeing you and it’s fine... And they look at you, they didn’t do anything. So after you left, you ask, why did I go because they didn’t do anything? They didn’t even touch you, they didn’t pay any attention, but when you choose your own preference and you see that one, he takes care of you, believe me... I didn’t choose specifically, but they saw my preference because they ask me at the time they schedule my, who do you want to see and I always say the same one.”

This is not to say that all the focus group participants had negative impressions of clinical care. African women felt that their clinical care was in general very good. An African woman described a positive experience with clinic care saying:

³⁷ “She tries tell everything to me to understand because she know I don’t speak right English but she try to explain everything how to understand and how to accept what’s she’s talking and what’s going on.”

A number of Latino women were also quite positive about their clinical prenatal care. Some quotes from the Latino group include:

³⁸ “I like the way they treated me, fast and they told me that everything was just fine, they check me.”

³⁹ “(I went to ___ clinic) because I didn’t have health insurance and they charge you less like 75% less. At ___ they leave us waiting too long, at ___ they do a great check up.”

⁴⁰ “A lady invited me to go with her and then we made an appointment with the secretary and the doctor saw me. I thought I was pregnant, so I went there and they did the test, I made an appointment and the doctor saw me, it was good.”

⁴¹ “Yes, now is better... ___ has more services and better even though when I go I have to use signing to talk to the provider, they gave me transportation to all my appointments. I wouldn’t go back to ___.”

One Latino woman even sympathized with the plight of her clinic saying:

⁴² “Before, there is a very nice lady there she used to hug me a lot. We understand them too, we know is very difficult for them with so many people.”

Hospital Care

Although participants were in general more positive about the quality of the hospital care they last received, variations in the perceived quality of care, similar to those seen among groups in their perceptions of clinic care, were still present.

Latino women tended to express very positive opinions about the care they received at the hospital. In the post-focus group survey, 80% of Latino participants felt that their current or last prenatal care service was good or excellent while none said that it was poor or unacceptable. Many thought that providers were attentive and treated them with respect. Some representative comments from this group include:

⁴³ “Services are okay...it was good that in my delivery the nurse speak Spanish.”

⁴⁴ “My daughter had a kidney infection and they treated her very well, they’re calling to monitor her.”

One Latino woman commented on the evolution of care that she had witnessed while living in the area saying:

⁴⁵ “It was good, because now, they take care of you better even at the emergency room they’re treating us better. When I went to ____, my

pregnancy had beginning of spontaneous abortion, after a couple of weeks I received a letter not from the ____ but some other place asking me, how were the services, they give you more attention now, the emergency room is faster not like before. If Americans would walk in, they would treat them first, now is different.”

When asked how they would describe the service they received at the hospital, Latino responded by saying that service at the hospital is:

⁴⁶ “Excellent, we feel important.”

⁴⁷ “Excellent, they treat you very well.”

⁴⁸ “(The facilities are) very clean.”

⁴⁹ “I would say it was good, they even gave me a bath on the tub.”

Of course, these positive opinions of hospital care were not unanimous. A number of Latino women complained about the medical procedures conducted while the women were in labor. Some comments related to this issue were:

⁵⁰ “When I went to the hospital I was in pain... and they send me back to the house because my water wouldn’t broke. I waited almost all day and my birth was dry so they gave me medication and they broke my water, and gave me medication again, then the anesthesiologist was scared because I was very sick and he pinch me again. After all I waited they did a c-section.”

⁵¹ “(I would like) good attention, because the doctor that treat me pulled me on the delivery, because she wouldn’t let me pushed.”

African focus group participants, similar to their assessment of the quality of clinic care, generally expressed their hospital care as superlative. In the survey, all the African participants rated their current or most recently received hospital care as excellent or good (mostly excellent). The following quotes represent this perception:

⁵² “With my experience (hospital care), I would say it was excellent... The pamphlets I received, they responded to me promptly when I called, even if I had to leave a message. I almost always had someone to speak to and also they gave me a lot of options, they did not push things on me, they gave me options, they explained to me what my options were, what I could decline in case of the test and things like that. I had the freedom to say I will not do this or do that. They gave me all these options.

⁵³ “Everything was fine, I didn’t have any problems. The nurses were nice. I just didn’t like people barging into your room at night trying to take

vital signs, they have to do their job, and nothing I can do about it, that's the only thing I don't like."

A Jamaican woman described her experience with hospital care saying:

⁵⁴ "It was okay, it was good because each time the nurse always asking me; _____ are you okay? Do you want me to take the baby or whatever? It was okay."

However, not all of the African participants described their hospital experiences as positive. A number of African and African American women took issue with how they were told to nurse their babies in the hospital. This topic will be dealt with in section E. *Cultural Differences Affecting Care*.

African American women were not nearly as positive as the African and Latino groups about their experience with their current or most recent hospital service. About half felt that their service was good (none said that it was excellent) and about a third felt that their experience was average or unacceptable. However, apart from problems they had with nursing, African American women did not describe what was negative about their hospital experiences in focus group. In the following quote, an African American woman describes her hospital experience saying:

⁵⁵ "My hospital stay was pretty good... (however) they didn't have a lactation consultant on staff, so when I was trying to nurse him, my nurses were very impatient. They were very impatient with me; they seem like I should naturally already know how to do it. It was a challenge in the beginning and they would like basically seem hurried to show me ok you do it like this and you put it in his mouth and da da da, yeah exactly, and it was like they didn't slow down your speed and take more time to show me you know it was very discouraging because you know, it was just, I was expected to already know how to do this.

One of the reasons why the perception of care between groups of African and Latino women and African women may have been so different is because of the expectations placed on care. Many of the immigrant women described the health care service they received in Manchester as relative to the service they received in their country of origin. Some quotes representing this contextualizing of service are:

⁵⁶ "In our country they take 3 or 4 women in one room." (Latino)

⁵⁷ "The rooms here are more private and prettier, better services of care." (Latino)

⁵⁸ "In Mexico you're seeing how women suffer while their delivering and we feel afraid." (Latino)

- ⁵⁹ “Here they don’t take the baby away from you.” (Latino)
- ⁶⁰ “In Mexico they take them (the baby) and sometimes they bring you the wrong baby, they change them, but they also put a bracelet on them.” (Latino)
- ⁶¹ “No, I think it (care) is good, it’s better because you know, there in my country is good but some people don’t have a lot of doctors, maybe some ladies in the village and the area far away maybe where the doctor maybe some where north or a midwife and some of the people can be pregnant for a whole 9 months with no seeing doctor to and you can still can have...the way they do their culture with no doctor and even you can have a healthy baby to but in t he culture, t hey know how to do it where they live...” (African)
- ⁶² “(In comparison to Sudan) here it's a good thing...I think of all those years you been alone with nobody and it making you feel tired and thinking that to your man here along with you together; but I think the care right here is a good one. If you pregnant you don't worry you know; if you get sick today you can call 911 to pick you up and the doctor is right next door. Back there (in Sudan) we was suffering a lot and you know...The only part of it, you don't live in a (farm) and some don't have friends close to you and things like that.” (Sudan)

Interpretation

For many Latino and African women, the quality of care in the United States is much better than the care they received in their own countries. As a result, the focus group participants are relatively content with their care despite the language and other barriers they experienced. On the other hand, the opinion of African American women has not been formed by this context. They have been integrated United States culture and expect great health care service. Their understanding of the quality of health care service in the United States allows them to critique the shortcomings of their care more accurately than Africans and Latinos who may lack this understanding.

One potential reason for the contrast between the survey answers and the focus group responses was the way the survey question was asked “How would you rate your current or last prenatal care service that you had in Manchester?” This question does not account for previous experiences that could have been negative. However, the focus group did not limit discussion to current or most recent prenatal care as asked in the survey; therefore, opinions regarding previous experiences could have been expressed in the focus group.

C. Barriers to prenatal care

Findings

One of the main objectives of the focus groups analysis was to identify the primary and secondary barriers to prenatal care experienced by minority women living in Manchester. In this analysis, a barrier to care is defined as something that hinders or restricts the process of receiving of care *or* something that hinders or restricts the process of receiving optimal care. As a result, a barrier to prenatal care can be something that prevents a woman from getting to a health care facility to receive care as well as something that restricts her ability to receive adequate care at a health care facility.

Latino, African, and African American women shared a number of similar barriers to prenatal care. However, the Latino and African groups in particular expressed highly analogous thoughts regarding the factors that hindered or restricted their access to care. These related barriers to care are likely a result of similar difficulties experienced as foreign people who do not know how to navigate the health care system and have difficulty communicating within this system. Due to the similarities among the Latino and African groups in accessing care, these groups will be categorized together for much of the analysis in this section.

Overall, there were two main barriers that affected the African American, African, and Latino groups were. These were:

1) Lack of insurance/Medicaid

The inability to receive care due to lack of insurance and Medicaid was either a current obstacle or a lingering fear for the vast majority of focus group participants. Many of the women participating in the focus groups did not have private insurance. As a result, their reliance on Medicaid to afford service was significant (see Graph 7). However, because many Latinos do not have proper documentation of their citizenship status, they are unable to receive Medicaid. One Latino woman commented on the situation saying:

⁶³ “My application was denied because my husband couldn’t verify the income information, he’s illegal, I’m the only one working and they need it a letter from his insurance, we never receive it.”

Another Latino woman said:

⁶⁴ “(We are unable to get Medicaid) because of work, we don’t have any papers we’re illegal aliens, we don’t have a social security number to be able to work.” (Two other Latino women in the focus group agreed with this.)

Another Latino woman agreed that lack of legal documentation was the main reason why Latino women did not receive health care saying:

⁶⁵ “We don’t have health insurance and no social security number.”

An African woman commented on a similar situation within the African community in which families are denied Medicaid once they no longer meet income requirements saying:

⁶⁶ “When the husband get the job they cut out the medical... like welfare (or Medicaid) and if the husband don’t have insurance right away maybe it can be holding her from going to the doctor...”

A Latino woman had a very similar comment:

⁶⁷ “I was denied (Medicaid) because I live with my mother, and they said that she makes too much.”

This particular woman did not know that she could apply for Medicaid under her own name considering that she was 18 years old. The moderator of the focus group helped the woman apply for Medicaid for which she was subsequently qualified.

The situation resulting from minority women not being able to receive Medicaid is one where many women are effectively unable to have medical insurance and are consequently forced to delay or dismiss care altogether, pay the full cost of care out of pocket, or use discount/charity care. Unfortunately, a large proportion of people who are eligible to receive discount/charity care do not know of its existence. According to a survey administered to REACH (an intervention funded by the CDC with a target population who share the same race/ethnicity and a very similar socioeconomic profile to focus group participants) participants which asked, among other things, if participants were aware of discount care provided at hospitals and clinics, 33 out of the 93 Latino participants (35%) and 28 out of 60 African/African American participants (47%) were not aware of discount services available at hospitals and clinics.

