

CULTRALLY COMPETENT HEALTHCARE in HISPANIC WOMEN

A RESEARCH PAPER

SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

MASTER OF SCIENCE

BY

FARRAH TAYLOR

DR. NAGAI ALI – ADVISOR

BALL STATE UNIVERSITY

MUNCIE, INDIANA

MAY 2014

Table of Contents

Table of Contents	i
-------------------------	---

CHAPTER I: INTRODUCTION

Introduction.....	1
Background and Significance	2
Theoretical Framework	3
Statement of Problem	4
Purpose of the Study	4
Research Questions	4
Definition of Terms.....	5
Limitations	5
Assumptions	5
Summary	6

CHAPTER II: REVIEW OF LITERATURE

Introduction	7
Organization of literature	7
Perception of Culturally Competent Care	7
Latinas and Abortion	10
Access to Prenatal Care	15
Perception of Patient Centeredness	16
Culturally Competent Nursing Care	18
Centering Pregnancy	21
Social Support	26

Cultural Health Practices	28
Prenatal Depression	31
Risk Factors for Prenatal Depressive Symptoms	34
Reproductive Health	37
Utilization of Prenatal Care	39
Summary	42
Chapter III	
Introduction	44
Research Questions	44
Population, Sample, and Setting	45
Protection of Human Rights	45
Methods/Procedures	46
Reliability and Validity	47
Instrumentation	48
Data Collection	49
Research Design	49
Method Data Analysis	49
Summary	49
References	50

CHAPTER I

Introduction

When a person goes to the doctor or hospital they expect to be treated appropriately for their medical conditions, but they also would hope to be treated with regards to their cultural beliefs, norms, and values. Providing culturally competent care to patients should be on the priority list for healthcare providers. It is difficult for healthcare providers to know all cultures represented in the United States, but healthcare providers should become familiar with the cultures that are most represented. Culturally competent care is defined by Wanda (2000) as “a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups” (Wanda, 2000, p. 203). In order to provide culturally competent care, the health care professional needs to have the knowledge and understanding of their patient’s culture.

The Hispanic/Latino population is rapidly growing in the United States, especially the Mexican subgroup. The US Census (2012) shows the Hispanics in the United States is 49,972 with the subgroup of Mexican making up 32,539. This study focused on the Hispanic population in Butler County Ohio. According to the 2012 US Census, the Hispanics in Butler County makes up 3.8% of the total population. Census data were not broken down in Butler County as to subgroups. The percentage of Hispanics may be even higher than 3.8% when one takes into account those individuals not report status (Wanda, 2000). Since the number of Hispanics are growing, it is vital that healthcare providers become familiar with the health practices, beliefs, norms, and values of the Hispanic culture. This study will focus on the Hispanic pregnant women and their views of culturally competent care and desire for social supports. The subgroup that will be studied is the Mexican and Mexican American group.

Background and Significance

When providing care to Mexican/Mexican American women it is important to know that they value family and social organizations. Mexican/Mexican American women believe in environmental control, which is the “perception of a person’s ability to plan the activities that control nature and direct aspects of the environment” (Eggenberger, Grassley, & Restrepo, p. 3). Healthcare providers should be aware of the fact that Mexican/Mexican American women may have particular health beliefs, such as folk medicine and examining locus of control. Having the knowledge of these cultural beliefs, norms, healthcare practices, and values will assist the healthcare provider in providing culturally competent care.

There has not been much research done on culturally competent care and desire for social support in Mexican/Mexican American pregnant women. There have been a few studies completed about both topics separately, but a limited amount on both. Studies such as Eggenberger et al. (2006) study of Culturally Competent Nursing care for families: Listening to the voices of Mexican-American women talks about both culturally competent care and social supports. Other study, such as Wanda (2000) study, was focused on Mexican Americans' Perceptions of Culturally Competent Care. Flueriet (2009) focused on problems in the Latina paradox: measuring social support for pregnant immigrant women from Mexico. All of the literature reviewed for this study has some aspect of culturally competent care and social support for the Mexican/Mexican American pregnant woman. The significance of this study is to bring to the forefront the need for culturally competent care in Mexican/Mexican American pregnant women. Providing culturally competent care starts with healthcare providers educating themselves on what patients need, want, and value. Interviewing Mexican/Mexican American pregnant women will bring knowledge and understanding to those working with them.

Theoretical Framework

The theoretical framework that will guide this study will reflect Giger and Davidhizar's Transcultural Assessment Model (2002). The Transcultural Assessment Model was created to assist nursing students and undergraduate programs in assessing and providing care to patients from other cultures. The Transcultural Assessment Model "postulates that each individual is culturally unique and should be assessed accordingly" (Giger & Davidhizer, 2002, p. 185). There are six phenomenon identified in the model: communication, space, social organization, time, environmental control, and biological variations. Communication is the means in which culture is transmitted and preserved. Space is the distance between people during interactions. A social organization is how a cultural group organizes itself around family. Time can be past, present, or future for a culture. If a culture is not focused on future, preventive medicine may not occur. Environmental control looks at the ability of a person to control nature. Biological variations look at the genetic variations a culture may have. The metaparadigm for the Transcultural Assessment Model is:

1. Transcultural nursing: A culturally competent practice field that is client centered and research focused.
2. Culturally competent care: A dynamic, fluid, continuous process whereby an individual, system, or health care agency finds meaningful and useful care delivery strategies based on knowledge of the cultural heritage, beliefs, attitudes, and behaviors of those to whom they render care. Cultural competence connotes a higher, more sophisticated level of refinement of cognitive skills and psychomotor skills, attitudes, and personal beliefs. To develop cultural competency, it is essential for the health care professional to use knowledge gained from conceptual and theoretical models of culturally appropriate care. Attainment of cultural competence can assist the astute nurse in devising meaningful interventions to promote optimal health among individuals regardless of race, ethnicity, gender identity, sexual identity, or cultural heritage.
3. Culturally unique individuals: An individual is culturally unique and as such is a product of past experiences, cultural beliefs, and cultural norms.
4. Culturally sensitive environments: Culturally diverse health care can and should be rendered in a variety of clinical settings. Regardless of the level of care, primary, secondary, or tertiary knowledge of culturally relevant information will assist in planning and implementing a culturally competent treatment regime.

5. Health and health status: Health and health status is based on culturally specific illness and wellness behaviors. An individual's cultural beliefs, values, and attitudes all contribute to the overarching meaning of health for each individual. (Giger & Davidhizer, 2002, p. 187)

Statement of Problem

The Hispanic culture, is very diverse with multiple groups making up the Hispanic population. In the Hispanic culture family, religion, and cultural practices are very important. This study will replicate portions of two studies, Fleuriet's study (2009) and Wanda's study (2000). Fleuriet's study (2009) title is "Problems in the Latina Paradox: Measuring social support for pregnant immigrant women from Mexico." Wanda's study's (2000) title is "Mexican Americans' perception of culturally competent care." Hispanic, specifically Mexican/Mexican American, pregnant women are not receiving the culturally competent care in the United States. These pregnant women are not able to utilize the social supports that they once did when living in Mexico. Without culturally competent care and social support, the Mexican/Mexican American pregnant woman may have increased depression, lack of prenatal care, and possible complications with the pregnancy and delivery. This problem can be addressed with education being provided to healthcare providers who are responsible for taking care of these patients.

Purpose of the Study

The purpose of this study is to determine how pregnant Mexican/Mexican American women view culturally competent care and their desire for social support during pregnancy.

Research Questions

1. What do Mexican/Mexican Americans believe are the most important areas that nurses should strive to when providing health care?
2. What are the barriers Mexican/Mexican Americans perceive to affect culturally competent care?

3. Do Mexican/Mexican American women desire social support during pregnancy?
4. How important is social support to Mexican/Mexican American women?

Definition of Terms

Culturally Competent Care

Culturally Competent Care is defined by Eggenberger et al. (2006) as “a process where a nurse continually strives to effectively deliver care within the cultural context of an individual, family, and community by seeking cultural awareness” (p.2).

Social Support

Fleuriet (2009) defines social support as “specific emotional, instrumental, and informational resources provided by a recognized social network” (p. 50).

Limitations

The limitations for this study are small group of participants and lack of eligible participants. The study is limited to participants from Butler County Ohio. Participants are only recruited from the Early Head Start program; therefore, may not be adequate number of participants for the study. The study is specific to pregnant women and there may not be adequate number of pregnant women enrolled in the Early Head Start program during the time the study is conducted.

Assumptions

1. Surveys and interview methods will accurately reveal Mexican/Mexican Americans perceptions of culturally competent care.
2. Participants will provide honest responses to the surveys and the interviews.
3. Collected data will be used to educate healthcare providers on what Mexican/Mexican American pregnant women view as culturally competent care.

4. Collected data will be used to educate healthcare providers on the desire of Mexican/Mexican American pregnant women to have social support during pregnancy.

Summary

Knowledge is a key to providing culturally competent care to any culture. By replicating Fleuriet (2009) and Wanda (2000) studies, knowledge identified from this study will be given to healthcare professionals. The Mexican/Mexican American pregnant women may not be receiving the culturally competent care they deserve. The lack of culturally competent care can lead to problems with the pregnancy and delivery. This study will identify information on how Mexican/Mexican American pregnant women view culturally competent care, what they perceive as the barriers, if they desire social support during pregnancy, and how social support can help them. With a growing population of Mexican/Mexican Americans, it is important to address culturally competent care.

