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Factors That Influence Health Practices Among Reproductive-Age Immigrant Hispanic Women

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"Factors that Influence Health Promotion Practices

Among Reproductive-Age Immigrant Hispanic Women"

by

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DISSERTATION

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Dedication

This work is dedicated to the inspiring women who participated in this study. It is their voice I sought to present. I wish to thank them for the time they willingly shared with me. They reminded me through their stories of the meaning of strength, courage, dignity, perseverance, sacrifice, and Hispanic women's fierce love for their families.

To my husband, Dan whose love has been everlasting and whose support made this work possible. Thank you, Sweetheart for the long hours of listening to me talk about my doctoral journey. Thank you for your endless patience.

To my children, Robert and Erica, thank you for your constant love, faith and words of encouragement. Mom is finally done!

To my parents, who have inspired me through their example all of my life. They taught me to believe in myself and in my dreams. They taught me to believe that nothing is impossible.

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Abstract

"Factors that Influence Health Promotion Practices
Among Reproductive-Age Immigrant Hispanic Women"

Ana C. Birkhead, RNC, MSN, WHNP, PhD (c)

Background and Significance

Immigrant Hispanic women continue to fare worse in terms of health status and health outcomes than white women. Hispanic women continue to be at high risk for developing diabetes, heart disease, and late-stage cancers (Borrayo & Jenkins, 2003). Some researchers contend that cultural factors may influence health care practices and consequently health outcomes among Hispanic women in the United States (Larkey, et al., 2001; Murguia, et.al, 2000). However, the literature is scanty about the traditional and non-traditional health practices performed by immigrant Hispanic women and how these health beliefs influence their health behaviors in a new society.

Purpose and Aims

The purpose of this study was to examine the influence of cultural factors on the health care practices of immigrant, reproductive-age Hispanic women. The specific aim was to explore the traditional culture-related health behaviors practiced by these women in their country of origin and to examine how these practices are influenced or changed with time and exposure to health care in the U.S.

Methods

This exploratory qualitative study was conducted in a community health center with a large population of immigrant Hispanic women. Individual in-depth interviews were conducted with 20 immigrant Hispanic women between the ages 20-45. Demographic and acculturation data were statistically analyzed. Narrative data were analyzed using Lieblich's (1998) approach to narrative analysis.

Results

This study's findings suggest that cultural factors significantly influence immigrant Hispanic women's health care beliefs and behaviors regardless of time spent in the U.S. Cultural overlap, mother's role, perceived discrimination, family connectedness, language difficulties, transition experiences, differences in health care systems, and desire to maintain cultural heritage were eight themes identified which influenced access to U.S. health care systems.

Conclusion

The findings of this study add to the gaps of information regarding the negotiating process of combining traditional cultural health beliefs with those of a new host culture for immigrant Hispanic women. This knowledge offers guidance to the development of culturally sensitive health interventions directed at improving the health outcomes among these women.

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CHAPTER ONE

Introduction

Health promotion and chronic disease prevention programs targeted at the general population of the United States (U.S.) have not been effective in reaching the Hispanic population (Larkey, Hecht, Miller and Alatorre, 2001). Health outcome benefits of established prevention programs such as for cervical cancer screening and mammography have lagged in the immigrant Hispanic population. Immigrant Hispanic women living in the U.S. continue to experience major health disparities when compared to the majority white population. Limited community efforts have made some progress at reaching Hispanic women, but this has not been enough to make significant changes in the population as a whole (McFarlane & Fehir, 1994). Immigrant Hispanic women are still more likely to die from a disease such as breast cancer than are non-Hispanic white women (Borrayo & Jenkins, 2001).

According to several researchers, immigrant Hispanic women continue to be at high risk for developing diabetes, heart disease, and late-stage cancers (Borrayo and Jenkins, 2003; Haynes and Smedley, 2002; Larkey, et al., 2001). Research indicates that high mortality rates among immigrant Hispanic women are more likely due to the late diagnosis of breast or cervical cancer than to their ethnicity (Ashing-Giwa, Padilla, Bohorquez, Tejero, and Garcia, 2006; McMullin, De Alba, Chavez, and Hubbell, 2005). There is evidence to support the fact that immigrant Hispanic women are less likely to know the danger signs of breast cancer, less likely to believe in early screening and detection procedures, and less likely to seek immediate care for health-related problems (Borrayo & Jenkins, 2003; Larkey, et al., 2001). They are also more likely to use home

remedies and folk medicine to treat illnesses than to seek medical attention in the U.S. (Higgins & Learn, 1999). Even when free clinics and health services are offered, many immigrant Hispanic women in the U.S. are hesitant to participate in regular screening exams (Borrayo & Jenkins, 2003; Lagana, 2003; Meikle, Orleans, Leff, Shain & Gibbs, 1995; Shaffer, 2002).