Knowledge of discount services was largely uncorrelated with income, indicating that a similar proportion of low income and high income participants did not know about discount care services. Even with an inability to obtain insurance and lack of knowledge as to where to receive discount/charity care, focus group participants, knowing that prenatal care is essential, often receive care without paying proper attention to the financial consequences of receiving care and simply hope to somehow avoid paying. A number of women in this predicament told stories of racking up incredible hospital bills. One Latino woman described this plight saying:

⁶⁸ “I have a bill of \$19,000 from Elliot for my daughter, because my Medicaid was discontinued, when she was born she had to stay at the hospital for a week.”

An African woman had a similar limited knowledge of the financial reality of her situation, as demonstrated in the following dialogue:

⁶⁹ (African 1): "You had to pay right?"

⁷⁰ (African 2): "I don't know. I didn't pay anything. I would just go to the doctor."

⁷¹ (African 3): "You didn't pay?"

⁷² (African 2): " I never pay, I tell the truth."

⁷³ (African 1): "No Medicaid."

⁷⁴ (African 2): "No I didn't have Medicaid but I have insurance from my ...because I was like unemployment but I had insurance but then I come here I was going to _____, they told me they don't take that (insurance), but they don't take that insurance but I would just go to the doctor, I would see two doctors, sometime I can find another one..."

Moderator: So you didn't have insurance for three of your kids and you felt that you were treated differently?

⁷⁵ (African 2): "No, I never say different, the first one I did the same thing, they give me, there is some I'm gonna pay, but then ask me for 5,000.00 and I say where I'm gonna find 5,000.00 to pay you."

All insurance is not created equal

Focus group participants who were able to receive insurance and Medicaid had widely divergent opinions as to how complete their insurance actually was. Some women felt that their private insurance allowed them excellent care while others complained about the limitations of their private insurance. Some women felt that Medicaid was great while others felt that they received inferior care using public assistance. These divergent opinions of insurance and Medicaid were not closely related to women's race and ethnicity.

Representing a positive perception of Medicaid was an African American woman saying:

⁷⁶ "I really liked it like with the Medicaid, it's accepted everywhere. I originally had Medicaid and that was working fine with me."

Another African American woman described her experience receiving health care with Medicaid relative to receiving health care without it saying:

⁷⁷ “Like now I don’t have it (Medicaid) again. I have to go back to the crappy doctors that I use to see before. So it was nice while it lasted, needless to say.”

A Latino woman described her positive experience with Medicaid with the following quote:

⁷⁸ “I have Medicaid and they treat me very well. It’s very beneficial.”

Other women, however, felt that the service they received with Medicaid was inferior to the service they received with private insurance. A Latino woman represented this viewpoint saying:

⁷⁹ “I had private insurance to cover my child, but now I don’t have it (and have Medicaid) and you see the difference in services provided to you.”

Also, a number of African American women described receiving substandard treatment and “labeled” because they used Medicaid. This issue will be dealt with at length in section F.

Perception of Differential Treatment

Still, other women described the pitfalls with private insurance. An African American woman said:

⁸⁰ “Then some people do have insurance, like I know with myself, I do have insurance, but it is the worst insurance you can have. I pay so much out of my pay check for a crappy insurance, the co-pay is twenty dollars, co-pays for medicines is twenty dollars and you know once you get to the end, it gets expensive. So not just not having insurance but not a good quality insurance.”

2) Language Barriers

After insurance, language difficulties were the most significant barriers to care among focus group participants. According to participants, the restricted ability for patients to communicate with their doctors severely decreased the quality of care they received. Participants described how language barriers affected each stage of receiving care, from making an appointment, to communicating with the doctor, to deciding among payment options. As a result, women with language barriers are at a great disadvantage when attempting to receive prenatal care. At the time when the focus groups were conducted, African participants had been living in the United States on average of four years while Latino participants had been living in the United States for close to five years, on average. One would expect significant language difficulties to occur in populations with this limited exposure to the English language. While certain African participants spoke English as their native language, problems communicating with providers were still reported among these participants resulting from their African accents. Latino women, however, almost

universally commented on the difficulties they experienced in receiving care resulting from language barriers. Some remarks from Latino women were:

⁸¹ “I tremble of fear when I have to talk to somebody. My communication is not excellent.”

⁸² “The communication is poor and you feel sad.”

⁸³ “You feel alone at the hospital because you don’t speak English, there’s nobody to help you.”

⁸⁴ “The communication is very poor. When you talk to the hospital we can’t say anything.”

⁸⁵ “I felt frustrated, I felt bad.”

⁸⁶ “I feel bad because when they answered the phone they answer in English.”

⁸⁷ “The communication is very difficult.”

Even when interpreters are present to facilitate communication, the quality of communication, according to both Latino and African women, can suffer. A Latino woman represented this viewpoint saying:

⁸⁸ “When I need an interpreter I get nervous.”

A Latino man, quoted as part of a REACH focus group on access to health care, described the issue of confidentiality as a concern when using interpreters in a health care setting. After hearing information regarding patients’ sensitive medical problems spread around the Latino community by interpreters, the man now does not trust interpreters to keep the information about his medical problems private. He described this problem saying:

⁸⁹ “Well, if the doctor speaks Spanish or is by himself I will tell him what I feel from head to toe. If there is an interpreter I only tell him what I feel from the waist up.”

An African woman commented on the difficulties encountered with interpreters saying:

⁹⁰ “Maybe the fear of not being able to express themselves, maybe the language barriers (are a factor in not receiving health care)... It doesn’t happen for me, but for a lady, I know her, she stay like three months or four months and she didn’t get her Medicaid cause you know... she knows Arabic but you know they bring for her somebody from Iraq. You know Iraq is different from country to country and the guy is speaking Arabic but she didn’t get anything and they give her like a lot

of papers, she can't even speak English, how she gonna fill the papers and after this, they send her. She stayed in the hospital for three hours; nobody came and talk to her until everybody is not there. She finds it difficult."

Another issue raised in focus groups was that patients may not be able to understand the meaning of the interpreters' words when translated into the patients' native language. A Latino woman describes this sentiment saying:

⁹¹ "I went to the clinic and they make you wait too long and they check us faster like in five minutes you are out, they only tell you: "You have a vaginal discharge" and that's it and she said it in Spanish she said "flujo" but I didn't understand her. What is flujo?"

Finally, even when English is spoken by patients, it may not be done so in a way that is familiar to doctors or other medical staff. This may result in similar frustrations experienced by women who do not speak any English. A Nigerian woman, whose native language is English but speaks with a heavy accent, commented on her experience trying to communicate with her doctor saying:

⁹² "Maybe sometimes they (patients) are trying to talk to them (doctors), they (doctors) will tell you, I can't hear you, even if they hear. I can't hear... Sometimes they hear. Even if I cannot speak American... I know I speak English. They should understand if they want to understand. Sometimes they will (say) I can't hear you please." (Nigerian)

3) Conflict with Work

Another barrier to care experienced by the Latino, African American, and African groups was the inability to attend doctor appointments because of the necessity of working. A Latino woman expressed this idea saying:

⁹³ "You have to work and you missed appointments, it's better to go to work so you don't miss money."

Another Latino woman echoed this notion with the comment:

⁹⁴ "When you're working they don't let you go to your appointments."

An African American woman remarked:

⁹⁵ "One of the things that can prevent you from doing what you should be doing might be job related or depends on where you are. You may not have your way, you're afraid to lose your job. You need the money so you have to be there.... For me, the job that I did in the beginning was

too labor intensive so I stopped and changed my job. Just changed it to the way I felt and what I could handle."

4) Child Care

Other health care barriers were mentioned in focus group discussions that did not pertain to all the participating groups. In the African American and African groups, the issue of childcare was a barrier to care. An African woman commented on this situation saying:

⁹⁶ "Yeah, you know that's because of the kid when you pregnant and you have children with you, it's really hard if you don't have babysitter, the kid don't have childcare and you have an appointment like 8 in the morning, you looking for somebody to take care of the kid and everybody have thing to do, so it's really hard... That time I went with them to my appointment, it was really, really no good."

5) Transportation Barriers

In the Latino group, transportation barriers were expressed to be significant factors in reducing a woman's ability to receive prenatal care. Although the issue came up in the African American and African focus groups, the problem was emphasized to a much greater extent in the Latino group. This trend mirrors our findings in the REACH survey where 19 out of 93 Latino participants (20%) reported there being a time in the last 12 months when they wanted to see a doctor but could not because of a lack of transportation compared to only 3 out of 60 African and African American participants (5%).

A large proportion of Latino women participating in the focus groups commented on their inability to find adequate transportation to health care facilities. Some comments representing this circumstance were:

⁹⁷ "(I cannot keep my appointments) because my taxi doesn't show up."

⁹⁸ "Transportation is a problem, when we call a taxi they're always late and you miss the appointment or they won't take you."

⁹⁹ "The taxi is late; if I'm late for the appointment they won't check me."

¹⁰⁰ "The taxi takes too long."

¹⁰¹ "I'm afraid the taxi driver might not understand me and take me to the wrong place."

An African American woman also commented on her transportation difficulties saying:

¹⁰² "The only reason that I can personally think it would be difficult (to receive prenatal care) is basically if you have; if you are pregnant here

and you know basically if you're not driving in that aspect having to find someone to take you to your appointments, transportation basically and then you know finding a way to get there... (I used) the bus sometimes. He was born in July so it was like June was very hot and pregnant and trying to catch a bus and trying to work the bus schedules out and trying not to miss the bus and things like that and certain places the buses go and certain places they don't run and if they do, you have quite a ways to walk. So trying to get appointments in that time frame of when the buses are running (was difficult)."

Interpretation

Focus group participants' experience with Medicaid, especially relative to private insurance was truly a mixed bag. However, the concerns participants had about inferior care as a result of their Medicaid status is validated in a study by Krieger *et al* which contends that Medicaid enrollees in managed care health plans showed poorer use of prenatal care and exhibited poorer birth outcomes compared with non-Medicaid enrollees of the same plans (Krieger, 1992). However, in more recent work, Dobie *et al* suggests that although Medicaid-insured women averaged 6% less visits than privately insured women, Medicaid status had no meaningful association with prenatal, intrapartum, or overall resource use among low-risk women (Dobie, 1998). Dobie concludes that there were no significant differences in birth weight or gestational age for Medicaid-insured women and privately-insured women. As among focus group participants, the opinion of the quality of Medicaid care and its impact on health outcomes is similarly divided among health care researchers.

Language barriers and their effect on care were much more widely reported in the Latino group than the African group (and of the African American group). In addition, the focus groups in which Africans participated were conducted in English. Consequently, those attending were more likely to have a solid understanding of the English language and therefore, less likely to have experienced barriers resulting from difficulties speaking English. However, we expect that, in the general population, African immigrants will share similar concerns regarding language as many of the Latino women quoted in this section.

A more extensive analysis of the transportation problems faced by women seeking prenatal care will be discussed in Appendix F. However, as a point of interest, many focus group participants complained about problems that occurred when trying to take taxis to access healthcare, but bus service was never mentioned as a means of transportation.