Chapter II

Literature Review

Introduction

This literature review covers selected studies pertaining to culturally competent care for Hispanics, focusing on Hispanic, Mexican women. All the were related to how Hispanic women viewed the care received or how the staff gave the care. The studies also looked at the cultural aspects that should be taken into consideration when working with diverse cultures. Overall the women in all the studies had one recurring theme, they wanted the staff to communicate with them in their native language and be sensitive to their cultural norms.

Mexican American cultures have different values and beliefs regarding care. It is important to understand both nurses' and Mexican American patients' perceptions of care to bridge the gap between cultures. The study by Wanda (2000) identified culturally competent care concepts from the perspective of Mexican Americans. The researchers looked at four areas of concern; family, spirituality, communication, and health beliefs and practice.

Wanda (2000) proposed the research questions posed were: What do you believe are the most important areas that nurses should attend to when providing health care to Mexican American? In cases where the nurse has sensitive or unpleasant information to communicate to the person/family, what communication process should the nurse use to relay the information?

The study was conducted between February and April of 1996. Subjects were recruited from community organizations and churches in the San Francisco bay area. The population in this study was Mexican American 18 years or older who had received care in the last year or who were receiving care in the United States. Twenty-two Mexican Americans ranging in age from 27-73, with a mean age of 38 participated in the study. Adequate distributions of age groups

were obtained. All participants in the study varied in their health status. Participants were placed into 4 focus groups.

Focus group one consisted of five registered nurses (4 female and 1 male), the second focus group consisted of four males, the third focus group consisted of three males and three females, and the fourth focus group consisted of seven females. Each group was given the option of having the group in either English or Spanish, but the group had to all use the same language. To be included in this study, the participants had to be Mexican American, 18 years or older, either received care in the past year or currently receiving care in the United States, and they had to speak either English or Spanish. Focus group interviews were conducted for the data in this study. The focus groups were specific in gender to help reduce the cultural norm of machoism. Machoism is evident when the male in the culture is dominant over the female. To make sure that the women could speak freely, the groups were divided by gender. The nurses were placed in a separate group to assure that the participants would not be uncomfortable answering questions related to health care.

Reliability and validity were established for demographic Questionnaire and the Short Acculturation Scale. A Semi structured interview guide was given and used to elicit information by asking open ended questions. The open-ended questions asked were: “What do you believe are the most important areas that nurses should attend to when providing health care to Mexican Americans” (Wanda, 2000, p. 208)? “In cases where the nurse has sensitive or unpleasant information to communicate to the patient/family, what communication process should the nurse use to relay the information” (Wanda, 2000, p. 208)?

For analysis purposes, the interviews were audio-taped and transcribed into a line-by-line format. To organize the experiences of the participants, grounded theory was used. There were

three different coding methods used to analyze data. Open coding was used once the interviews were transcribed. “The process of open coding was used to deconstruct, examine, and conceptualize the data” (Wanda, 2000, p208). Axial coding was completed after the open coding was done. The axial coding was used to look at the “description of the attitudes or characteristics that pertained to each of the categories” (Wanda, 2000, p. 208). After the axial coding was done the theoretical schema was developed.

Demographic data that were collected included age: educational level, income level, acculturation level, and marital status. Educational level showed 50% of participants had less than an eighth grade education, 9% of participants listed “none” for educational level, and the five registered nurses represented who had an above eighth grade education. Income level showed that 58% were low income and mainly housewives and blue-collar workers. Acculturation level showed that 82% were low acculturation level. Eighty percent were born in Mexico, and the mean number of years living in the United States was 14.5 years. Marital status indicated that 64% were married or living with a partner (Wanda, 2000).

The participants identified areas that the nurses should attend to when providing health care. The areas that were most noted were language and cultural competence. The participants believed had a better experience when staff spoke Spanish, even if were not fluent in Spanish. Also participants believed care was better when the nurses/staff were culturally sensitive to norms. For example, one participant noted that when the doctor gave participant information about the medication, the physician gave participants some home remedies that may be useful. This was comforting to the participant who was use to using home remedies more commonly. To answer the question about communicating sensitive information, the participants preferred it to be in their native language (Wanda, 2000).

Barriers identified to health care included economic constraints, limited knowledge of health care system and health care practices, and monolingual fluency in Spanish. Due to the presence of some barriers perceived by Mexican Americans, nurses need to have better cultural education and communication to help make patients more knowledgeable and comfortable (Wanda, 2000).

There is a gap in knowledge when it comes to knowing about Latina women and abortion. Latina women have abortions, but the reasons for having an abortion are not known. Kaplan, Erickson, Stewart, and Crane (2001) studied cultural factors, reproductive behavior, and alternative roles to motherhood to see how the factors affected the abortion rates.

The purpose of this study was to determine the correlation between cultural factors, reproductive behaviors, and alternative roles to motherhood and abortion use among Latina women. Kaplan et al. (2001) tested the following hypothesis:

1. More acculturated Latina women will be more likely to use abortion for fertility control when faced with an unintended pregnancy than those who are less acculturated.
2. Young women who have less traditional beliefs about women's roles will be more likely to have abortion than those holding more traditional values.
3. Past reproductive experiences that increase exposure to an unwanted pregnancy and high number of pregnancies will be associated with higher reported use of abortion.
4. Women who participate in activities that offer concurrent or alternative roles to motherhood will be more likely to report past abortion (Kaplan et al., 2001, pp. 671-673).

The study was conducted in Los Angeles County between May 1992 and March 1993. Participants were recruited from two publically funded family planning clinics. The researchers were looking for participants between the ages of 14-24. All adolescents receiving services at the clinics were approached to participate in the study. Only 25% of the participants was selected randomly. Young Latina women (n=1,390) were interviewed. Because the study was to be restricted to women who had abortions, the study yielded a total sample of 1,202 (78%). Sample characteristics included: age, education, marital status, and country of birth represented

the demographic indicator, N=1,307. Age: less than 17 was 20.4%, 18-19 was 25.2%, 20-21 was 19.9% and 22 and older was 34.5%. The mean age was 20.0 with a standard deviation of 2.6. Education of 6 years or less was 29.6%, 7-11 years was 56.8%, and 12 years or more was 13.6%. Mean years of education was 8.4 with a standard deviation of 2.8. Marital status was identified as 33.6% and not married was 66.4%. Country of birth, foreign born was 91.5% and U.S. born was 8.5% (Kaplan et al., 2001).

The researchers used the following demographic indicators: age, education, marital status, and country of birth. The cultural factors were measured using the language-based acculturation scale. This scale measures beliefs about women's roles within the family and familism. Linguistic acculturation was also measured. Kaplan et al. (2001) used the Hispanic Health and Nutrition Examination Survey (HHANES) to determine the Linguistic Acculturation, where participants responded to 11 items to determine if they preferred to read, write, and speak in English or Spanish. The scale was 0 to 4, 0 being Spanish only and 4 being English only. Cronbach's alpha reliability was 0.9.

The National Longitudinal Survey of Youth was used to assess a woman's role within the family. Participants responded to five statements with either an agree, disagree, or no opinion. The answers were combined into a single scale from 1 to 3, 1 being very traditional to 3 being less traditional. Cronbach's alpha reliability was 0.8.

To examine familism the participants responded to eight items about obligations to support family members, Cronbach's alpha reliability of 0.51. Reproductive-related behavior variables were also assessed. Variables included whether contraception was used at the last sexual intercourse, number of sexual partners, number of pregnancies, number of live births, and

number of years respondent had been sexually active. Participants were asked about involvement in work or enrollment in school or both (Kaplan et al., 2001).

A correlation was done to determine relationship between the cultural-related scale parts. Bivariate analyses were used. A p-value of .05 was used for statistical significance. When assessing cultural factors, reproductive indicators, and alternative roles to motherhood a logistical regression was used to assess past reported abortions (Kaplan et al., 2001).

The cultural indicators included acculturation, beliefs about women's roles, and familism scale. Findings from the Acculturation scale were: Spanish orientation 75.5% and English orientation 24.5%, with a mean of 1.9 and a standard deviation of 1.0 Findings about beliefs about women's roles were: traditional was 37.0%, medium was 37.4%, and nontraditional was 25.6%, with a mean of 1.9 and standard deviation of 1.0 (Kaplan et al., 2001).

Findings from the Familism scale were: traditional 70.2% and nontraditional 29.8% with a mean of 6.0 and standard deviation of 2.1. Reproductive indicators were also assessed. Findings for the number of pregnancies were: one 50.5%, two 32.6%, and three or more 16.9% with a mean of 1.7 and a standard deviation of 0.9. Number of live births was reported as: zero 1.6%, one 58.7%, two 29.2% and three or more 10.5%, with a mean of 1.5 and standard deviation of 0.7. Number of abortions was reported as: zero 92.5%, one 6.8% and two or more 0.7%. Length of sexually active life results were: two years or less 39.4%, three-five years 41.7%, and six or more 18.9%, with a mean of 3.5 and standard deviation of 2.2. Number of sexual partners was: one 73.9%, 2 were 17.2%, and three or more 8.9 with a mean of 1.4 and standard deviation of 0.9. Used method of birth control was: no method 30.2% and any method was 69.8%. Alternative roles to motherhood; School/working participation was: no participation was 56.8% and school/work 43.2% (Kaplan et al., 2001).