It is not clear from the literature whether their lack of knowledge and action are due to inadequate health education, a failure to overcome language barriers, existing cultural/health belief barriers, citizenship status, perceived discrimination, patient dissatisfaction, and/or a lack of insurance. It is more likely a combination of one or more of these factors. What is clear in the literature is that Hispanic women continue to experience survival rates lower than their non-Hispanic counterparts *despite* numerous efforts to address this concern. What continues to be elusive is a method to determine how health care providers and systems might more effectively respond to their cultural health care needs and beliefs in order to positively influence their long term health outcomes. Understanding the factors that affect this health disparity among immigrant Hispanic women is crucial in changing this trend.

Statement of the Problem

Why I Chose to do This Study

My interest in Hispanic women's cultural health beliefs and practices stems from many years of working with this population as a women's health nurse practitioner. Over the years, I have sensed a growing concern and frustration among many of my colleagues when Hispanic women fail to come in for their annual well-woman care or follow-up breast and pelvic screening exams. The validity of their concern (and my concern as well)

is confirmed in the overwhelming literature that speaks to the disparities in health status and long term health outcomes among immigrant Hispanic women, especially those who are foreign-born. I continue to be alarmed at the unnecessary rate of end-stage cancers discovered among this population (Borrayo & Jenkins, 2003; Portillo, Villarruel, Siantz, Peragallo, Calvillo, & Eribes, 2001). Over the past 15 years I have been involved in developing several incentive and follow-up exam programs in an effort to encourage Hispanic women to seek out preventive screening exams for the purpose of improving their overall health outcomes. Unfortunately, many of these efforts demonstrated only a moderate improvement in our clients' adherence to health screening guidelines.

I sensed that Hispanic women's cultural and traditional health beliefs and values had an effect on the way they prioritized their health seeking behaviors. My experiences also caused me to wonder if there were other unknown or unspoken health care needs of which we, as health care providers were not aware and/or were not providing. I wanted to better understand the factors that influenced these women in their health care decisions. As a busy clinician I realized we were not always careful to examine existing research to guide the development of new interventions. I realized how important is was to understand the potential influence that culture has on their health care decisions. This study provided me the opportunity to develop the research skills to address this issue.

Purpose and Specific Aims Guiding this Research

The overall purpose of this study was to understand factors that influence health promotion practices and health care decisions among reproductive-age immigrant Hispanic women. The specific aims of this study were to a) explore the culturally-related factors that affect their health care decisions and b) to develop research-based knowledge

that will support the development of culturally appropriate interventions to improve the present and long-term health outcomes for this population.

Study Significance

Hispanics constitute the largest and fastest growing minority group (13%) living in the U.S. High birth rates and immigration are responsible for the rapid increase in the number of Hispanics in this nation. The census 2000 predictions estimate that the Hispanic population will continue to grow, reaching 25% of the U.S. population by the year 2025 (U.S. Bureau of Census, 2000). In the year 2000, 20% of all reported births were to Hispanic women. Currently, approximately 39 million Hispanic people reside in the U.S.; half of them are women. Between 1991 and 1998, 7.6 million immigrants were admitted to the U.S. Of these, 3.1 million came from Latin America. The Census Bureau 2000 also estimates that out of the 8.7 million unauthorized immigrants 5.4 million are Hispanic (45% are from Mexico). As Hispanics encompass a larger percentage of the total population of the U.S., the overall health statistics will increasingly reflect the health status of this population. Despite the increasing number of research studies aimed at exploring the health status of Hispanic women, there remain gaps of knowledge to precisely portray an accurate picture of their complex daily health care needs (Molina, Abesamis, & Castro, 2003).