D. Knowledge of healthy prenatal practice

Findings

The knowledge of healthy prenatal practice as well as the approach that pregnant women take towards caring for themselves and their unborn child have an obvious impact on birth outcomes. In the focus groups conducted, a series of questions were asked of participants about how women cared for themselves after they found out that they were pregnant. In an

attempt to gauge the knowledge that participants had of healthy prenatal practice, we asked the following question:

In general, what are the things a woman should do if she thinks that she's pregnant?

In general, Latino, African American, and African women all agreed that a woman should see her doctor right away when she finds out that she is pregnant. Most women agreed that one should eat a well balanced meal, drink a lot of fluids, have plenty of rest, get moderate exercise, and not lift heavy things. Some quotes from the focus group participants were:

¹⁰³ "See a doctor"

¹⁰⁴ "Get plenty of sleep, eat a lot of fruits and vegetables, and just try to be as healthy as you can be."

¹⁰⁵ "Do not lift heavy things"

¹⁰⁶ "to have a good pregnancy, don't do anything risky"

¹⁰⁷ "Sleep a lot."

¹⁰⁸ "Walk, take prenatal vitamins, be at home..."

¹⁰⁹ "Exercise, and walk"

¹¹⁰ "Take it easy. To have a good pregnancy (that is) normal, don't do anything risky; eat well and do a lot of exercise."

The need to break bad habits was also emphasized by all of the participating groups. A Haitian woman described her need to quit smoking when she was pregnant saying:

¹¹¹ "...I smoked for nineteen years, but each time I find out that I was pregnant, and I stopped. I never smoke with my baby... now I don't smoke anymore, I quit. I quit two years ago."

A Latino woman said:

¹¹² "If you drink, stop drinking. If you smoke, stop smoking. If you don't sleep enough, start sleeping."

An African American woman commented:

¹¹³ "Like if you're smoking, stop smoking. I had to stop. I stopped way before I found out I was pregnant."

However, another African American woman described the difficulty she has faced in breaking these bad habits saying:

¹¹⁴ “Certainly, most pregnant know that they are not suppose to smoke, not a good idea to be smoking and when you give someone that piece of information, you have to understand that it’s information that they already know. It’s my body, it’s a baby in there that I’m creating, but it’s my option to smoke. It was very hard for me to quit smoking and I continue to smoke. People look at you crazy, especially the white people.”

When asked how the women learned about what to do when they are pregnant, most said that they learned from experience of having had a previous child, through friends and family members, or through their health care providers. A few commented that they learned about the need to take folic acid from the pamphlets they received at the hospital and clinic at the time of their prenatal appointments.

In short, women in the focus groups generally feel comfortable in describing what a woman needs to do to take care of herself when she is pregnant. All felt that bad habits should be dropped during pregnancy. Most women understand that light-to-moderate exercise is recommended for a normal healthy pregnancy while a few of the Latino and African women believe that exercise should not be practiced during pregnancy.

Despite the fact that all conveyed a knowledge that a woman should see a doctor right away, four out of thirty nine women interviewed wrote in a separate written survey that they did not begin their prenatal care during their first trimester. Three of the four women were Latinos and one African American. Only the African American woman had insurance (Medicaid) while the other three Latino women did not have insurance. When asked why the African American woman did not begin her prenatal care in her first trimester, she responded that she did not know that she was pregnant until her third trimester.

As for the other three Latino women, the greatest barrier in accessing care during their first trimester was the lack of health care coverage. One Latino woman did not begin her prenatal care until her second trimester. Her reason for delaying care was the need to wait to enroll in insurance through her place of employment.

The third Latino woman explained that when she had her first baby at the age of eighteen, her Medicaid insurance privilege was taken away because her mother's income was over the qualifying limit. She ended up with an outstanding hospital bill of \$19,500 from her first child. As a result of the large bill and lack of insurance, she was afraid to go the doctor. A Latino focus group moderator (who works for the New Hampshire Minority Health Coalition) later went with her to the Medicaid office and helped her apply for Medicaid insurance under her own name instead of her mother's. Through this process, the participant was helped to get Medicaid insurance. Also, through the participation of the focus group, this participant learned about the Healthy Families program that the New Hampshire Minority Health Coalition is administering and subsequently enrolled in the

program. The goal of the Healthy Families program is to work with underserved and at-risk women to help them to have healthy pregnancies and successful births. After enrolling in Medicaid, this Latino mother went with the moderator of the focus group to her first prenatal care visit. During this first visit, she learned that her cervix was dilated to 6 cm, putting her at risk of delivering her second child early. The doctor immediately instructed her to go to the hospital where she needed to stay for 3 more days at bed rest before it was safe for her to deliver the baby. Had it not been for the moderator's intervention, she would have not gotten the proper care that she needed for her and her baby.

Interpretation

Lack of knowledge about the importance of starting their prenatal care early was not a reason why participants did not receive prenatal care. Instead, other barriers to care, documented in section C, especially lack of insurance, were the primary reasons why most women did not receive early prenatal care.

E. Cultural practices affecting prenatal care

Findings

In addition to asking how woman behaved once they knew they were pregnant, we also tried to understand how cultural beliefs may have impacted pregnant women's behavior. Participants in most of the focus groups indicated that many of the decisions they made with regard to their pregnancy and prenatal care were driven by their culture. Even when not explicitly asked, many of the focus group participants discussed how their cultural beliefs influenced their actions and how many of these beliefs contrasted with advice given by providers. However, we also sought information regarding the link between culture and prenatal behavior by asking the following questions:

Are there any ideas or views about pregnancy and what to do that are unique to being Mexican, Puerto Rican, African, or African-American?

Can you tell us a story about a specific action that you might take during your pregnancy that you learned from your relatives or other Mexican, Puerto-Rican or African American/African women in your house or community?

Unlike the knowledge of healthy prenatal practice, in which the African American, African, and Latino groups had very similar ideas, the influence of culture uniquely affected prenatal behavior in the different groups. Although culture tended to affect each of the participating groups differently, certain cultural practices were held in common among the participating groups. For instance, the Latino and African groups shared an emphasis on inactivity and relaxation, as well as avoiding stressful situations during pregnancy. Even though a number of the participants reported getting regular exercise during their pregnancy, many of the participants in these groups stressed the importance of remaining inactive. Some quotes from the Latino group representing this perspective were:

¹¹⁵ “Do not lift anything heavy or use stairs”

¹¹⁶ “Be at home”

¹¹⁷ “Don’t get upset”

¹¹⁸ “Take it easy”

¹¹⁹ “Don’t do anything for 40 days after giving birth”

An African woman represented this viewpoint in the following manner:

¹²⁰ “When you are pregnant, everybody want to take a lot of care for you like when you have a little kid maybe you have your grandma or you ma, they have to take that kid away from you for a while and then you can rest because when you pregnant and you have kid around you, you get mad. Because in my country they say that when you pregnant you don’t want to be (angry) a lot or fighting. Even with your husband you don’t have to be fighting with him when you pregnant because (it will) affect the baby to. When you have a baby, you have a lot of family come over; you take like one month or two month or three month doing nothing. No cooking, no nothing. You don’t have to take care of the little baby and your mom or your aunt, neighbors you know take the little baby and clean and make you feeling good and then you can get sleep and take rest in the house. No going outside, no working no nothing until the baby, usually it takes like 4-5 days.”

In addition, several Latino women said that pregnant woman should not, sweep, mop, or use a mop saying:

¹²¹ “No brooming, no moping, no vacuuming”

¹²² “(You cannot) sweep the floor”

¹²³ “I clean the stove and use the broom to clean the carpet and I got a big stomach after.”

Many Latino women were unaccustomed to the level of activity exhibited by American women. Several women compared their cultural beliefs that women should relax and remain inactive with American social norms regarding pregnancy saying:

¹²⁴ “Here you have to do everything by necessity.”

¹²⁵ “Woman here act like as if they weren’t pregnant.”

¹²⁶ “In my country we take care of ourselves...”

¹²⁷ “Here after two days you are already cooking and mopping the floor.”

Both the Latino and AA/African groups shared the belief that certain foods should and should not be eaten during and after pregnancy, although these foods varied widely between the groups. A number of Latino women mentioned that pregnant women should eat only “light” foods and drink a lot of water saying:

¹²⁸ “(I eat) only light things like soup because I had a c-section.”

¹²⁹ “Drink a lot of water.”

¹³⁰ “We have a lot of chicken soup, no meat.”

Several other Latino women discussed eating certain foods as a means of producing more breast milk saying:

¹³¹ “Eat corn muffins to make more breast milk.”

¹³² “Eat bread with corn to produce more milk.”

¹³³ “Have a lot of oatmeal it helps to produce breast milk.”

¹³⁴ “Drink chocolate ... when I had my baby my father brought me crackers, to produce more breast milk.”

A Jamaican woman commented on the subject saying:

¹³⁵ “After the baby’s out back home, you suppose to be drinking like porridge or cereal. Back home in Jamaica, we call it porridge, corn meal porridge; you drink a lot of soup... because they said when you do that, it helps you to produce milk... for the baby so you have something strong, if you gonna have something weak, like you drinking syrup, not like orange juice or some kool aid, that’s not nourishing to help you produce milk for the baby.”

A final issue related to food is the extent to which the food given to women in the hospital and through WIC is culturally appropriate. A number of Latino focus group participants said that they did not like the food they received from WIC and that it was not food that they would normally eat. Others complained that the cost of milk at WIC was too expensive. Some Latino women elaborated by saying:

¹³⁶ “WIC doesn’t give food we like.”

137 “WIC gives you food like juices, cereals, without sugar, we need food we like.”

138 “I went there for milk, eggs the rest, I don’t like it.”

139 “The milk is too expensive I change my coupons at the Latino store and they benefit with my coupons.”

140 “I have a lot of milk, juices, cereal we don’t eat them.”

141 “I go to the Latino store and I change the milk, now I have to buy it and I spend like \$200 Dollars.”

Another theme shared by both groups, but emphasized more by the Latino group was the need for pregnant women to keep their body covered during and immediately after their pregnancy. Some comments from the Latino groups about staying covered were:

142 “My sister told me not to go out without covering my head.”

143 “Cover our head after having the baby.”

144 “Keep cover so the air won’t make me sick on my head.”

145 “You have to cover yourself after the pregnancy, your pores are open you could get air.”

146 “Cover your head for 40 days.”

147 “You should cover yourself with a scarf.”

A Jamaican woman added:

148 “Well I mean like here as you watch and you see, you notice other people like things back home in my country Jamaica that when a woman is pregnant or you just had a baby, you not suppose to be out, you’re not suppose to be in like shorts.... No, I mean you’re not suppose to go to the stores if you just had a baby, two weeks, one week. You stay in until like a month. Like the other part down here, you know that it still have to be there until like a month. Some people back here in America, they just don’t care about that. Because if they had a baby like two weeks ago or maybe like a week they’re out on the street, they are in shorts, rain is falling, they out in the rain. Back home in my country, we don’t have that.... After the baby’s out, you can contract a cold and that cold can be very dangerous (that is why shorts are not worn)... It can cripple you, whatever so I mean, certain things you know how late at night after the

baby, like one week, two week, you don't do that. It's totally different from here."