Other findings related to demographic indicators, cultural indicators, reproductive indicators, and alternatives to motherhood were assessed. Age of less than 17 had 20.6% no abortion, and 17.8% abortion. For the 18-19 years old, 25.3% had no abortion and 23.3% abortion. For the 20-21 years old, 20.0% had no abortion and 18.9% abortion. For the 22 and older, 34.1% had no abortion and 40.0% abortion. There was a mean of 20.0 and standard deviation of 2.7 for no abortion and 20.3 and standard deviation of 2.5 for abortion. Those with an education of 6 or less years 30.4% had no abortion and 18.9% abortion, 7-11 years 56.2% had no abortion and 64.4% abortion; 12 or more years 13.4% had no abortion and 16.7% abortion. A Mean of 8.3 and standard deviation of 2.8 for those who had no abortion and 9.1 and standard deviation of 2.6 for abortion was noted. As for marital status, of those who indicated they were married 33.8% had no abortion and 31.1% had an abortion, and not married 66.2% no abortion and 68.9% abortion. Nation of birth noted that those who were foreign born 92.2% had no abortion and 83.1% had an abortion, U.S. born 7.8% had no abortion and 16.9% had an abortion (Kaplan et al., 2001).

Acculturation was reported as Spanish orientation 76.3% no abortion and 65.2% abortion. Beliefs about women's roles were traditional 38.0% no abortion and 23.4% abortion, Medium 38.1% no abortion and 28.6% abortion, nontraditional 24.0% no abortion and 48.1% abortion. A mean and standard deviation for no abortion was 1.9 and 0.6 and mean and standard deviation for abortion was 2.1 and 0.7 (Kaplan et al., 2001).

The familism scale was traditional 71.1% no abortion and 59.3 abortion, and nontraditional 28.9% no abortion and 40.7% abortion. Number of pregnancies were one 54.0% no abortions and 7.8% abortion, two 31.7% no abortion and 43.3% abortion, and three or more 14.3% no abortion and 48.9% abortion. Number of live birth were 0 0.4% no abortion and

15.6% abortion, one 59.7% no abortion and 46.7% abortion, two 29.5% no abortion and 25.6% abortion, and three or more 10.4% no abortion and 12.2% abortion. Length of sexually active life were 2 or less years 40.6% no abortion and 24.4% abortion, 3-5 years 41.1% no abortion and 48.9% abortion, and 6 or more years 18.3% no abortion and 26.7% abortion (Kaplan et al., 2001).

The used method of birth control was no method, 30.7%, no abortion, and 24.4 abortion, any method 69.3% no abortion and 75.6% abortion. Number of sexual partners were one 76.2% no abortion and 44.9% abortion, two 16.3% no abortion and 29.2% abortion, and three or more 7.5% no abortion and 25.8% abortion. School/working participation were no participation 57.7% no abortion and 45.6% abortion, school/work 42.3% no abortion and 54.4% abortion.

The hypotheses in this study were not supported. Acculturation did not affect the number of abortions as originally thought. Family loyalty did not play a role in the choice to abort or not as previously thought. The variables that predicted abortion most strongly were number of pregnancies, number of lifetime sexual partners, and length of sexually active life (Kaplan et al., 2001).

1. Chi-square shows that there were was not a significant finding that more acculturated Latina women would be more likely to use abortion for fertility control when faced with an unintended pregnancy than those who are less acculturated
2. T-test showed that young women who have less traditional beliefs about women's roles were not more likely to have abortion than those holding more traditional values.
3. Past reproductive experiences did not increase exposure to an unwanted pregnancy and high number of pregnancies will be associated with higher reported use of abortion.

4. Women who participate in activities that offer concurrent or alternative roles to motherhood were not more likely to report past abortion

Kaplan et al. (2001) looked at factors that would cause Latina women to obtain abortions. Only part of the authors' hypothesis was shown to be supported. Latina women were more acculturated did not have more abortions, then those who were less acculturated. Younger women were not the most likely group to get abortions, all ages were having abortions. There was support for the idea that Latina women were getting abortions due to unwanted pregnancies. Latina women and American women both participate in abortions even though abortions are illegal in the countries in which they live. Most commonly abortions are completed due to unwanted pregnancies, cases of rape or incest, and in cases where the mother's life is in danger.

It is not known what influences women to access prenatal care. Along with accessing prenatal care, receive culturally competent care. Since women who move to the United States have cultural practices that are to be followed, culturally competent care is important for healthcare providers to provide. The purpose of Shaffer's (2002) study was to examine the factors that influence access to prenatal care for Hispanic women. Shafer (2002) describe the care received as culturally sensitive, accessible, and provided in Spanish.

A convenience sample of 46 Hispanic women was recruited from local county clinics and teaching hospital clinics over a 12 month period. The participants were interviewed either in person or by phone. The only data collected were from telephone interviews. The participants were asked five open ended questions. The questions were as follows: (1) How many weeks pregnant were you when you began coming to the clinic? (2) What was it that influenced you to attend the prenatal clinic? (3) How many pregnancies have you had? How many were born alive? How many of your children died in the first year of life? (4) In what country were you

born? (5) tell me about the experience you have had in clinic where they don't speak Spanish. The responses were recorded on the interview sheet (Shaffer, 2002).

All the women in the study were foreign born. They ranged in age from 18-45 years, with the mean age being 24. Out of the 46 participants, 34 had past pregnancies and 20 of those children currently living, 7 died in infancy, and 7 were spontaneous abortions. The women were in the US ranging from 2 weeks to 4 years. Sixteen started prenatal care in their first trimester, 23 started in their second trimester, and 7 started in their third trimester (Shaffer, 2002).

All 46 participants noted that having a Spanish speaking person available was a major influence in receiving prenatal care. About half (22) of the participants mentioned that having a bilingual staff member demonstrating cultural sensitivity was another significant factor. Availability of prenatal care was the third significant factor. A fourth (13) of the participants noted that there were some limitations, such as transportation and appointment availability that effected them accessing prenatal care (Shaffer, 2002).

Spanish speaking women need to have providers who speak Spanish. Culturally competent care needs to be available for clients. Barriers that affect Spanish speaking women from getting care should be diminished, so that the women are able to get the care she needs.

Prenatal care is an important area of prevention in women. Women from other cultures are having trouble receiving culturally competent care here in the United States. Hispanic women have identified in previous studies that they did not feel that they received the kind of care they desired. Tandon, Parillo, and Keefer (2005) had three areas of concern: how many Hispanic women received patient-centered care, if Hispanic women were less likely to have received patient-centered care, and to determine how Hispanic women viewed patient-centered care.

Tandon et al. (2005) set out to recruit a stratified random sample of 427 mothers, 369 initiating prenatal care in the first trimester, and 70 initiating prenatal care in the third trimester. The participants would have delivered at one of the areas 10 Palm Beach county maternity hospital in 2002, over a 2 month period of time. Over the 2 month period, interviews were conducted at each hospital. After recruiting efforts were made, the sample consisted of 359(88%) of women who initiated prenatal care in the first trimester, and 68(83%) of women who initiated prenatal care in the third trimester.

Two semi-structured interviews were completed. One interview was specific to women who had initiated prenatal care in the first trimester and a separate interview was conducted for women who initiated prenatal care in the third trimester. Questions asked during the interview were:

1. Did doctors or nurses treat you with respect during your prenatal care appointments?
2. Did other office staff treat you with respect during your prenatal appointments?
3. Did you have language or communication problem with your doctor or nurse during your prenatal care appointments? (Tandon et al., 2005).

The answers to these questions were a yes or no.

A Chi-square and ANOVA were used to “assess comparability of mothers from different racial/ethnic groups of seven key demographic variables” (Tandon, 2005, p. 314) The demographic variables were: level of education, marital status, insurance status, age, pregnancy history, trimester of prenatal care initiation, and number of months living in the US.

The data were collected and analyzed. The authors were looking to see how the Hispanic women believed healthcare providers were treating them personally. The authors examined the perceived respect and language barrier.

The results showed that 86% of Hispanic mothers believed that the staff treated with respect during prenatal care. When it came to communication, 27% of Hispanic mothers experienced communication problems. The Hispanic women identified communication as most challenging portion of prenatal care. The women received respect from staff for the most part, but overall did not feel that doctors were as patient-centered as would have liked. We as a profession need to be more conscious of our communication and patient-centeredness, not only with Hispanic clients but will all of (Tandon et al., 2005).

Culturally competent care is extremely important when dealing with any client. The authors found that there are still some gaps in the culturally competent care of Hispanic women. Identifying the needs of a client can benefit both the client and the healthcare provider. Being respectful and communicating with a client in their preferred language will make the healthcare system better and the care of the clients better as well.

The Mexican-American population continues to grow in the United States. Hispanic women have been identified as a medically underserved group by the Centers for Disease Control (CDC). Because the Hispanic women have been identified as underserved, it is important to look deeper into why this is true (Eggenberger et al., 2006).

Eggenberger et al. (2006) completed research as part of a doctoral class they were taking. The authors wanted to “increase awareness of Mexican-American cultural phenomena and guide nurses in providing culturally competent nursing care that meets the needs of Mexican-American women and their families” (Eggenberger et al., 2006, p. 2). The authors wanted to look at how Mexican-Americans view social organization which includes family, and environmental controls such as locus-of-control, health beliefs, and folk medicine.

Eggenberger et al. (2006) chose Giger and Davidhizar's Transcultural Assessment Model as their theoretical framework for this study. The model includes six cultural phenomena: communication, space, time, biological variations, social organization, and environmental control. The authors focused on only two cultural phenomena for this study social organization and environmental control.

Social organization looks at the groups in the social environment that influences cultural development and identification (Eggenberger et al., 2006). The family is the focus of social organization. Environmental control focuses on locus-of-control, health beliefs, and folk medicine. Locus-of-control looks at how a person perceives their ability to control what happens to them and their health. Health beliefs affect the health practices, use of health resources, and responses to experience of health and illness. Folk medicine is the last component. This involves alternative therapies like the use of herbs and visiting folk healers.