Social and cultural factors influence the decisions that immigrant Hispanic women make regarding the utilization of health care. For some immigrant Hispanic women, relocating to the U.S. may mean a change in socioeconomic status. This change may increase risks for poor nutrition, unsafe living conditions, sedentary lifestyles, and lack of health insurance and continuity of health care (Diaz, 2002). Unfamiliarity with the

health care system in the U.S. may also influence decisions regarding when and how to seek appropriate or adequate health care (Jones, Cason, & Bond, 2002).

The process of immigration, acculturation, and the formation of a new "ethnic" identity presents many challenges to the health status of Hispanic women in the U.S. as they attempt to integrate their past and present cultures (Portillo, et al. 2001). Research in acculturation indicates that newly immigrated Hispanic women bring certain cultural traditions, values, and health behaviors which serve to support and protect their health. However, there is an increasing body of research that also shows that these health protective factors decrease as immigrant Hispanic women acculturate to the societal norms of the U.S. (Perez-Stable, Marin, & Marin, 1994; Zambrana, 1997). Studies also indicate that the acculturation experience is uniquely different for each individual woman. Because the variables in the process of acculturation can vary widely among individuals, researchers disagree on how to accurately measure the concept. This conflict presents a significant dilemma in light of the negative influences that acculturation seems to have on health behaviors and health status of immigrant Hispanic women (Molina, et al., 2003).

Little is known regarding the effects of racial and gender discrimination on the health status and health behaviors among immigrant Hispanic women. Many immigrant Hispanic women confront issues of racism and discrimination, perhaps for the first time after arriving in the U.S. Anti-immigration sentiments and discriminatory behaviors in health care and educational settings augment the stress experienced during immigration (Diaz, 2002). Vasquez (1994) states that, "Each individual that experiences discriminatory behavior has to struggle to incorporate and deal with the painful

experience" (p. 353). Encounters with racial discrimination coupled with gender and social status discrimination can be painfully traumatic and affect a woman's self-esteem and self-concept. Recurring discrimination may also lead to feelings of depression, grief, and anxiety (Vasquez, 1994) Research is needed to examine the effects of discrimination on the physical and mental health status of immigrant Hispanic women.

It is important to ascertain the significance that the process of immigration, acculturation, and a new ethnic identity have on the lived experiences of immigrant Hispanic women. Understanding this significance may help to clarify how these embodied constructs affect the health beliefs and health-related behaviors of this group of women. It is also important to understand how these processes are similar or different among and within the varying subgroups of immigrant Hispanic women.

Recent studies and research reports have concluded that despite the many attempts made to educate and encourage immigrant Hispanic women to seek regular health screening exams, disparities in health knowledge and health status among Hispanic women continue to exist. This study is significant to health care and to nursing because of its potential to provide a deeper understanding of the culturally influenced health needs of a group of foreign-born, immigrant Hispanic women. This study will address these concerns from the perspective of women from this population.

CHAPTER TWO

Review of the Literature

Significance and Background of the Research Problem

The following discussion will provide background information about the current knowledge regarding the health status of Hispanic women in the U.S. It will also examine the health disparities that continue to exist in this group of women and will identify the gaps in the literature regarding these disparities.

Hispanics in the U.S.: A Brief Cultural and Demographic Profile

The last decade has seen a population explosion among Hispanics in the United States. According to a U.S. Census report, the current population of Hispanics (of all races) is 39.9 million (U.S. Census Bureau Press Release, dated June 14, 2004). This number excludes the 3.9 million residents of Puerto Rico. The new estimate in population growth places Hispanics as the largest minority group in the nation.

The Hispanic population is categorized into subgroups or according to country of origin: Central American, Mexican American, South American, Puerto Rican, Cuban, Dominican, and Spanish. Sixty-seven percent of the Hispanic population in the United States is of Mexican background; 14% is of Central and South American background; 9% Puerto Rican; 4 % Cuban; and 7 % percent is of "other" Hispanic origins (Figure 1). Seventeen million Hispanics living in the U.S. are foreign-born. Most are from Latin America (9.9 million alone are from Mexico).