Several other cultural practices and attitudes which affected care were brought up by African participants alone. These themes were related to:

- **Going through labor**

A number of African women commented on the different approaches used to deliver babies in the United States versus those used in their native countries. One African woman addressed the matter saying:

¹⁴⁹ "There is a lot of difference... (between) what they (doctors) do (in the United States and) what they do in our country. It's a big difference... In Africa they gonna have a nurse to help you to push or explain to you what to do or they gonna touch you. But here the doctor says push, the doctor is already there for you to push, but you don't know how to push... You did it like once in Africa you come here cause over there you don't even need doctor, the midwife over there just like a nurse who gonna do everything, that registered nurse gonna help you even to touch, that they will practice because they doing something, if the doctor is just gonna stand up and tell you push and watching you push, the nurse is near over there to, but they don't do anything. In our country like the nurse can touch you or they can help you push but the nurse who's in front try to catch the baby...to make a you easy labor."

Another African woman said:

¹⁵⁰ "I say if it's getting ready, I will push if I feel the baby's coming out... Just leave me alone.... For translation, I need to say anything when you have the baby in my country, I just see maybe the difference from my country and here because when I have my baby and I tell my husband, you can take me to hospital and when I come, and it's time for the baby to come and talk to the doctor...and t he doctor say no no no you need to push push...you can not do that to push the baby..It was a big problem for me to the doctor after this one to carry the...they say. ...after that they say...if you die, it's your problem and after that I sign the paper, after 30 seconds, the baby come."

- **Hygiene for the baby after birth**

Several African women objected to the practice of not bathing their babies after birth, the advised practice in the United States. A comment from an African woman on the matter was:

¹⁵¹ “I asked my doctor how to take care the baby and he said “Oh you shouldn’t wash the baby so many times because the skin (will become dry).” People don’t have the knowledge about black kids here. The first time I did it the way we do home, you wash the whole baby, hair and everything, but the second time, when I followed my pediatrician, I didn’t wash the baby that much, I was just wiping the baby and (as a result of not being washed) she got eczema until today. She’s six years old, she’s still battling with it....”

Another African woman said:

¹⁵² “So you keeping this baby, no oil, they say you don’t put oil on the skin because it blocks the pores. So you holding this baby and it’s all dried up, and flakes are everywhere, and the hair is thick, it’s not like other kids hair, they re born bald, most of our kids are born with a lot of hair and if you don’t really wash it, then you get that problem with eczema and other things...”

Finally, a Haitian woman commented:

¹⁵³ “As a Haitian woman I think that’s nasty (not immediately bathing the baby), so my babies (are bathed) all the same (if) they’re born ... in Haiti or they’re born here. There’s no difference. I bathe my baby; I take care of my baby the same way. That’s nasty (not washing the baby).”

- **The Technique of nursing**

A number of African and African American women mentioned that they were told by providers to nurse their babies by using a technique that was foreign and uncomfortable to them. An African woman described this issue saying:

¹⁵⁴ “They give a prenatal class to explain what happen for the baby, the breast-feeding, they always explain like this [woman demonstrates technique]. What I said for the African woman they need something because then they come over there, they have a something in their mind always told them (about breast feeding) ... They need help... (If) they gonna tell her don’t do it (breast feed in a certain manner), (then) ... she need someone to explain to her why you cannot do it.”

An African woman said:

¹⁵⁵ "I had her to tell me that I didn’t really know. Right after the baby was born. I didn’t know anything. When the nurse came, the first thing was I didn’t want to nurse the baby because I say this is bad and so I stayed like that for a long time and I couldn’t take it anymore so I called her maybe at 1 am and said I can’t nurse the baby and she said what is going

on and I explained the problem and she said; you have to nurse the baby and you have to do this and you have to do that so after the baby's born, maybe to me, that was the biggest problem cause I didn't have that knowledge."

Another comment from an African woman was:

¹⁵⁶ "And also for the nursing, when the nurse come to teach me how to nurse the baby, she say to me "Don't hold up your breast, just put like this in his mouth." And I say "What about his nose? It's too big for the baby." I have to hold, to help the baby and then he can (feed) and they say to me "No" I say to her "Just leave me alone, just go out. I'm the mother and I know how to take of the baby, don't think (because I come from) Africa, I don't know anything. I have the baby in Africa before and she's healthy. I take care of my child. And now for this baby I'm going to take care so you can help me (but) don't say to me ... (that I don't know how to take care of my baby). How I'm gonna leave my breast to his mouth and he's just like a week old. He can't hold the breast by himself. You have to help him.... Like 15 minutes (of nursing), it's not enough, like 20 minutes, that's enough for him, not like 5 minutes here and 5 minutes there, if he is... what I gonna do."

The frustration with how nursing techniques were taught in the hospital setting was expressed by an African woman saying:

¹⁵⁷ "They have to respect the Africans, the way they breast feed their baby, you have to hold the baby."

- **Announcing to everyone that they are pregnant**

Finally, several African women said that the issue of being pregnant is sensitive, and that they feel that other people should not talk about the fact that they are pregnant, unless necessary. Some comments representing this idea were:

¹⁵⁸ "And the other thing, you don't tell people you're pregnant."

¹⁵⁹ "Yes, whenever I go to the doctor and he say it, I don't tell anybody, they don't need to know that it's coming, everybody will see that.... It's not very nice to say I'm pregnant, I'm pregnant."

¹⁶⁰ "But here you pass on the street and they say "How long?"

¹⁶¹ "Here, (in the) hospital, every time you go, they ask you "Are you pregnant?"

Interpretation

Culture and Birth Outcomes

A number of epidemiological studies have emphasized the role that cultural differences play in pregnancy outcomes. The elevated preterm birth rates (accounting for the difference in mortality rates) among African American women compared with white women has been linked to more unwanted conceptions, poorer nutrition, less sufficient prenatal care, and stress-associated behavioral risks (Hogue, 2001). The relationship between chronic psychological stress and preterm delivery, through the elevated levels of placental corticotrophin-releasing hormone and through the greater susceptibility to vaginosis as a result of reduced immune functioning, has also been postulated. Consequently, women who have been targets of racism or violence may be at particularly high-risk for preterm delivery (Hogue, 2002). Although empirical evidence supporting this relationship has thus far been inconclusive, the “biologic plausibility” of such an effect is commonly held by epidemiologists (Hogue, 2001).

Other issues relating to culture and pregnancy is the extent to which acculturation, or cultural integration, affects birth outcomes for immigrant women. A study on Mexican American women and Mexican immigrant women by Zambrana et al showed that the integration into United States culture was associated with higher prenatal stress and preterm delivery. This prenatal stress was also associated with substance use and low social support, further increasing the high risk status of Mexican American women relative to Mexican immigrant women (Zambrana, 1997). These findings imply that “Mexican-American women, as they integrate into the United States, experience a decrease in culturally-specific protective factors that are integrally related to the quality of the community environments in which they live.” Another study, conducted by Guendelman *et al* found similar results showing that Mexican immigrants who had lived in the United States for more than five years were more likely to deliver preterm infants and low birth weight infants, had more pregnancy complications, fewer planned pregnancies, and were more likely to smoke than Mexican immigrants who had lived in the United States for less than five years (Guendelman, 1995). These ideas suggest that Mexican American women, and possibly other minority women, experience deteriorating health outcomes as a result of acculturation. Consequently, newly acculturated women should be targeted by outreach efforts in an attempt to reduce the negative impact of cultural integration on pregnancy outcomes.

Food and culture

According to Siega-Riz *et al*, calorie and nutrient consumption vary significantly between black and white women who are pregnant. Her results show that pregnant black women consume significantly more calories and higher absolute values of nutrients than pregnant white women while pregnant white women consume more protein, iron, folate, and fiber than pregnant black women (Siega Riz, 2002). Siega Riz found that, in general, pregnant white women favored a higher “nutrient-dense” diet (meaning the proportion of nutrients to calories.) Although it is difficult to comment on the extent to which these results were

borne out of our focus groups and that white women were not included in the study, it is worth noting that minority women may have different eating habits during pregnancy which can affect health outcomes during and after their pregnancy.

Adoption of new practice

Several African focus group participants objected to not washing their babies after birth. One woman even linked this practice to her daughter contracting eczema. In these cases, it appears that doctors did not make a sufficient attempt to educate the woman why not washing their babies was a good idea. Instead, it appears that the doctors simply conveyed to the women what they perceived as the “best” way of doing things. The same problem occurred when women were advised on how to breast feed their babies. Judging by the accounts given by focus group participants, a proper discussion between patients, doctors, and nurses regarding why women should adopt practices with which they are unfamiliar is not taking place to the extent that it should be.

F. Perceptions of differential treatment when receiving care

Findings

In the course of conducting the focus groups, a number of women described feeling discriminated against as a result of their race, language, and insurance status when they received medical care. Women expressed this sentiment while answering general questions about their health care as well as when prompted by the question:

When seeking care during your pregnancy, have you experienced feeling frustrated, angry, mad, or uneasy? What made you feel this way?

In asking the question, the focus group moderators were instructed to allow the participants to state their own perceptions of the reasons why they were treated in a certain way. The moderators would then use the participant's own words to probe for further details on an incidence. Only when the participants did not respond thoroughly to this question would the moderators probe further by using a series of words such as "race, age, sex, language barrier, etc." Through this process of questioning, the moderators would not feed the participants with the responses; rather, they allowed the participants to express their own interpretation of their experience first. In short, we tried to give participants the opportunity to initiate the dialogue concerning discrimination while receiving health care before we asked them directly whether they had experienced any discrimination.

Although African American participants felt themselves to be victims of discrimination while receiving care to a much greater extent than African or Latino participants, different groups varied in how sensitive they were to the different types of discrimination. This section is organized into three parts according to the three methods of discrimination reported by focus group participants including: 1) Differential treatment due to language barrier, 2) differential treatment due to insurance status, and 3) differential treatment due to race.

1. Differential treatment due to language barrier

Differential treatment due to language barrier was only raised in the Latino focus groups. A few Latino women believed that the main reason for receiving differential treatment in a health care setting was because of a language barrier:

¹⁶² "(they treat us differently) because we don't speak English."

¹⁶³ "When I went to ___ to bring my daughter, the doctor asked me if I spoke Spanish and he twisted his mouth; also, the receptionist kept signaling me to leave. They use phone interpretation, but they said my daughter didn't have anything and sent her home. Eight days later they call saying she has pneumonia; they don't like to work with us."

2. Differential treatment due to insurance status

Insurance status was another reason for differential treatment commonly cited by focus group participants. For the African women participating in the same focus group, insurance status was the only reason mentioned for having received differential treatment. A participant from this focus group commented:

¹⁶⁴ "The treatment is totally different; when you have real insurance, the treatment is different. I had a friend that told me a totally different thing because he didn't have insurance...."