Participants were recruited at two senior citizens centers in Texas. The senior citizen centers were located in primarily Mexican-American populated areas of Texas. Permission was obtained through the Internal Review Board at the authors' educational institution. A convenience sample of six bilingual women was involved in the study. The age range of women was 64-84 years of age, with a mean age of 71 years old. All six participants identified themselves as Mexican-American and were born in the United States (Eggenberger et al., 2006).

A semi-structured guide was used to look at health beliefs. The interview questions were submitted to content experts for review before using. With feedback from content experts the questions were revised and prepared for use. There were four investigators who conducted the interviews. The participants were asked to give consent for their participation. The answers to

the questions were written verbatim as participants answered. No audio recording was done during the interviews (Eggenberger et al., 2006).

The results of the interviews were as follows: social organization family shows that family was a significant group for Mexican-Americans. Family was defined as the nuclear and extended family. The participants noted that they were close to their families, that they had taken care of grandchildren and their children had moved close to them to help with their healthcare needs. Under social organization the authors also looked at male and female roles. Results showed that women are to be self-sacrificing in the relationship. The women are to take care of the family, and the men are to make the decisions.

Under environmental control, locus-of-control was an area that authors looked at. The participants noted that their faith played a part in their lives. Many participants talked about prayer helping them, and saying that God would take care of them. Participants also believed that physicians could help with their healthcare needs. Internal locus-of-control was also discussed by the authors. Participants stated that they themselves had control over what happened to their health. Health beliefs are also part of environmental control. Eggenberger et al. (2006) noted that “Mexican-American belief that health occurs when there is a balance between forces of hot, cold, wet, and dry” (p. 14). The authors were not able to make a connection with this and the participants. The authors note that it may be because participants were too acculturated to believe this. Folk medicine was the last area looked at in environmental control. The authors did determine that participants did still use herbs in their lives to deal with illness. Participants discussed using mint tea, chamomile tea, tamolindo a common herb used in Hispanic culture, and cinnamon.

Through the interview process and the analysis, the authors showed that family, religion, and locus-of-control are important to health beliefs, attitudes, and lifestyle practices of the Mexican-American culture. Knowing how the Mexican-American views on family, religion, and locus-of-control can help nurses and other healthcare providers better care for the group. To be culturally competent in healthcare, healthcare providers should focus on family and extended family. Also taking into account religion and use of folk medicine can give healthcare providers to a better understanding of how to treat Mexican-American clients. Overall the more you know about your clients, the more culturally competent the care will be (Eggenberger et al., 2006).

With an increase in the number of pregnant women from varying cultural backgrounds nurses need to rethink the prenatal care given. Some problems that may be identified with women using traditional care are that they may have problems in several areas: self-esteem, knowledge of pre and postnatal care, behaviors that are related to health during pregnancy, breastfeeding, and depression. The infants of the mothers may also have low birth weight, premature delivery, or higher incidence of cesarean deliveries. Robertson, Aycock, and Darnell study (2009) was done to compare these areas in both the Centering Pregnancy Model and Traditional Care. The purpose of this study was to compare the maternal and infant outcomes using the Centering Pregnancy Model (CPM) and traditional care in Hispanic women. When examining the two forms of care for the pregnant women, the researchers examined a number of different things. Robertson et al. (2009) examined the woman's level of self-esteem, knowledge of pre and postnatal care, what behaviors were related health during her pregnancy, whether the women breastfed or not, and if there were any signs of depression. The researchers also looked at the outcomes of the infants. Were the infants born prematurely, what were their birth weights, and were there any complications during the delivery. Centering Pregnancy Model is carried out

when women are given the opportunity to meet in support groups in addition to traditional care. This has been found to be a benefit to women in minority groups who may not have much social support.

The research questions posed by Robertson et al. (2009) were:

1. Will Hispanic women in CPM have better self-esteem, prenatal/postnatal care knowledge, pregnancy related health behaviors, breastfeeding practices, higher satisfaction, and lower depressive symptoms compared to women with traditional prenatal care?
2. Will Hispanic women in CPM have better infant birth weights, less preterm deliveries, less cesarean deliveries, and shorter hospital stays compared to women in traditional care? (Robertson et al., 2009)

The population is made up of Hispanic women who are receiving prenatal care at hospitals that offer CPM. The women were given the opportunity to choose which group they wanted to be in, either the CPM or the traditional. Twenty four women selected CPM and 25 women selected traditional. Data were collected from the participants at three points at the initial contact, when women were 34-36 weeks gestation, and postpartum (Robertson, 2009). The criteria used to select women for this study were as follows: self-identified as Hispanic in their Ethnicity, 18 years or older, and the ability to read and speak English to Spanish. To assure the adequate exposure, the participants had to have had at least four visits in either the CPM or Traditional care. The participants also must be at least 24-26 weeks gestation.

Pregnancy History Scale determined age, due date, past and present pregnancy information, education, employment, financial support, and relationship status. The mean age of participants in the traditional group was 26.5, and 24.6 in the traditional care group. The mean age of the

partners was 29.4 for the traditional group, and 26.8 for the CPM group. The length of time in the relationship was 4.7 years for the traditional group, and 4.6 years for the CPM group. The number of living children was 1.56 for the traditional group, and 0.83 for the CPM group. Number of other pregnancies was 1.88 for the traditional group, and 0.87 for the CPM group. When it came to educational level 3 (16%) of the traditional group had an education less than high school, and 16 (84%) with education high school or higher. In the CPM group 6 (33%) were identified as having less than a high school education, and 12 (67%) had a high school or higher education. When talking about employment status, the traditional group had 8 (33%) working and 16 (67%) not working, the CPM group had 5(21%) working and 19(79%) not working. In the traditional group, 9 (38%) of the participants indicated this pregnancy was planned, and 15(63%) were not planned. The CPM group had 13(57%) indicated this as a planned pregnancy, and 10(44%) as not planned. Additionally, for marital status 21 (88%) of the traditional group was either married or living with significant other, or 3 (13%) per single/separated/divorced. For the CPM group, 22 (92%) were married or living with significant other, and 2 (8%) were single/separated/divorced (Robertson et al., 2009)

The Rosenberg Self-Esteem Scale was used to assess self-esteem in participants. This was completed at both the initial contact meeting and at postpartum. For this scale, there were 10 items that the participants had to answer using a 4 point Likert scale. Scores ranged from 10 to 40, with a reliability range from 0.84 to 0.92, with good validity identified. On average prenatally the traditional group scored 31.0, and the CPM group scored 31.3. Postnatal, the traditional group scored 33.2, and the CPM group scored 29.9 (Robertson et al., 2009)

The Center for Epidemiologic Studies Depression Scale (CES-D) was used to assess depression. This was completed with participants during the postpartum period. The CES-D

consisted of 20 items with a 4 point Likert scale. The scores ranged from 0 to 60 with a score of 16 or greater, indicating a high level of depression. The reliability score was 0.90 with good validity. The results of the CES-D were: in the postnatal period the traditional group had mean score of 13.1, while the CPM group had a mean score of 10.3. (Robertson et al., 2009)

The Patient Participation and Satisfaction Questionnaire (PPSQ) was used to determine the level of satisfaction with prenatal care. This questionnaire was administered in the postpartum period. The PPSQ used a 4 point Likert scale to gather data from 22 items. The scores ranged from 25 to 125, with a higher score indicating a greater level of satisfaction. The reliability score for this questionnaire ranged from 0.83 to 0.97 with good validity. The results of the PPSQ were the traditional group had a mean score of 109.0, and the CPM group had a mean score of 110.0 (Robertson et al., 2009).

The Prenatal/Postnatal Care Knowledge Scale was used to assess the participants knowledge in several different area: nutrition, labor, baby care, breastfeeding, and general maternal/infant care. This scale consisted of 19 items with a possible score range of 0 to 100. The reliability was 0.59 for this scale. For knowledge during the prenatal period, the mean score for the traditional group was 55.5, and for the CPM it was 58.1 (Robertson et al., 2009).

The Pregnancy Relevant Health Behavior Scale is a 20 item scale that measures how often in a 2 week period the participants engaged in a health related activity, such as exercise. The Alpha coefficient is 0.68. The mean score for the traditional group was 36.2 and 34.8 for the CPM group (Robertson et al., 2009).

The Breastfeeding Behavior Scale is a 12 item questionnaire given to participants in the postpartum period to determine breastfeeding behavior. By either answering yes or no to whether mothers breasted or not, led to additional questions. Due to the fact that it was difficult

to collect data in the postpartum period, the results of the breastfeeding scale were determined by the amount of time the participants stated that they spent talking to provider about breastfeeding. Forty-eight percent reported just enough time, 38% too much time, and 13% not enough time (Robertson et al., 2009).

The Centering Questionnaire was only completed by the participants in CPM. It examines the communications given what type of communication were given, and how often. Women in the CPM group, who reported on the Centering Questionnaire, had a positive experience and 87%, would participate in a CPM in the future.

The results of the study noted that out of the 49 participants, there were very few significant differences between the group receiving CPM, and the group receiving traditional care. The two significant findings were that the traditional care group had more living children and higher self-esteem during the postpartum period. The authors noted this may be because the participants were allowed to select which group wanted to be in. The two groups were similar in age, marital status, partner's age, length of relationship, education, and employment. Overall, there was no real identifiable difference between a prenatal woman participating in CPM or traditional care (Robertson et al., 2009).

In conclusion, the women who participated in the CPM had similar outcomes in the areas of self-esteem, pre and postnatal care knowledge, behaviors related to health during pregnancy, breastfeeding practices, level of satisfaction, and depression symptoms as women in the traditional care. It was also identified that receiving CPM had infants born with average birth weight who were not premature, and were born via vaginal delivery. The findings were comparable to the infants born to participants of traditional care.