Another participant affirmed this by saying:

¹⁶⁵ "Maybe because everybody says that when you have insurance the doctor will treat you different from when you have Medicaid."

When probed further, the same African woman responded with the following question:

Do you feel that you're being treated differently? She answered:

¹⁶⁶ "...I'm just having my way, this is the first time (of being pregnant), but I don't know what's going to happen in the future."

Her response suggests that she had not yet experienced differential treatment during prenatal care herself despite the fact that she was on Medicaid (which she reported on a separate written survey regarding the participant's socioeconomic information.) She continued to believe, however, that health care treatment may be different depending on one's insurance status. Furthermore, she was not certain of how she might be treated in the future as she will continue to hold Medicaid insurance.

Later in the discussion, the African woman participant (who made a statement in quote 164) continued to explain why she perceived insurance status as a reason for receiving differential treatment by asserting the following experience:

¹⁶⁷ " The reason I'm saying this is because when I had my baby, I had a break at some point. I had insurance through (my job) but when I had the baby I had to stop my job ...and I lost my insurance for a short while so I had to apply for Medicaid. The people I spoke with is not the regular people; the people I spoke with are very different. I had a very different experience so I'm just saying and from what my friend told me the kinda things that she went through and what they told her and the patience they had for her was very different from what I had."

Similarly, the Latino women participants also shared the same viewpoints as the African participants regarding the link between insurance status and differential treatment:

¹⁶⁸ "They don't give us health insurance; they don't give us the same services."

¹⁶⁹ "(they treat you differently) because they take you faster when you have health insurance."

¹⁷⁰ "They treated my daughter once, but they told me they weren't going to see her again because she doesn't have health insurance."

¹⁷¹ "I also took my daughter and they told me that they weren't going to see her again because she doesn't have health insurance."

Not all women perceived that they were treated differently because of their insurance status. Some African women and Latino women had positive experiences with the way they have been treated while receiving care regardless of their insurance status:

¹⁷² "But that experience, I can say this: (it) maybe depends on the doctor. That's what I can say because with all three of my kids, I didn't have any insurance...but they treating me the same."

¹⁷³ "Really, like when you go there, the one question that they ask you is do you have insurance. I say: I don't have insurance, but I had Medicaid (and) the doctor was good there and also for my children, he's really good. But now I don't have insurance but Medicaid for my kids. They have Healthy Kids and I use to go there, (and) they help me like (I) have discount card from ____ because I can't pay everything (since) I don't have insurance, I don't have Medicaid...My doctor help me...That's the only way I feel they help me and I feel happy."

¹⁷⁴ "I haven't experienced anything."

¹⁷⁵ "If you go to ____ and you don't have health insurance or money, they still help you, and we know they have to help us."

¹⁷⁶ "If you have your discount card they will help you. I have my card; it's the same as if you don't have one."

Unlike the Latino focus groups, which were conducted in Spanish, the African focus group was held in English due to the impracticality of providing interpretation services for the multitude of African dialects and languages. Thus, African women participants were selected based on their ability to communicate in English. This selection bias may have impacted their responses to differential treatment. Thus, for some African women who do not speak English adequately, language barrier is also likely to be an important factor for having differential treatment in a health care setting.

3. Differential treatment due to race

Throughout the discussions within the three Latino women focus groups and the one African women focus group, the sentiment of differential treatment due to race or skin color was not stressed as a primary concern. This sentiment, however, was emphasized much more in the last the two focus groups where African American women predominated. One African American drove an hour from where she now lives to explain what she experienced while receiving prenatal care in Manchester last year (2001). As a result of these events, she vowed to personally never live in Manchester again nor would she go to a doctor in the City. These are her words:

¹⁷⁷ “...I was about a month and a half pregnant. I had already gone to the doctor; started taking my prenatal pills and started having sharp pains in my side. I had those half the day and I’m thinking these are really sharp; something is wrong here. I went up to the emergency room (and) my husband wasn’t able to come with me because I had the twins at home and it was at night at that point. I go up to the emergency room, I sign in, and I sit for about 45 minutes with pains in the sides... And I went in and sat around for about, I’d say a half an hour before the doctor came in. The doctor came in, asked what was wrong and I told him I was having pains and that I was pregnant and he proceeded to ask me in a not a nice way at all. He said, well did you plan this pregnancy?”... He (the doctor) left. He came back (and he) got to do an exam on you to make sure it’s not an ectopic pregnancy so on and so forth. So he comes in, he does the exam and they decided that he needed to send me up to ultrasound... While I’m waiting, I’m in the room with my friend. My friend came with me. I’m in the room at this point, hysterical. I was scared to death. I knew what was happening. I’ve been pregnant before. I know I was having a miscarriage. I’ve had a previous miscarriage, so I knew it was happening again and during that hour from when they called the ultrasonographer to when they came in. They left me in there crying hysterically. I had a nurse walk in, a male nurse. His name was _____. I’ll never forget his name and I’ll never forget the way he looked either. He came in and he looked at me and gave me this dirty look and he said: are you in pain? I said yes, I’m in pain, but that’s not why I’m crying. He said: well why are you crying? But, he didn’t say it nice, well why are you crying? I said I’m concerned about it being an ectopic pregnancy. He asked me the same thing. He looked at me, looked down at me like I was a piece of dirt and asked me the same exact thing. Well did you plan to get pregnant? He asked me too, how old are you, and then walked out of the room and left me there crying. Nobody tried to comfort me... I deserve to be treated like a person... and out of respect. This was November, 2001... My experience growing up in this state is the only time that does happen, it’s out of racism, sexism, ageism. It includes all the isms, but I can say for sure that the reason I was treated

like that, because, here I was coming in on Medicaid, black, having a kid, looking like I'm 15 years old....”

Interestingly, the perception of racially motivated differential treatment is also reflected in the comments of two other African women who participated in the same focus group. This sentiment was not raised in the focus group of all African women discussed earlier. After hearing the African American story above, a Haitian woman commented the following:

¹⁷⁸ “(I have received a different treatment) from some of them.”

Moderator: From some of them because of your skin color?

¹⁷⁹ “I don't know. I used to ask myself, but I didn't let that bother me. (I want) to be treated the same with whomever I saw.”

Another African American participant in the same focus group asked her:

¹⁸⁰ “Why do you think they didn't, that the other doctors didn't treat you the same?”

The Haitian woman responded:

¹⁸¹ “I don't really know. I used to ask myself is it because I'm black? It's because of the way they are.”

In the last focus group composed of four African American women and a Sudanese woman, one African American woman also sensed differential treatment that may be attributed to race. She made the following comparison:

¹⁸² “...Sometimes, not very much, but sometimes I do sense a little bit of a difference like as far as the male doctors go. I see male doctors don't seem as friendly as they could be. A lot of male doctors here seem really impersonal; like hi, how are you today? Okay, let me check your blood pressure, let me check this, let me check that; okay you're fine; good-bye.”

The moderator then probed with the following question:

“Did you observe the doctor with a different person?”

She replied:

¹⁸³ “I hear, I haven't observed; but I hear just basically other people who say...he's really great you know.”

The moderator continued to probe her with the following question:

The other person, who told you the doctor treated that person differently, was that person of a different skin color?

The African American woman participant responded:

¹⁸⁴“Yes. White skin (who was) basically just out waiting for an appointment. Well after our appointments, our sons know each other, you know just basically playing. She seemed to like the doctor a lot and I didn’t have problems you know. Basically, I could care less what people think or whatever.”

A few Latino women also thought that they were treated differently because they were of Hispanic or Latino origin. One participant alluded to her belief that Latinos generally received differential treatment because of their ethnic origin by making the following statement:

¹⁸⁵ "This is going around every place not just here. It's all the United States; they treat us differently because we are Hispanics."

Another Latino participant provided an example of her experience of a dentist mistrusting her by citing:

¹⁸⁶ "I went to the dentist and he charged me \$100 dollars and he asked me to show him the money before he would work on me."

One other Latino described that she did not receive a similar service as other patients in the hospital room:

¹⁸⁷“I had a woman doctor that never touched me. She would leave me in the room with three women; normally you are with two. She treated better the other two; at night, she brought them food and because I couldn’t understand to ask her for juice, she wouldn’t bring me anything. She wouldn’t pick up my trash. The place was clean, but I noticed she would bring them change of garment or the bedding but not for me.”

The reference of “doctor” was probably used to describe other hospital staff such as a nurse’s assistant or someone who brings food and provides fresh bedding for the patient. Often foreigners (who are not accustomed to the medical garment symbol in a hospital or clinic setting) interpret anyone wearing a medical uniform as a doctor.

Other African American and African women, however, thought that they were treated fairly. When one African American woman was asked whether or not she had received any differential treatment in a health care setting because of her race, she replied:

¹⁸⁸ “I haven’t experienced anything.”

One Sudanese woman in the same group was probed with the same question:

¹⁸⁹ “...the doctor I see...look at me like I’m different from here; but I think it’s not a problem to being a different color. I don’t know what to say.”

In short, most Latino women attributed differential treatment in a health care setting primarily to language barriers. In addition, some Latino women mentioned insurance status as a potential cause of differential treatment. However, there were contrasting views on this matter. For some Latino women, they reported that they had been receiving the same health care treatment regardless of their insurance status. Language was not discussed by the African women as the primary concern to having differential treatment in a health care setting, but rather insurance status. Similar to the sentiments of the Latino women, African women also conveyed opposing viewpoints to insurance status for the reason to receiving differential treatment. The perception of differential treatment due to race was raised in the two focus groups dominated by African Americans. One African American woman reported differential treatment due to race quite extensively. Other African American women also sensed this but did not provide any lucid examples on the matter. African women grouped with African American participants also voiced their experiences of having received differential treatment in a health care setting, which may have been linked to race, but the cause of their differential treatment was not clear. Similarly, Latino women also sensed differential treatment but were unsure of the cause for this treatment.

Interpretation

For many people, particularly those who have just immigrated to the United States, the subtlety of racial discrimination is quite difficult to interpret and pinpoint. For this reason, racial discrimination may not be articulated explicitly because he/she lacks the experience of interpreting and voicing it. As such, racial discrimination is often voiced more clearly by African American individuals with years of history and awareness on the issue. This trend is also found in another study on *Racial and Ethnic Discrimination in Health Care Settings* of 2,425 King County residents in Seattle, Washington (Public Health Department, Seattle & King County, 10/98.) In this study, questions on the perception of racial discrimination were asked of residents from eight different groups—White, African American, Chinese, Filipino, Japanese, Korean, Vietnamese, and Latino/Hispanic. A greater percentage of African-American residents (29%) in this County claimed that they had experienced racial/ethnic discrimination when seeking medical care as compared with residents from the other seven groups (White, 1%; Chinese, 8%; Filipino, 15%; Japanese, 5%; Korean, 15%; Vietnamese, 5%; Latino/Hispanic, 12%).

In addition to one's roots, age is another factor that should be considered when studying racial discrimination. For example, an older person with years of experience living in the U.S. is likely to be more in tune with the subtlety of racial discrimination as compared to a younger person. As such, if a new immigrant or a young person does not have much to say on this issue, this does not necessarily mean that the person has not experienced it.

G. Different Expectations between patient and provider in the delivery of care

Findings

In the previous discussion of differential treatment, many participants questioned whether or not they were appropriately treated by a health care professional or staff. Some questioned the way they were treated in an emergency room while others questioned the role of a doctor on call or how their labor was managed. However, it is possible, and even likely in some cases, that the perception of differential treatment resulted from a difference in expectations between patients and providers and was not racially, culturally, or linguistically motivated.

Prejudice and discrimination come in many subtle shades and are often difficult to identify and substantiate. However, it is important to distinguish between discriminatory treatment and treatment that is merely perceived as discriminatory by patients who lack knowledge of common medical practice. This section aims to identify examples where a patient's misconception of medical or clinical practice may have resulted in the patient's perception of differential treatment. It also aims to document instances where providers may not have accounted for the differing expectations of their patients and were consequently unable or unwilling to address the fears and concerns of their patients.

The first example comes from a Haitian woman who expressed her anger of how she was treated in an emergency room by saying:

¹⁹⁰“Eliminate the emergency room... When you have an emergency, it's an emergency. You know what happen to me. I call that racism because my son was screaming with his ear one night and I (took him) to the emergency room. I got there, there were two white people after me; they came after me. I got there before them and they went inside before me and my son was screaming. You know what I did? I left. I left, I went back home and said baby you know why? I'm going to give you some Advil; try to calm down and fell asleep. That happens to me. I hate emergency room. You get there, they ignore you. It's an emergency; you have an emergency; you go for an emergency and they should take care of you at the same time you get there. That's what the person should do; have you inside and take care of you, but it's not like that. And they have people running before you. That's because you black, tell

me!...Do something! Do something! You're baby can die before they see him."

After hearing the Haitian woman speak, an African American in the same focus group voiced her expectation of how her case should have been handled when she brought her son to an emergency room for the treatment of an ear infection saying:

¹⁹¹ "Yeah! I was raising hell in there (the emergency room). They were ready to call (the cops) on me...Past this year. My son was just starting to grow his teeth in and stuff like that, so you know the ear infection come after that. I didn't know what to give him and I didn't have the stuff to give him so I took him to the emergency room. It was about 2:30 in the morning... Ambulance came, took him to the hospital, get there and they had me sit in the waiting room. Now if you come through the ambulance, you're already entitled to a room. I'm correct? So I'm (sitting) there and they like call somebody named xxx to get up, they see him and check his temperature; it's 102.6... When was the last time you gave him Tylenol? (I responded) I gave him Tylenol before the ambulance came already. (Sitting) there and I'm looking, clock is going, 15 (min), 30 (min), an hour, 30 (min). I'm like, my son, and then a little girl comes in with a little burn on her hand, look like a match burn and they take the girl right in there and (bandaged) her up; she's walking out like this, my son's sitting there crying and all that. I'm aggravated. I'm like you, if ya'll don't take care of my son now, all hell is gonna break in here. I was kicking over chairs. I was like get my son in here; give me some prescriptions so I can take my son home and lay him down (or) something. They looked at me and they were like miss, calm down or we'll have to call the police. I said: well, call'em, call'em. I'll call'em for ya. I picked up the phone and I dialed 911. The guy said hello and they hung up. Now that's when they called me in."

Moderator: "So what happened to your son that made him go the ER?"

Woman: "He was teething... ear infection."

In both of these cases, the participants believed they received differential treatment when they brought their children to the emergency room for care. Both participants felt that their children were not seen by a doctor as fast as they should have been. One participant felt that since she brought her son into the emergency room by an ambulance, her son should be entitled to be treated first over the others regardless of the nature of the emergency.

Another African American woman in the same focus group complained about how she was treated by a doctor on call. This woman had a breast infection and went to her doctor for a visit on Monday. She was given antibiotics and was told that the antibiotics should cure

her. After three days of taking the antibiotics, her pain was not cured. She then proceeded to call the doctor on call at 9:00 pm after office hours. She describes the phone call with doctor as follows:

¹⁹² "...He said to me "I don't know what you expect me to do at this time of night about a breast." That's what he said to me, and I said well I'm so sorry; now mind you, I'm very emotional, I'm very pregnant. I was taken back and I said: I'm really sorry (that) I bothered you at this time of night, but I don't know what to do, and I had been on the phone with ask-a-nurse...and they said: call your doctor, you have to call your doctor. So of course, I did and I told my doctor that ask-a-nurse told me to call you and I feel really bad, but I don't know what to do. I'm in so much pain and he said "There's nothing that I can do for you this time of night. Either you go to the emergency room, or you'll just have to wait (until in the morning when the office reopens)." So here I'm, eight (months pregnant), I'm about to deliver in a month; I'm ready to deliver. I go to the emergency room where there's a new, I know there's a new pain management system where they really have to take your pain seriously. At least they are suppose to, which they did for me. Put (me) on IV morphine, IV antibiotics, and I stayed there for quite a few hours on the morphine, and went home and saw...the nurse practitioner and had surgery that day on my breast.

Similar to the perceptions of differential treatment in the African American group, a few Latino focus group participants voiced concerns regarding what they perceived as a drawn out labor process. Two comments on this topic from Latino women were:

¹⁹³ " They also treated me differently. They sent me home after walking for hours. I got there at 9:00 and they saw me at 11:00. They said by 4:00 you'll have the baby and it was by 7:00, my husband got upset because they said by 2:00 and he want...the delivery to be at 2:00. He said "Why are we here all day for nothing?""

¹⁹⁴ "I also went at 5:00 in the morning to ____ with my husband and they said by 8:00 she'll be out and they opened me at 2:00 in the morning. I think the doctor was tired and gave up the battle. He was very angry. He would leave me with the nurse and come back later; that's why he did the c-section."

These women expected the delivery of their babies to occur at a specific time and questioned their doctors when the time of delivery was later than that expected time. They thought that because of the long wait for their baby to be delivered, they were not treated properly.

Interpretation

The stories documented in this section are all examples of patients perceiving discrimination in the process of receiving health care. However, it is likely that this perception resulted from a lack of familiarity with health care practice and the health care system.

In the two cases in which women felt that their children were victims of discrimination while receiving care in the emergency room, the participants suffered from a number of misconceptions. First, the participants believed that one should have the right to be treated by the order of appearance rather than by the order of urgency. Secondly, one of the women thought that because she brought her son into the emergency room by an ambulance, her son should be entitled to be treated first over the others regardless of the nature of the emergency. Finally, the concept of “emergency” under which these women were operating is not the same concept used by the medical system.

Both of these situations could have been avoided if the women were more familiar with triage and the health care system. These women perceived that they were given unfair treatment by the staff at the emergency room whereas the emergency room staff followed the normal protocol of providing care by giving attention to those who were in most urgent need first.

The case of the African American woman who called her doctor after clinic hours and expected him to address her problem is another example of misplaced expectations. In this instance, the doctor had very few options at his disposal at the time of the phone call. He was not able to properly evaluate the woman because he was unable to see her in person. Consequently, the doctor was only able to advise the patient to either go to the emergency room or go to the clinic the next morning. However, the doctor could have been more sympathetic to the pain and worry of the patient and could have apologized for his inability to deal with the situation at that time. Also, he did not need to say “I don't know what you expect me to do at this time of night about a breast.” Nonetheless, he replied to the patient with the only answer he could in the situation: either go to the emergency room or wait until the office reopens in the morning.

Finally, in the case of the Latino women, it was unreasonable for them to put so much faith in the forecasted time of delivery. Issues and complications can arise in the course of labor, which may delay the time of delivery.

As has been documented in section I and throughout the focus groups, women feel like doctors do not give them enough information about their pregnancy and about the medical system. If physicians and other health care providers took the time to answer women's questions and to provide them with the information necessary to understand their pregnancy and to navigate the health care system, they would probably have been able to avoid a number of the misunderstandings described in this section.

H. Social Determinants of Health

Findings

The relationship between health outcomes and social dynamics, financial conditions, and the physical environment conditions is well documented in health research (Smith et al, 1997; Wunch et al, 1996, Bartley, 1997). In an effort to understand how environmental forces confronted by minority women living in Manchester may have affected their access to prenatal care or the health outcomes of the children, we asked the following questions:

How easy or difficult is or was it to be pregnant here in Manchester (especially relative to anywhere else based on your experience)?

How would you describe the neighborhood you live in? What makes it or would make it easy or hard to raise a family?

What are all the different concerns or worries that you (or a woman like you) had or have during pregnancy?

In answering these questions, the participants identified several key environmental, economic, and social factors that could directly or indirectly impact their health and their children's health. This section is divided in three sections focusing on: 1) Physical Environment, 2) Financial Concerns, and 3) Social Factors. These sections cover participant's comments detailing the relationship between environmental factors and health.

Physical Environment

- Adequate housing condition

Although most women did not express much concern about the quality of their housing condition, a few newly immigrant African women, Latino, and African American residents of Manchester mentioned the following concerns:

¹⁹⁵ "Right now because you know it's my first pregnancy and I'm worried because the house that I'm living in is not comfortable because for me maybe I'm a big person (and) I can take care of myself, but after I get my baby maybe something will happen to my baby because you know, it's like the house is not, you know like when you call the landlord and you complaining, the bathroom is not good. You know when you get the baby, it's suppose to be very clean because your baby can get sick...if somebody from health come there you cannot feel comfortable and that's why I'm worried. I'm worried about my baby. How can I give him a shower; even for me, I'm not comfortable with this bathroom."

¹⁹⁶ "... When we arrived we go to the center. I'm pregnant and I have daughter and my husband. We gonna be in one bedroom. They say

that's all we can do for you. You have to accept this like this until your husband found the work then you can find another place; you see it's good for you. If they say, what I gonna do; I have to accept this because I'm a refugee. Until I get the baby and me and my baby, my husband, and daughter, all in one place."

¹⁹⁷ "...I live on third floor with stairs. To hike my baby and my stroller and my exerciser and her pen up and down the stairs a lot of the time. ...(there is) no elevator, no washer and dryer hook up. We're not allowed to have that. I have to lug all the laundry down, and then I have to go across the street, go down stairs into the basement. That makes it really hard in my neighborhood to have kids."

¹⁹⁸ "I don't like it. I live on the third floor (and) it's hard with two kids going up and down (the stairs) all day."

- Safety in neighborhood

The majority of focus group participants were content with the living conditions of their neighborhood. However, a few of the Latino women articulated the following concerns about the safety of their neighborhoods:

¹⁹⁹ "I don't like it where I live because there are a lot of accidents. I don't let my daughter out; my daughter saw an accident. I feel it's not safe even though there is a bar in the back and the police is always around. They stole antenna from my husband's truck."

²⁰⁰ "Someone hit my husband's car 15 days ago and broke a glass and someone tried to steal tires after."

²⁰¹ "I was out for a week and they broke in my house."