When women leave Mexico to live in the United States, they may lose social supports. Fleuriet (2009) identified that the lack of social support may have an effect on the birth outcomes. Social supports are thought to decrease the likelihood that people will participate in unacceptable behaviors. Women with social supports tend to have a better emotional and physiological state. The authors defined social support as “specific emotional, instrumental, and informational resources provided by a recognized social network” (Fleuriet, 2009, p. 50). The purpose of this study was to examine the culturally distinct topics that were identified in the literature. The researchers addressed Mexican immigrant pregnant women, and their desire for social support. The assumption was that the women of Hispanic culture would desire social support from female kin.

This study was an ethnographic study conducted in the southernmost part of Texas. This area of Texas consists of a large Hispanic population. In this research, Hispanic “refers to any person who considers herself to be Mexican descent” (Fleuriet, 2009, p.51).

A sample of 34 women was interviewed. The sample of women was obtained from public community clinics or religious birthing centers. The women were from Mexico or self-identified as Mexican-American or Latina. Ninety percent of the participants were low-income.

Over an 8 week period of time, data were collected at local clinics in the southernmost part of Texas. The quantitative data were used to devise a table comparing the number of children, religious identification, duration at primary residence in the United States, preferred language, and points of origin in Mexico. The qualitative data were collected and excerpts of the data were presented. There were focus groups at each clinic. Each group was followed with a report and discussions with staff.

The interview topics for this research included: demographic profiles, open-ended questions about expectations, experiences, and observations of prenatal social support, formal prenatal care, and birth. Open-ended questions about perceptions of the US health-care systems and its providers in relation to prenatal care, birth, and maternal and well-child care were used. The social support questions included: definitions, expectations, and experiences of kin and non-kin emotional, instrumental, and informational support. Experiences of kin and non-kin social support during pregnancy and reaction to this support were also obtained.

Findings for demographic taken were that twenty-eight were immigrants from Mexico whose household income was less than \$15,000 per year. None of the women worked outside the home. Twenty-four women had more than one child. Eighteen of the participants were Catholic. Fourteen of the women had lived in the US for 5 years or more. The preferred language was Spanish (Fleuriet, 2009).

When describing the desire for social support, 13 women had a desire for support, 8 women were ambivalent, and 7 had no desire for social support. The women had different views of pregnancy. Some women saw pregnancy as part of being part a woman, but was fearful due to past experiences, and desired social support to help alleviate fears. Another woman saw the social support as being intrusive and unnecessary. Believing social support was unnecessary because would handle pregnancy the way she wanted to. The woman that did not desire social support saw pregnancy as part of what women should do. Sought social support from husband rather than female kin, when desired support. Believed that should focus on the baby not on herself needs (Fleuriet, 2009).

The conclusion was that the cultural aspects have less to do with the woman desiring social support, and then did personal preference. Pregnancy is one condition that is individualized, and cannot be placed on a chart of what will or will not happen.

The use of cultural health practices differ from one culture to another. Some cultures have very strict and specific health practices that pregnant women must follow, and others cultures are much more lax on their health practices. In the Latino culture, the use of alternative healing is observed. Barragan, Ormond, Strecker, and Well (2011) noted that “To best understand the management and coping mechanisms of the Latino population, it is important to understand and be aware of patients’ use of alternative healers, as they may be supplementing or replacing the use of healthcare services within the United States medical system” (p. 610). Some of the cultural health practices that Latinos believe are practices such as: wearing safety pens during pregnancy because they believe this will help prevent anything from happening if an eclipse should occur. They also believe that pregnant women should make sure to satisfy any cravings they have during pregnancy, the thought is if they don’t satisfy those cravings the baby will come out with part of the craving.

The purpose of this study by Barragan et al. (2011), two fold; to look at the integration of cultural health practices and Western medicine in a Mexican-origin, and the factors thought to influence the outcomes of pregnancy, the practices used during pregnancy, and how often and how much are the cultural health practices passed down through generations. All these factors would be looked at in the different levels of acculturation. The authors looked to see if the level of acculturation has an effect on the use of cultural health practices.

The study was reviewed and approved by the Stanford University Institutional Review Board. Participants were recruited in Salinas and Soledad, two cities in California. The two

cities contain 70% Latinos, and a significant portion is of Mexican descent. Recruiting was done through convenience sampling and snowball sampling. The authors had Spanish-English bilingual public advertisements that told about the aim of the study, requirements for participation, and eligibility criteria. The public advertisements were on local radio stations, school functions, and on posters in local shops. The criteria desired were females self-identified as Mexican or Mexican-American, between the ages of 18 and 65, without a history of children or prior pregnancies with birth defects, and currently living in Salinas or Soledad California.

The Barragn et al. (2011) chose to use four areas of instrumentation: acculturation, religiosity, demographics, and interview questions. Acculturation was measured using the Acculturation Rating Scale for Mexican Americans II (ARSMA-II). The ARSMA-II is a 30 item Likert type scale. The scale measures acculturation based on language ability and preferences, ethnic identity, and ethnic interaction. There are five possible levels of acculturation, Level 1 (AL1) to Level 5 (AL5). AL1 are very Mexican oriented and least acculturated to the United States. AL5 are very Anglo oriented and most acculturated to the United States. The participants for this study were ranging from level 1 to level 3 (Barragan et al., 2011).

A Religiosity Scale was completed by participants. The Catholic Religiosity Scale measures religious background, religious practice, religious beliefs, and reproductive morality. The Protestant Religiosity Scale measures religious beliefs, religious practices, and reproductive morality.

The demographics included data about length of time in the United States, educational background, household income, and preferred language. The Interview Questions were semi-structured and open-ended. The authors explored issues surrounding general practices in pregnancy and participants' perceptions of their benefits, understanding of Western medicine,

finding a balance between medicine and cultural childbearing beliefs and practices, and the role of the family and community. The participants were asked to answer questions by thinking about their most recent pregnancy or the most recent pregnancy of a family member. Interviews were completed in person with small groups or via telephone interview. Interviews were conducted in participants' preferred language.

There were a total of 15 participants in the study. Six were AL1 (40%), five were AL2 (33%), and four were AL3 (27%). The mean age was 38.9 years old with a range being 26-62 years old. The mean time in the United States was 31.5 years with the range of time being 20-46 years. For educational background six participants had primary or less education, five participants had some college, three had Bachelor's degrees, and one had a Master's degree. Spanish was the preferred language for the AL1 group, AL2 and AL3 groups were bilingual. The household income for each group were: six participants made less than \$20,000 per year, four made \$20,000-\$40,000 per year, one made \$40,000-\$60,000 per year, two made \$60,000-\$80,000 per year, and one made greater than \$80,000 per year. For religion thirteen were identified as Catholic and two were identified as Protestant (Barragan et al., 2011).

Regardless of the participants level of acculturation, the majority discussed the importance of Western Medicine in pregnancy. All the women understood the importance of taking prenatal vitamins. Participants noted the importance of a healthy diet, blood pressure monitoring, abstaining from alcohol and drug use, and obtaining routine pregnancy monitoring.

The authors, Barragan and colleagues (2011), identified through interviewing that women who were in the AL1 group were much more likely to practice and maintain cultural health practices. Those in AL3 were less likely to practice the cultural health practices. Those in AL3 noted that they did not always understand the cultural health practices, but they would sometimes

participate in the practices just because. Some participants noted they did either because their mother told them to or they didn't want to take any chances that their baby may have a birth defect.

Women in the AL1 group noted that they had more difficulty sharing cultural health practices with healthcare providers, than more acculturated women. The authors noted that "Cultural health practices during pregnancy may serve three roles (a) They offer a comprehensible and seemingly sensible explanation for what may otherwise be regarded as perplexing; (b) They confer a perceived sense of some control or ability to favorable influence the outcome of pregnancy; and (c) They may serve as the foundation of pregnancy support networks among female friends" (Barragan et al., 2011, p. 619).

The authors discuss practice implications to this study. It was noted previously that less acculturated women are less comfortable discussing their cultural health practices with their healthcare providers. Barragan et al. (2011) stated "If healthcare providers inquire about such practices in a manner that conveys true interest and lack of judgment, it may provide for a more mutually comfortable, candid, and fulfilling discussion regarding health and health-related issues" (p. 620).

The study had some limitations, especially sample size. For future studies, a larger sample size may give a better picture of the Latino culture. Overall, the study showed there are still cultural health practices being used, whether all the women understood it or not. This study also showed that women no matter what their acculturation is, they want their healthcare provider to listen to them and be respectful.

Pregnancy is a time in a woman's life in which there are physical and emotional changes. Along with the physical and emotional changes, a woman goes through a process of

transformation and reorganization of her identity. Some women can experience symptoms of and a clinical diagnosis of depression. There has been a significant amount of research done on postpartum depression, but not as much done on prenatal depression. Lara, Le, Letechipia, and Hochhausen (2009) noted the purpose of their study was to “add to the limited knowledge on depressive symptoms during pregnancy in two understudied groups of women: Latinas in the U.S. and in Mexico, comparing the prevalence and risk factors associated with prenatal depression symptoms” (p. 568).

Two separate groups were used to collect data on for the study, one group from the United States and one from Mexico. The sample included 108 women from the United States, and 117 women from Mexico. Data were not collected at the same time. For the sample from the United States a sample was extracted from the medical charts of pregnant women in a Washington D.C. community clinic. The database was made up of 469 clients receiving prenatal services. The year was chosen because it was the first year the clinic started tracking CES-D data. The year the study was completed was June 2005 to January 2006. Lara et al. (2009) chose the name of every third client, so the sample was random. The random sample ended in a sample size of 164. Data was collected from the medical charts of those selected.