- Transportation problems

Numerous focus group participants expressed the problems they had getting to appointments and traveling around Manchester. Because the public transportation system in Manchester is limited, those without access to a vehicle often face difficulties in traveling to places. For many Latino women, using the Manchester public bus system can be an overwhelming task because of their language barrier. Also, Latino women with limited English skills tend to fear that a taxi driver might misunderstand them and take them to a wrong location than intended. Problems with Manchester's public transportation system were documented in section *C. Barriers to Care* and are discussed in greater detail in Appendix G.

Financial Concerns

Additional financial concerns resulting from pregnancy and child rearing were mentioned by several focus groups participants. Some comments regarding these concerns were:

²⁰² "(It is difficult to afford) milk, diapers... To make more money to cover for all these (is a concern of mine)."

²⁰³ "The money doesn't last, we don't make enough."

²⁰⁴ "...I'm paying around \$500 dollars a month for child care; that's like another apartment... Yeah, and they (the state) pay for the kids to have Medicaid but they say my income is pretty good which I'm trying to figure this out. Like how do they figure, you know, there's no way. I have a care payment, I have rent, I have car insurance, I have toiletries. I have to pay his child care, I pay her child care. But that's what they figure so I can't argue with them."

Social Factors

- Unfamiliarity with a new culture

Arriving in a new culture can be shocking for some, particularly if they have to do it alone coupled with language and information barriers. A few of the newly immigrant African women voiced their own and others' experiences in the following quotes:

²⁰⁵ "It's a culture shock when you get here, finding everything from food to banking. I relied on my people that were here first... Find where food was, knowing what is this called. You go into a supermarket and you don't know where to start."

²⁰⁶ "(Recent immigrants) need someone to explain to them how to live in this country, how to find a job, that is necessary..., how people live here."

- Language barriers

For those who do not speak English, conducting daily tasks such as calling a taxi, visiting a doctor, or filling out papers can be a daunting experience without additional help from someone who can translate for them. This is a major barrier faced by many Latino and African women living in Manchester. Due to the difficulty in communicating with a provider (particularly if the provider does not have adequate medical interpretation services), some might dismiss preventive care and only go to a doctor when they experience discomfort or pain. Problems regarding language barrier are discussed in great length in section C. *Barriers to Care*.

- Child care issue

For women responsible for taking care of their children, receiving training, attending a doctor's appointment, or going to an ESL class can be a difficult task. Comments from African women expressing an interest in learning English and in improving their skills so they could find a job are included in this section. For many of these women, sending their children to day care is not an option due to financial barriers. Also, because of their child care responsibility, it is difficult for these women to work a regular job, if they are able to find one. This series of problems form a continuous cycle for these women inhibiting them from advancing their lives and careers. Describing this situation is an African woman saying:

²⁰⁷ "...for some people too they don't know even ABCD so they you know, back in my country they learn Arabic so some of the ladies right here, they know (only) how to write Arabic, but they don't know English, and they need (to go to) school but the problem is...the kid. Nobody watching them (so they)...can go and study ESL until you know a little better cause if you want to go to work, it good to speak good and have a little bit writing so you can get a job. (If) you don't know how to speak good, some job they don't hire you...Too hard for us now to find (a) job because of my people, the way they don't know English...It's really a little hard."

A Haitian woman commented on her difficulties affording child care saying:

²⁰⁸ "I'm going to go for (a) training in August. I'm looking for day care right now. Day care is so expensive. Why they make we mother pay so much for day care. I don't think some of them take assistance."

One Sudanese woman expressed how she wants to go back to work but is not able to find adequate child care for her children. This woman has two children, one daughter who is two years old who is currently in the Head Start program, and a five-year old son who will be going to kindergarten; however, her difficulty is finding someone to pick up her son everyday after kindergarten if she works. She does not have any family members here to help her and she cannot afford to send her son to an after-kindergarten day care program. Working the night shift is not an option for her because of the young child and working in the morning will be difficult because of her son's kindergarten schedule. Her comments regarding this difficult circumstance were:

²⁰⁹ "...My son now is 5 and he going to go to kindergarten so (Head Start) will not take care of him anymore so I think my little daughter is 2, she's staying in there...I don't know right now who gonna pick them up and gonna drop them in and if I'm gonna work at night, it's not going to be good for the little baby. I just need to work in the morning..."

- Children being labeled and stereotyped

A number of African and African American participants described situations where their children were racially discriminated in a school and neighborhood setting. These women expressed concern that their children had been labeled and stereotyped as poor kids or troubled kids by other parents, teachers, and school administrators. Below are excerpts from a lengthy discussion of three women (two African American) and one Haitian woman on this issue:

²¹⁰ African American woman 1 (AA1): “I think that my children are labeled, and I think that automatically they're poor, whether they are (or) not because they're black or whatever goes along with being black. Those are the labels my children have.”

Moderator (M): So do you feel that you have to move out of Manchester?

²¹¹ AA1: “I'm probably gonna move down south, but I've lived down south where there's a lot of places in the south where it's very racist; but, there's also places ... that are really a Mecca for black people. I lived in Atlanta which is the Mecca of black, African American people, where my children, there are plenty of black people that aren't on welfare, who aren't, you know as if people in Idaho are black and on welfare, they're not. There's this thing about being African American in this area where you're automatically (labeled as) on public assistance.”

²¹² AA2: “It's not just the kids, the parents are labeled (also). Yeah, well I walked up into the school, my son was having a tantrum and I heard them. He had not had any issues, he has ADHD (attention deficit hyperactivity disorder) syndrome, asthma; he's allergic to everything, so he's a mess, and I walked in and they didn't know I was there, and one of the teachers looked at the other teacher and said: I wonder what's going on at home. I went to the principal and said: Do you want to know what's going on at home, you come ask me what's going on at home. So you're labeled, your kids are labeled, they suffer academically because of it... (I) ...had Tufts insurance and when I first enrolled them into the school, we having a meeting and they asked me: So, do you have their Medicaid cards? I immediately looked at her and said: they're not on Medicaid.”

²¹³ Haitian woman (H): “Yeah, can I add something. By being black and have your kids in school in Manchester, when they see you, they think you nothing. You're nothing. They ask you everything because you nothing. I don't know if you understand what I'm saying, they just keep on questioning you and believe that you... have no answer to them cause you nothing... I have my son, he misbehave himself. He's not a bad kid. He's only ten years old, and they don't understand that. This year, his

teacher, the last day of school, no two days before school, I had enough and I have to run to the school and talk to her, and I told her (that) I was glad that the school is over because if I was and I had to be there at the beginning of the year, I would have to deal with her. Yeah, because you know why? As a single mother, I do anything that I could to take (care) of my kids. I don't want my kids to go out there hungry and look at people eating, saying: I want that, I want this. I don't want my kids being treated like crap in school because they have dirty clothes on (or) they don't look good, you know. I like to look good, and I like my kids the same way but what happen, anything (I) did, she (the teacher) called my son a thief. Even a kid gives something and my son took it from another kid, and she just put in that my son stole it...He's not the only black child. I think there were two of them. I think anything he did either good or bad she take it wrong. I wasn't happy with that because my son never steals at home.”

²¹⁴ AA2: “Or if you know your child needs services, you can't get services in the school districts. I went up and I'm in an all white town; no black people, none like I said before, and I have so many services flying in right now (where I live outside of Manchester). I thought it would be worse, where I am than in Manchester... (but) I (now) have occupational services coming in and they are hiring professionals to come in. My son lost 2 years of education being in the Manchester school district.” (Note: this is the woman who moved out of Manchester as a result of her bad prenatal care)

²¹⁵ AA1: “One of the points I wanted to make, was that, like (where) I live, it's funny because I live in a neighborhood where, I actually live in a nice area. A lot of children go to the same school with my children live (are) in not a very good area. There's a lot of poverty, a lot of children that don't have anything who go to the same school with my children, white and black. I think that the African American children, and I say this because of my own children, we don't have a lot of money, but certainly we're okay. They are treated, they are stereotyped. There shouldn't being any stereotype for children that don't have money because it's not their fault. But because these children are sort of in poverty, a lot of them that go to this school, all the African American children are treated the same kind of way and the parents are treated as if they have no education, we don't want to take part in much of anything. It's this stereotype and I don't know what school your son is in, but I do know that my son and my daughter are not the only African American kids by far. There's Africans, there's Indians, there's Spanish people, there's some of everybody in this school, but I feel like they're not driven the way that they should be. These are poor black kids and we're not going to worry too much about them, and I'm an active mom and I participate and I deal with the school principal all the time. I'm really on top of my

children. My daughter stole something from school actually one time, and I was the first one on the phone with that principal saying: Listen, this is what she did. I need to know what her punishment is going to be. In need to know how the school is going to take action about it, and even though all those things I do, I still feel like my kids are being treated like inner city, poverty African American children.”

²¹⁶ H: “One of the ladies said to some of the White kids, do not walk with my kid, with my son.”

Interpretation

Minority women, refugees, recent immigrants, their children and family members are likely to be at risk for social isolation. Some contributing factors may include race, cultural differences, communication barriers, inability to immerse in a new culture, economic difficulties, or lack of opportunities for higher education.

A few African American women in a focus group voiced their concern about their children being labeled in a school where kids are predominantly White. One African American woman even spoke of the thought of moving to Atlanta, a place where she considers a "Mecca" for black people and where she would feel welcomed. African women spoke of their need to have someone to immerse them into the U.S. culture when they first arrive. Latino women expressed their economic concern of making ends meet with limited dollars. High child care costs are a major concern for many women, particularly if they want to better themselves in improving their skills to hold a meaningful job. These problems can add stress to one's life. Continuing anxiety, low self esteem, insecurity, lack of control over home life and work, and social isolation have negative impacts on physical and mental health.

How is stress linked to health? When stress hormones are activated, they affect the cardiovascular and immune systems. Previous studies of primates demonstrate that subordinate animals are more likely than socially dominant animals to suffer from clogged blood vessels and other changes in their metabolism. In humans, such changes are associated with a greater chance of cardiovascular disease (WHO Europe, 1998). Therefore, the association between subordination and greater chance of cardiovascular disease is likely to be more common in vulnerable populations.

Environmental conditions, economic insecurity, and social factors are all important ingredients of health and quality of life. They can also be reasons for social isolation. The stories and concerns that focus group women participants expressed call for the need of social support networks. The section below will highlight the types of desired social support identified by the women participants. We hope that the findings in this section will stimulate some thought on the types of interventions required to help minorities

(particularly women and children) develop social relationships and a sense of belonging to the Manchester community.

I. Social Support

Findings

For the purpose of this paper, social support as applied to pregnancy can be defined as “social relationships, information, nurturance, empathy, encouragement validating behavior, constructive genuineness, instrumental help, or recognition of competence shared between patients, medical personnel, friends, and community groups” (Brown, 1986, in Oakley, 1992:27). Social support can also be seen as a means of facilitating access to community resources in an effort to address problems arising out of deficient social, environmental, and economic conditions.

In the course of conducting the focus groups, participants almost unanimously commented on the need for them to receive greater social support during their pregnancy. This section attempts to address these concerns by documenting the type of social support that participants desire and also documenting the extent to which participants expressed that they utilized existing support services.

Types of social support needed:

Although a few women had the privilege of having family members and friends nearby to support them throughout and after pregnancy, many other women, especially relative to their prior experiences, did not have the social support that they would have liked during their pregnancy. The experience of lacking adequate social support during pregnancy was expressed by all three participating groups. The range of potentially beneficial social support services expressed by focus group participants included:

- 1) Have someone to mentor them through their pregnancy.
- 2) Have someone that they can verify if something they experienced is a normal.
- 3) Have someone to help them with household chores and help them to care for their babies.
- 4) Have someone to interpret for them.
- 5) Have a single parent support group.
- 6) Have a support group to discuss pregnancy and parenting issues.
- 7) Have someone to advise them about financial issues.

Many Latino and African women spoke of the extended family support structure that they enjoyed in their countries relative to the lack of support they received in Manchester. After moving to Manchester, many of these women no longer had the extended family support, and many stressed the need for having a similar type of support here. Below are some of the comments from the Latino and African women:

²¹⁷ "Here, we have to do everything because we are alone."

- 218 "I don't have anybody to help me."
- 219 "In Mexico your family is with you."
- 220 "We don't have anybody."
- 221 "The church hasn't helped us."
- 222 "I haven't received any help."
- 223 "Here you have to do everything because you don't have any family; my mother and grandmother used to help me in Mexico."
- 224 "I didn't have anybody just my husband (and) I cried a lot..."
- 225 "I feel embarrassed to ask for help..."
- 226 "I spent a week by myself because I didn't have anybody."
- 227 "... Those that come from the country that don't speak English (they) need translation... in Africa, when you have a baby everybody is around you; but here, you don't have nobody, you see that, you don't have nobody."
- 228 "... So you come here, at least... that you need an interpreter or you need translation or even if you need somebody to ask questions like she's saying, she wasn't sure if she should take the Tylenol... she needed somebody to say, it was o.k."
- 229 "... I had good pregnancies with my kids, so that made it easy; but, because my relatives are not close by and don't have too many friends, that's what was hard about it."
- 230 "When somebody is pregnant, they should be able to see if she has someone else to mentor her in the community; someone to help her and give her some ideas... the woman may need a mentor. If she chooses to have one; mentoring is a cultural component."
- 231 "Well, because this is the first time. I'm worried... I want somebody to talk to me, even me and my husband. My husband doesn't have any experience... You need somebody to talk to..."
- 232 "Here the culture is different; even your neighbor can't come for you; like you know, nobody can know I have the baby but it is very difficult sometimes. If my husband is working, I'm alone, nobody can come to me you know."

The need for social support was also voiced by the African American women in the focus groups:

²³³ "I think it would be also be helpful for pregnant women, especially in this area for there to be some type of group. Right down to the day care situation; there could be so many people sharing about day cares; there needs to be something. I know they have groups for younger people."

²³⁴ "Basically, my son is six and I don't let him go outside yet because I don't feel he's ready. I'm just nervous about something happening to them; maybe as far as taking turns maybe to sit out with the kids and make sure they're safe and playing. He wants to go outside, so he says so and so is outside. Well so and so mother maybe is not as concerned. I'm really busy with your sister right now. I can't go outside so that you can ride your bike, maybe later or something. So maybe being outside with the kids or also maybe even get together more and do some stuff together like family things with other single parents."

²³⁵ "I don't know who they are for advocates; but I know that maybe what I went through, it would have been nice to be able to have someone I could call and say, is this the norm? Should the doctor have told me, there's nothing I can do for you and he can't believe I'm calling him? Do you know what I mean? Just to get some validation as to know, this is not the way it's suppose to be and if this did happen to you, there are the steps we need to take. Somebody to be some sort of advocate for women. I mean even an educated woman. I'm an educated woman. I'm far from an idiot and there are idiots out there having babies. If I can't figure it out, I know they can't so there's gotta be someone to help figure out--what's appropriate and what's not for the health care community and how they're treating us."

²³⁶ "I think they should have more input even throughout your prenatal classes... I know they're suppose to be shorter but maybe if they could allow an hour maybe or you could do half an hour every session--have an hour prenatal like (and) the half an hour going through and explaining things about the baby or explaining some budgeting stuff or you know just a few extra minutes to just chit chat and talk and you know basically to see things that you could be doing."

²³⁷ "... some parents might need help on finding a good quality child care center, things to look for; you don't want a center that's going to do this and this; you know, ways to teach them about things, about kids, how to find a good pediatrician,..., find a good after school program or a support program or things that are more child related, and things that are

more related for yourself to find how to get yourself into groups and outings; maybe there will be a sewing club on Thursday..."

In addition to the types of needed social support services described above, the focus group women also suggested the following services that they would like to have in the Manchester community:

- A library van on wheel for families who cannot go to a library.
- Transportation service to appointments for people who do not have a vehicle.
- A dentist who accepts Medicaid insurance.
- Someone to help when faced poor quality housing condition problem
- Someone to help immigrants to immerse in the U.S. culture and learn how things operate.
- Lamaze classes for Latino and African women that are held in their native language and taught by a person from their culture.
- Pregnancy clothes.
- Job referral.

Awareness and Utilization of Community Social Support

When the women in the six focus groups were asked what types of community social support have they used, Latino women seemed to be more aware of some of the community social support programs for pregnant women than the African women and African American women. Most Latino women have used the WIC program. However, as discussed in the Cultural Differences section, several of the Latino participants complained that the food in this program was not culturally appropriate. Some Latino women mentioned that they have participated in the Healthy Families program run by the New Hampshire Minority Health Coalition. A few Latino women said that they have also accessed Child and Family Services and interpreters from the Latin American Center. A majority of the Latino women also mentioned that they had not participated in any Lamaze classes hosted in the hospitals because these classes were not available in Spanish. Likewise, African women also expressed the same discontent. African women and Latino women have suggested that they would have gone to these classes had the instructor been from their culture and if the classes were held in their native language. Head Start and Healthy Kids were the only programs used by the African women. Most African women were not aware of the other programs mentioned by the Latino women.

As for the African American women, the only community support program they used was the state assisted program for child care. Perhaps the underlying reason for the lack of the use of existing community support programs is the mother's conflict with full time employment. As a result, these working women would have a difficult time utilizing these community programs during office hours. One African American woman expressed the difficulty for her using such a program with these words:

²³⁸ "Do I know of any kind (of social support program)? No I don't know, but I haven't really looked into it. By the time I get to work, I get to

work probably around 8 o'clock in the morning; by the time I get home, it's like 6 or 7 (pm). It's so late at night. Maybe someone in the neighborhood to keep the kids after school or something like that, that would be nice too. Somewhere close."

Interpretation

Previous studies have shown a strong positive link between social support and health. A century ago, Emile Durkheim demonstrated that suicide rates were greater among populations that were less cohesive (Ichiro, Kennedy, and Lochner, 1997.) More recently in 1979, epidemiologists Lisa Berkman and S. Leonard Syme conducted a nine-year study of 6,928 adults living in Alameda County, CA. The study found that people with few social ties were 2-3 times more likely to die of all causes than were those with more extensive contacts (Ichiro, Kennedy, and Lochner, 1997.) Simkin and Enkin (1989) argued that women living in a traditional environment often shared their birthing experiences, passed information from mother to daughter, and obtained material needs from community midwives. These informal networks of support started to deteriorate as industrialization emerged and brought about increased mobility of the nuclear family. All of these studies suggest the important role of social support in health care intervention. This link should not be undermined when one develops an intervention program that targets women in need of good prenatal care. This section of the report tried to highlight the social support needs voiced by the Latino, African American, and African women. Through better awareness of their problems and concerns (whether they are racial discrimination, language barrier, or financial constraint), one can more effectively address these issues and provide resources to better prenatal care.

References

- Bartley, M. et al (1997). *Health and the Life Course: Why Safety Nets Matter*. British Medical Journal, 314: 1194-1196.
- Bureau of Census (1990 and 2000). www.census.gov/
- CDC, MMWR, December 23, 1994/43(50); 939-942.
- Dobie, Sharon MD, MCP; Hart, L. Gary PhD; Fordyce, Meredith PhD, C; Andrilla, Holly A. MS; Rosenblatt, Roger A. MD, MPH. *Obstetric Care and Payment Source: Do Low-Risk Medicaid Women Get Less Care?* American Journal of Public Health. 88 (1). 51-56. 1998.
- Guendelman, Sylvia; English, Paul B. *Effect of United States residence on birth outcomes among Mexican immigrants: An exploratory study*. American Journal of Epidemiology. 142 (9 SUPPL.). S30-38. 1995.
- Hogue, Carol J. Rowland PhD, MPH; Vasquez, Cynthia MPH. *Toward a Strategic Approach for Reducing Disparities in Infant Mortality*. American Journal of Public Health. WOMEN OF COLOR. 92 (4): 552-556, April 2002
- Hogue, CJ; Hargraves MA. *Preterm Birth in the African American Community*. Seminars in Perinatology. 19 (4). 255-62. 1995
- Hogue, CJ; Hoffman S; Hatch MC. *Stress and Preterm Delivery: a conceptual framework*. Pediatric and Perinatal Epidemiology. 15 Suppl 2:30-40. 2001
- Krieger JW; Cornell FA; LoGerfo JP. *Medicaid prenatal care: a comparison of use and outcomes in fee-for-service and managed care*. American Journal of Public Health. 82 (2). 185-90. 1992
- National Vital Statistics Report, 1999, 2002.
- Oakley, A. 1992. Social Support and Motherhood. Blackwell Publishers, United Kingdom.
- Seattle and King County Public Health (January, 2001). Public Health Special Report: Racial and Ethnic Discrimination in Health Care Settings. Public Health—Seattle & King County, Epidemiology, Planning, and Evaluation Unit, 999 Third Ave, Suite 1200, Seattle, WA 98014-4039.
- Siega-Riz, Anna Maria PhD, RD; Bodnar, Lisa M. MPH, RD; Savitz, David A. PhD. *What are pregnant women eating? Nutrient and food group differences by race*. American Journal of Obstetrics and Gynecology. 186 (3). 480-486. 2002.
- Smith, Davey et al (1997). *Lifetime Socioeconomic Position and Mortality Perspective Observational study*. British Medical Journal, 314: 547-552.

Wunch, G. et al (1996). *Socioeconomic Differences in Mortality: A Life Course Approach*. European Journal of Population, 12: 167-185.

World Health Organization Europe (1988). Social Determinants of Health: The Solid Facts. Edited by Richard Wilkinson and Michael Marmot.

Zambrana, Ruth E. PhD; Scrimshaw, Susan C. M. PhD; Collins, Nancy PhD; Dunkel-Schetter, Christine PhD. *Prenatal Health Behaviors and Psychological Risk Factors in Pregnant Women of Mexican Origin: The Role of Acculturation*. American Journal of Public Health. 87 (6). 1022-1026. 1997.