Undergraduate and graduate students collected the data. Forms were researched in the medical records. The forms included: prenatal care records, previous birth records, and mental health and social work forms. The sample size was decreased to 108 when the data collection was narrowed to those who were Latina and had CES-D depression scores. Independent samples t-tests and chi-squares were performed to examine socio-demographic differences between participants, with CES-D (n=108) and without CES-D (n=56) data. Results indicated there was no significant difference in groups.

The sample for the Mexico study consisted of 120 pregnant women living in Mexico City. Participants were interviewed in the waiting room of one of four locations: primary care community centers and three health houses that provided very basic health care. Data was collected between May 19 and July 19 2005. After receiving consent the women were interviewed in the waiting rooms. Of the 120 participants, three questionnaires were excluded, two due to lack of data and one due to no consent being obtained. The final sample was 117 prenatal women (Lera et al., 2009).

The instrumentation used was socio-demographic variables: age, years of schooling, marital status, number of children, order of pregnancy, planned pregnancy, gestational trimester, and social support. The other instrument used was the Center for Epidemiological Studies Depression Scale (CES-D). The CES-D is a 20 item questionnaire that determines how many days the previous week did a person experience a variety of depressive symptoms. Scores range from 0-60, a total score of 16 or higher is the usual cut-off for being at risk for clinical depression or having high number of symptoms (Lera et al., 2009).

When assessing data analysis, the data for the two samples could not be combined, due to data collection methodology. Comparisons were done between socio-demographics and depressive risk factors. Independent sample t-tests for continuous variables and chi-square test for categorical data were completed. Results for socio-demographics showed age in US $M(SD) = 2.59(5.5)$ and Mexico $M(SD) = 23.2(5.0)$, $t=3.8(223)$. Years of education had the US $M(SD) = 9.2(4.0)$ and Mexico $M(SD) = 8.3(3.2)$ with $t=1.35(158)$. Marital status for the US group $M(SD)$ = single 32(29.6), married 30(27.8), and cohabitation 46(42.6). For the Mexico group marital status was $M(SD)$ = single 22(18.8), married 21(17.9), and cohabitation 74(63.2). Number of children for US study was $M(SD) = 1.1(1.1)$ and for the Mexico study $M(SD) = 0.79(1.0)$. First

pregnancy in the US study: yes 35(33.3) and no 70(66.7), for Mexico study yes 57(47.9) and no 60(51.3). Planned pregnancy in the US study: yes 13(59.1) and no 9(40.9), and in the Mexico study: yes 46(39.3) and no 71(60.7). Trimester of gestation in the US study: first 35(36.1), second 34(35.1), and third 28(28.9). For the trimester of gestation in the Mexico study: first 7(6), second 48(41), and third 62(53). Social support in the US study: yes 84(96.6) and no 3(3.4), for the Mexico study: yes 108(92.3) and no 9(7.7) (Lera et al., 2009).

Results for the depression variables recorded as total CES-D in the US study $M(SD) = 12.9(10.7)$ and for the Mexico study $M(SD) = 14.7(12.6)$. Prenatal depression history for the US study: yes 28(28.0) and no 72(72.0), for the Mexico study: yes 71(60.7) and no 46(39.3). Family psychiatric history in US study: yes 14(13.7) and no 88(86.3), and for the Mexico study: yes 85(72.63) and no 32(27.4). History of suicidal thoughts in US study: yes 14(14.4) and no 85(85.6), for Mexico study: yes 16(13.7) and no 101(86.5). Overall $n=87-108$ and $p<.05$ (Lera et al., 2009).

Lara et al. (2009) found that 32.4% and 36.8% of each sample respectively suffered from high depressive symptoms. The data from this research reliability predicts postpartum depression. With this prediction, early suitable interventions should be implemented during pregnancy. Being able to help those who have depression or are at high risk for depression makes screening during pregnancy worthwhile. Also because screening can help predict postpartum depression, help can be given to women during and after pregnancy.

A common complication of pregnancy is depression. Fortner, Pevow, Dole, Markenson, and Taber (2011) noted “Prenatal depression is also an important predictor of postpartum depression with one third of women diagnosed with postpartum depression experiencing the onset of depression while pregnant” (p. 1287). Most studies previously completed focused on

non-Hispanic white women. The purpose of Fortner et al. (2011) study was to examine the “association between pre and early pregnancy factors and depressive symptoms in early pregnancy” (p. 1287).

Fortner et al. (2011) used data from Projecto Buena Salud. Projecto Buena Salud is an ambulatory obstetrical practice located in Western Massachusetts Baystate Health. Projecto Buena Salud works with women of Caribbean Island heritage. They look at the relationship between physical activity, psychological stress, and risk of gestational diabetes in Hispanic women. The study was approved by University of Massachusetts and Baystate health’s Internal Review Boards. To be eligible for the study women had to be from Puerto Rico or the Dominican Republic. Women were excluded if they were taking medication that would affect their glucose level, if they had multiple gestations, history of diagnosis of diabetes, hypertension, heart disease, or chronic renal disease. Participants were to be between the ages of 16 and 40. Interviews were conducted with participants in Spanish and English. The interview was to gather data on socio-demographics, acculturation, behavioral, and psychosocial factors. There were 21 participants in the study.

Depressive symptoms were assessed by using the 10 item Edinburgh Postnatal Depression Scale (EPDS). The EPDS is available in both English and Spanish. The EPDS asks questions about how the person felt in previous weeks. Possible answers were: yes, most of the time, no, or not at all. Items are rated on a 4-point scale of 0,1,2,3, with a range of 0-30. A score of greater than 12 is considered to have depressive symptoms. The EPDS “has been validated as a depression screening tool in pregnant and postpartum Hispanic women and has a sensitivity of 90-100% and a specificity of 78-88% for the identification of major and minor depression” (Fortner et al., 2011, p. 1288).

Socio-demographic factors assessed during the interview process were: age, education, annual household income, marital status, living situation, and number of children and adults in the household. Acculturation factors were assessed using the Psychological Acculturation Scale (PAS). The PAS looks at ten items that assess how psychologically attached to and sense of belonging within Anglo-American and Latino/Hispanic cultures. The PAS uses a 5-point scale with 1 being only Hispanic/Latino and 5 being only Anglo/American. The PAS has reliability of 0.94 (Fortner et al., 2011).

Behavioral factors were assessed using the Pregnancy Risk Assessment Monitoring System (PRAMS). The PRAMS is a project of the Center for Disease Control and Prevention (CDC) that includes pre and early pregnancy alcohol consumption and cigarette smoking. The Cohen's Perceived Stress Score (PSS-14) was used to assess psychosocial factors. The PSS-14 is a 14-item evaluation that addresses a person's sense of control over daily life demands. The PSS-14 demonstrates adequate reliability with internal consistency, $\alpha = 0.81$ and test-retest $r=0.73$. The PSS-14 also shows adequate validity and sensitivity (Fortner et al., 2011).

Data analysis was completed using chi-square tests and Fischer's Exact Test for small cell size. A multivariable logistic regression module was used at $p>0.20$. Statistical analysis was conducted using SAS 9.2 software. Results of the study show that 30% of participants were classified as having depressive symptoms per the EPDS. The mean + SD scores of $9.28 + 5.99$ were obtained. Seventy percent of participants were less than 24 years old. Those who had not graduated High School were 49%. Those with low annual household income were 48%. For acculturation factors 46% were born in Puerto Rico or the Dominican Republic, and 80% reported they were closer to the Latino culture. When asked about alcohol consumption, 32% of women reported pre-pregnancy alcohol use, and 39% reported smoking cigarettes. In regards to

psychosocial factors, mean $\pm$ SD PSS score was 26.2 $\pm$ 7.1. Results also showed women who did not live with spouse/partner, who were second generation in U.S., those who smoked cigarettes and drank alcohol all were at higher risk for depressive symptoms.

Fortner et al. (2011) showed that Projecto Buena Salud serves Hispanic women with a higher level of depressive symptoms compared to their non-Hispanic white counterparts. The researchers have shown that routine screenings for depression are necessary in the Hispanic population. Also educating Hispanic women about prenatal care is extremely important.

In a study by McDonald, Suellentrop, Paulozzi, and Marrow (2008), it is noted that in 2002 14% of the United States was self-identified as Hispanic. By 2020, it is estimated that the United States population will be 18% Hispanic. At the time of the study, McDonald et al. (2008) noted “Births among Hispanics already account for more than one in five U.S. births” (p. 343). With the increase in the Hispanic population, there has been more attention paid to the Hispanic women and their reproductive health, in comparison with non-Hispanic white women. For example, Hispanic women have higher rates of preterm births, adolescent pregnancy, and abortions. The purpose of this study was to look at reproductive health outcomes and indicators between Hispanic women and non-Hispanic white women. McDonald et al. (2008) also wanted to examine heterogeneity in the Hispanic population, using the Pregnancy Risk Assessment Monitoring Systems (PRAMS) to determine heterogeneity.

McDonald et al.’s. (2008) study was completed as a cross-sectional study using the PRAMS survey. The PRAMS looked at selected maternal behaviors and pregnancy outcomes. A random stratified sample of women was collected each month from state birth certificate files. There were six states involved in the study: Alabama, Arkansas, Georgia, North Carolina, South Carolina, and Tennessee. The sample design and fraction were specific per state. The Hispanic

women were mailed Spanish and English language questionnaires. If the women did not respond to the questionnaire, they were contacted via phone. The PRAMS includes: questionnaire, birth certificate, and operational variables. Selected birth certificate data was linked to the questionnaire. “The results were weighted for survey design, nonresponse, and non-coverage” (McDonald, 2008, p. 344). The sample was limited to Hispanic and non-Hispanic white women. Hispanic women were included if they were coded as Hispanic ethnicity. Non-Hispanic white women were included if they were coded non-Hispanic and white. The sample consisted of 5,104 Hispanic women and 22,808 non-Hispanic white women.

Vital statistics data were used to calculate the percentage of increase in Hispanic births. Tertiles were used to divide the group into 3 groups, each being a third of the group. Tertile 1 had the greatest increase, Tertile 2 was less increase, and Tertile 3 had the least amount of increase. The sociodemographic and access to care indicators measure of contraception and pregnancy intention, pre pregnancy and prenatal risk behaviors, labor and delivery characteristics, and birth and infant health outcomes were included in analysis. Hispanic and non-Hispanic white women were compared overall with Tertile 1 and Tertile 3 separately. Crude risk ratio (RR) and 95% confident interval (CI) were calculated for all levels of interest for variables studied. The sociodemographics between Hispanic and non-Hispanic white women was adjusted by repeating analysis using multivariate logistic regression. Analysis was conducted using SAS-callable and Software for Survey Data Analysis (SUDANN) was used to account for weighing and complex sampling design of PRAMS. Crosstab calculations were used to determine crude RR. Logistic regression was used for conditional marginal probabilities for adjusted RR. McDonald et al. (2008) used t-tests to determine differences between Tertiles in crude and adjusted RRs, $P < 0.05$ was used as cut-off to indicate statistical significance.

Hispanic and non-Hispanic white women had similar reporting of their intention to become pregnant. Hispanic women were twice as likely to not use contraception trying to conceive as compared to non-Hispanic white women. Hispanic women were less likely to report unhealthy behaviors such as drinking alcohol and smoking cigarettes. There was no significant difference in the type of delivery that Hispanic and non-Hispanic white women had. The birth outcomes of the Hispanic infants and non-Hispanic white infants were similar.

Overall, this study showed that Hispanic women that gave birth tended to be young, less educated, less likely to receive prenatal care, and less likely to participate in unhealthy behaviors. There was no evidence in the study that infant health outcomes were different between Hispanic and non-Hispanic white infants. Even though there are some differences in the reproductive health of Hispanic and non-Hispanic white women, there is no significant findings in the outcomes of the infants born to both groups.

In a study by Thompson, Curry, and Burton (2001), *The Effects of Nursing Care Management on The Utilization of Prenatal Care by Mexican-Americans in Rural Oregon*, looked at factors affected by prenatal care such as birth weight. Early and adequate prenatal care helps reduce the incidence of low birth weight (LBW) and other negative outcomes in pregnancy. Utilization of prenatal care correlates with sociodemographic variables that predict LBW, such as race, ethnicity, age, marital status, income, education, and whether lives in rural area. There are many barriers to prenatal care including low income, low education, less health insurance, and distance to provider. For Mexican/Mexican-Americans, there may be additional barriers such as language and cultural barriers. The purpose of this study was to examine “eliminating barriers to care, especially language and transportation, combined with meticulous

tracking and follow-up, were responsible for positive outcomes” (Thompson, Curry, & Burton, 2001, p. 83) of the Rural Oregon Minority Prenatal Program (ROMPP).

The ROMPP blends concepts of culturally appropriate care, outreach, nursing care management, and home visitation. The ROMPP has community nurse/case management (CHN) and outreach workers (OW). The CHN was responsible for assessment, planning, coordination, and evaluation of nursing care. The nurse case manager facilitates access to prenatal care and other community resources. The program took place in participants home. There were bilingual and bicultural outreach workers.

Participants were recruited for the ROMPP interventions by approaching eligible women in the potato sheds, grocery stores, and in neighbor’s kitchens. Factors for determination included history of preterm of LBW infants, history of pregnancy complications, pre-existing medical conditions, and age less than 17 years. Mexican-American was defined by preferring to speak Spanish or having a Spanish surname. An attempt was made to recruit women before 20 weeks gestation, but could participate at any point in their pregnancy. There were 124 Mexican-American women who received ROMPP services, but only 100 received a minimum of three visits. The average number of visits women received ranged from three to 15, with the mean being six. Visits from the outreach workers ranged from none to 54, with the mean being 15. To have a comparison group for the study, birth certificate data was used from the Oregon State Health Division Department of Vital Statistics. One hundred demographically similar women were chosen. Chi-squares and t-tests showed no significant differences between the two groups (Thompson et al., 2001).

The research questions were six questions, Did ROMPP improve patterns of prenatal care utilization by rural, pregnant Mexican-American women, compared to Mexican-American

women who did not receive the intervention? Did the treatment groups initiate prenatal care earlier in their pregnancy and have a more adequate number of visits than the comparison group? Were prenatal visits distributed throughout the pregnancies in a more appropriate way in the treatment group? Did the treatment group have fewer ER visits and fewer inpatient admissions during pregnancy? What were the diagnoses associated with these visits and admissions? When admitted, did the treatment group have shorter lengths of stay? (Thompson et al., 2001).

The study completed by Thompson et al., (2001) was a secondary analysis of data drawn from a larger study, to study the benefits and cost of ROMPP. The study was given approval by the Institutional Review Board and informed consent guidelines.

The results of the study showed no statistically significant differences in the adequacy of initiation of prenatal care or the number of prenatal care visits as measured by Kotelchuck's Adequate of Prenatal Care Utilization Index. Prenatal visits occurred more often in months 2, 3, 4, 5, 6, and 7 than in the comparison group with $p < 0.05$. There were also no statistically significant differences in the number of ER visits. For inpatient admission there was statically influence. There were eleven inpatient admissions for the ROMPP group and six for the comparison group. The ROMPP group had longer lengths of stay, 2.0 ± 0.63 days versus 1.5 ± 0.55 days in the comparison group (Thompson et al., 2001).

The study did not show any real advantage of women having The ROMPP interventions compared to not having them. Barriers still remained with The ROMPP interventions. Thompson et al. (2001) identified limitations with the study. The use of birth certificates and accuracy of medical records were identified as limitations. The interventions were helpful and should be offered to pregnant women. The study should be replicated with a comparison group that will help prevent limitations.

Summary of Literature

All reviewed articles in this section examined cultural competence in the Hispanic community. All of the authors focused on Hispanic women. The variables that appeared in all the studies were demographic variables: age, education, marital status, and time lived in the United States. There were other demographic variables examined within these studies as well: number of pregnancies, number of living children, and number of abortions. The articles main focuses were on how the women perceived prenatal care, what affected them getting care, and what would improve their care.

The samples in these studies were Hispanic, pregnant women over the age of 18. Most of the authors recruited from local clinics and hospitals. The studies in this review were either qualitative or quantitative, with some of them having both qualitative and quantitative components.

The data were gathered through interviews with participants, either in person or by phone. The interviews were conducted in Spanish by bilingual staff. The data were collected and analyzed to determine cultural competence. Some of the studies used analyses such as: Chi-squares, while others used ANOVA for data analysis. Authors used open-ended questions to gather information from the women about their experiences.

The authors in all the studies agreed on a few things, such as pregnant women do not fit into a mold. Just because clients are Hispanic pregnant women does not mean that all of them are the same in how they feel and what they want. They also agree that the women prefer to have their care given by bilingual staff, and they want staff to be sensitive to their cultural norms.

The majority of the articles presented had very small populations and they only looked at the surface of the problem. There were no articles found that gave specifics about what women viewed as culturally sensitive or culturally competent care.

Chapter III

Methods and Procedures

Introduction

Culturally competent care occurs when healthcare providers are careful to provide care to clients with different cultural beliefs, practices, and norms. According to the 2012 US Census, the percentage of Hispanic/Latinos living in Butler County is 3.8% of the population, whereas, the White alone made up 87.1%. The Hispanic culture is very diverse with multiple groups making up the Hispanic population. In the Hispanic culture, family, religion, and cultural practices are very important. This study will replicate portions of two studies, Fleuriet's study (2009) and Wanda's study (2000). Fleuriet's study (2009) title is "Problems in the Latina Paradox: Measuring social support for pregnant immigrant women from Mexico." Wanda's study's (2000) title is "Mexican Americans' perception of culturally competent care." The purpose of this study is to determine how pregnant Mexican/Mexican American women view culturally competent care and their desire for social support during pregnancy.

Research Questions

1. What do Mexican/Mexican Americans believe are the most important areas that nurses should strive to when providing health care?
2. What are the barriers Mexican/Mexican Americans perceive to affect culturally competent care?
3. Do Mexican/Mexican American women desire social support during pregnancy?
4. How important is social support to Mexican/Mexican American women?

Setting, Population, Sample

The desired sample for this study is 50 Mexican/Mexican American pregnant women living in Butler County Ohio. Participants will be recruited from the Butler County Early Head Start program. The Butler County Early Head Start program serves women and children from pregnancy to until the child is three years of age. The Butler County Early Head Start program serves 125 families including children and pregnant women. Out of the 125 served approximately, 30 (2.4%) to 50 (4%) are Spanish speaking families. Not all women are pregnant, but may become pregnant during the program.

Participants will be asked to participate in the study if they are 18 years old or older, are residents of Butler County Ohio, of Mexican descent, obtained healthcare in the United States, and currently pregnant or have been pregnant in the past month. Participants will be asked to complete a portion of the KnowledgePanal Demographic survey, the Acculturation Rating Scale for Mexican Americans (ARSMA), and an interview. All questionnaires and the interviews will be completed in the participants preferred language.

Protection of Human Rights

Before the study can be completed, a detailed proposal will be sent to the Internal Review Boards (IRB) of Ball State University and the Butler County Educational Service Center, which conducts the Early Head Start program. Permission will also be obtained from the Ohio Board of Nursing. Each participant will be given a letter explaining the study and what participation in the study will mean for the participant. The participants will be offered the letter in their preferred language or the letter can be read to them verbally for their consent. The researcher contact information will be provided to all participants with the option to speak to someone in either English or Spanish. Once the participant has given consent to participate in the study, a

time and a place will be set up with them to partake in an interview. This study will adhere to all ethical consideration in research.

Method

After receiving approval from the Internal Review Boards and the Ohio Board of Nursing, and consent from the participants the interview process will begin. The participants will be asked to complete a portion of the KnowledgePanal Latino Omnibus demographic survey. The KnowledgePanal Latino Omnibus demographic survey is made up of 37 demographic variables. This study will only focus on eight demographic variables. The eight demographic variables are age (in years), Education (less than HS, HS, some college, Bachelor's degree or higher), Race/Ethnicity, household income (annual income), marital status (married, widowed, divorced, separated, never married, living with partner), language spoken at home (options provided are Spanish, more Spanish than English, Both Spanish and English equally, more English than Spanish, only English, neither Spanish or English), country of birth, and years lived in United States. The reason for only using eight of the 37 demographic variables is because some of the variables are repeated using different criteria, and some of the demographic variables are not applicable to the study participants. Participants will be asked to complete the Acculturation Rating Scale for Mexican Americans provided by the American Psychological Association. The ARMSA is a 5-point Likert scale that differentiates between five levels of acculturation: Very Mexican, Mexican oriented, Bicultural True Bicultural, Anglio oriented, and very Anglicized. Acculturation looks at those who have been in the United States, and how much they identify with Mexico or the United States. The rationale is that those who have lived in the United States for longer periods of time will be more likely to identify with Western culture versus Mexican culture. For example, those who have lived in the United States for five

years would be more likely to identify with Western culture than those who have only lived in the United States for one year. For studying culturally competent care, knowing how acculturated a pregnant woman will give an idea of the expectations and beliefs.

The participants will be interviewed by a single researcher in the participants preferred language. The interview will be conducted either in person or via telephone. The interview will consist of asking participants four open-ended questions: a. While you are pregnant do you desire social support from family and friends? b. How important is social support to you while you are pregnant? c. What do you think is the most important thing that a nurse can do while taking care of you, to make you feel they are providing culturally competent care? d. What barriers exist for you to receive culturally competent care? The interview will be audiotaped to assure that answers are recorded completely and accurately. Once all interviews have been completed, answers will be reviewed and categorized for data analysis. This study will be completed using ethnographic qualitative research. Ethnography looks at how people view their own culture and the cultures of others. It is known to be the “portrait of people” (Burns & Grove, 2009). Ethnography originated from anthropology and anthropology is used in many disciplines such as sociology, political science, and nursing. Leininger, a nurse theorist, started introducing anthropology into nursing in the mid-19th century. Ethnographic research describes and analyzes particular cultures, subcultures, and subculture groups (Burns & Grove, 2009). Ethnography looks for patterns of behaviors. Ethno nursing observes and documents interactions with people and how life and culture affect health.

Reliability and Validity

Validity and reliability of qualitative research are developed through trustworthiness of data (Polit and Beck, 2008). Trustworthiness consists of four criteria. The first is credibility

refers to the truthfulness of the data and interpretation. The second criterion is dependability which refers to reliability of the qualitative data over time. Conformability is congruency among two or more persons of the accuracy of the study data and interpretation. The last criterion is transferability, which is about generalizability of the study data to other groups. In this study, the researcher will ask the experts of qualitative research to judge trustworthiness of the data yielded through the interviews.

Instrumentation

To complete the study, three instruments will be used. The first instrument is a quantitative measure, KnowledgePanel Latino Omnibus. It is a demographic survey that contains 37 demographic variables. Participants complete the survey online and then compiled by the computer system using SPSS, SAS, or an Excel data file. Variables are given post stratification weight and a table is created in a Word table with standard set of demographic banner points. Validation is given through the American Association for Public Opinion Research (AAPOR), Online Task Force, and Scientific Comparison Research.

Acculturation Rating Scale for Mexican Americans (ARSMA) is a 5-point Likert Scale used to establish the acculturation level of participants. The ARSMA uses two subscales, the Anglo Orientation Subscale (AOS) and Mexican Orientation Subscale (MOS). AOS and MOS were found to have good internal reliabilities and a high Pearson's correlation coefficient of .86 and .88.

The interview questions will be asked to all participants by one researcher in their preferred language. The interview will take place at the participants' home or via telephone, so the participant is comfortable and free of anxiety. The interview will be audiotaped to establish accurate information is reported.

Data Analysis

Once participants have completed the KnowledgePanal Latino Omnibus demographic survey, Acculturation Rating Scale for Mexican Americans, and interview, data will be analyzed. The answers given by participants to the open-ended questions will be coded using open coding. Open coding is a technique used to identify further meanings and information of questions asked when a researcher looks for distinct concepts and categories in the data. Data obtained through audiotaping will be analyzed, synthesized, and placed in categories to identify common themes. In addition, answers to the study designated research questions will be listed under each question. SPSS program (Knowledge Network, 2010) will be used to analyze data yielded from the KnowledgePanal Latino Omnibus program and the Acculturation Rating scale. *Summary*

This chapter describes the purpose of this study along with the sample, population, setting, protection of human rights, methods of the study, and how the data will be analyzed. Findings of this study will be compared with Fleuriet's study (2009) findings and Wanda's study (2000). The study will determine whether Mexican/Mexican American women prefer social supports during pregnancy and how important those social supports are to them. The study will determine what Mexican/Mexican American women identify as culturally competent care and barriers that are identified. For healthcare providers, the knowledge of the desire for social supports and importance of social supports, along with the views of culturally competent care and barriers to culturally competent care will make healthcare providers care much more accurate and appreciated.

Reference

- Barragan, D. I., Ormond, K. E., Strecker, M. N., & Weil, J. (2011). Concurrent use of cultural health practices and western medicine during pregnancy: Exploring the Mexican experience in the United States. *Journal of Genetic Counseling*, 20(6), 609-24.
doi:<http://dx.doi.org/10.1007/s10897-011-9387-4>
- Burns, N. & Grove, S. K. (2009). *The Practice of Nursing Research Appraisal, Synthesis, and Generational of Evidence (Fifth Edition)*. St. Louis, Missouri: Saunders Elsevier.
- Eggenberger, S., Grassley, J., & Restrepo, E. (2006). Culturally competent nursing care for families by listening to the voices of Mexican-American women. *Online Journal of Issues in Nursing*, 11(3), 7. Retrieved from
<http://search.proquest.com/docview/229511265?accountid=8483>
- Fleuriet, K. J. (2009). Problems in the Latina paradox: Measuring social support for pregnant immigrant women from Mexico. *Anthropology & Medicine*, 16(1), 49-59.
- Fortner, R., Pekow, P., Dole, N., Markenson, G., & Chasan-Taber, L. (2011). Risk factors for prenatal depressive symptoms among Hispanic women. *Maternal and Child Health Journal*, 15(8), 1287-1295. doi:10.1007/s10995-010-0673.
- Giger, J. N., & Davidhizer, R. (2002). The Giger and Davidhizer Transcultural Assessment Model. *Journal of Transcultural Nursing*, 13(3), 185-188.
- Kaplan, C. P., Erickson, P. I., Stewart, S. I., & Crane, L. A. (2001). Young Latinas and abortion: the role of cultural factors, reproductive behavior, and alternative roles of motherhood. *Health Care for Women International*, 22, 667-689.

- Lara, M., Le, H., Letechipia, G., & Hochhausen, L. (2009). Prenatal depression in Latinas in the U.S. and Mexico. *Maternal & Child Health Journal*, 13(4), 567-576.
doi:10.1007/s10995-008-0379-4.
- McDonald, J., Suellentrop, K., Paulozzi, L., & Morrow, B. (2008). Reproductive health of the rapidly growing Hispanic population: data from the Pregnancy Risk Assessment Monitoring System. *Maternal and Child Health Journal*, 12(3), 342-356.
- Polit, D., & Beck, C. (2008). Nursing Research: Generating and Assessing Evidence for Nursing Practice. 8th ed. Philadelphia, PA, Wolters Kluwer.
- Robertson, B., Aycock, D. M., & Darnell, L. A. (2009). Comparison of centering pregnancy to traditional care in Hispanic mothers. *Maternal Child Health Journal*, 13(3), 407-414.
- Shaffer, C. F. (2002). Factors influencing the access to prenatal care by Hispanic pregnant women. *Journal of the American Academy of Nurse Practitioners*, 14(2), 93-96.
- Tandon, S. D., Parillo, K. M., & Keefer, M. (2005). Hispanic women's perception of patient-centeredness during prenatal care: a mixed-method study. *Birth*. 32(4), 312-317.
- Thompson, M., Curry, M. A., & Burton, D. (2001). The effects of nursing case management on the utilization of prenatal care by Mexican American in rural Oregon. *Public Health Nursing*, 15(2), 82-90.
- United States Census Bureau. (2012). Retrieved from
<http://www.census.gov/population/hispanic/data/2011.html>
- Wanda, M. R. (2000). Mexican Americans' perceptions of culturally competent care. *Western Journal of Nursing Research*, 22(2), 203-224.