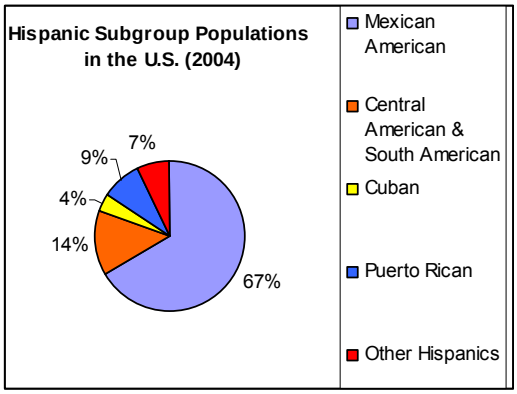

Figure 1 **Source: U.S. Census Report, dated June 14, 2004.**

Research indicates that foreign-born immigrant Hispanics have better health indicators than their U.S. born counterparts. However, among the foreign-born Hispanics health beliefs and behaviors differ with regard to acculturation levels and experience with the American culture (Escarce, Morales, & Rumbaut, 2006). Because Hispanic subgroups are greatly diverse, access to healthcare, health beliefs, healthcare behaviors, and health status can vary greatly among and within these subgroups. Immigration presents varying and unique challenges for all immigrant Hispanic women. Many arrive economically disadvantaged making it difficult to attain employment opportunities. Immigrant Hispanic women comprise a unique at-risk group because of the many challenges presented by the current stigma of "undocumentedness" in this country. These women are disproportionately affected by limited educational opportunities, the inability to speak English competently, the quality of available healthcare, and the perceived discrimination encountered in various milieus in U.S. society.

Despite their difficulties, many Hispanic women find fulfillment in their maternal roles of caring for their friends and families (Clark, 1995). Many find freedom and opportunities in the U.S. that they may not have had in their country of origin. Their

networks of social support with other groups of Hispanic women become their safety nets and lifelines in an unfamiliar world.

Epidemiological paradox

The term "epidemiological paradox" refers to the research findings that demonstrate consistent results on several measures of health that immigrant Hispanics have more "favorable health indicators" than non-Hispanic whites. This seems confusing or paradoxical because of the known lower socioeconomic profiles of the majority of foreign-born immigrant Hispanic in the U.S. (Escarce, Morales, & Rumbaut, 2006). Many studies have been conducted to explore and explain the reasons for this paradox. Two main indicators are consistent in the literature: mortality and birth outcomes.

Three possible reasons have been proposed for the epidemiological paradox in adult mortality. The first is a possible underreporting of Hispanic deaths on vital statistic records (Rosenberg, et al., 1999). The second reason is selective migration or salmon-bias effect. Proponents of this reason posit that Hispanics who migrate to the U.S. are healthier and in better physical and mental health. They return to their country of origin later in life and thus do not grow old or die here in the U.S. (Abraido-Lanza, Dohrenwend, Ng-Mak, & Turner, 1999). The third reason attributes the paradox to influences of social and cultural characteristics unique to Hispanics. According to this explanation, Hispanics benefit from protective social and cultural characteristics "that operate by positively influencing individual health and lifestyle behaviors, family structures, and social networks" (Escarce, Morales, & Rumbaut, 2006).

The epidemiological paradox is also found in birth outcomes among immigrant Hispanic women. Overall birth outcomes for these women are more favorable than

expected, given their low socioeconomic conditions. In 2001, the infant mortality rate for Hispanics was 5.4/1000 for Hispanics (compared to 5.7 for non-Hispanic whites and 13.5 for non-Hispanic Blacks). Foreign-born immigrant Hispanic women were also found to have infant mortality rates lower than their U.S. born Mexican counterparts despite having lower incomes and less education (4.7/1000 versus 5.9/1000) (Matthews, Menacker & MacDorman, 2003). Selective migration and benefits of social and cultural characteristics have been found to be the more common reasons for the paradox in the differences in infant mortality rates (Escarce, Morales, & Rumbaut, 2006, p. 394).

Current Health Status of Hispanic Women

Hispanic women in the U.S. represent a young population; the median age is 26.3 years (U.S. Census Bureau, 2000). Many immigrant Hispanic women are unemployed, less-educated, and impoverished; yet they give birth at a young age, have fewer childbirth complications, and are less likely to give birth to low- birth weight babies (Baezconde-Garbanti, 1999; Fuentes-Afflick et al., 1999; Guendelman, Gould, Hudes, & Eskenazi, 1990; Stinson, Lee, Heilmann, Goss, & Kosher, 2000). Aldrich and Variyam (2000) found that new immigrant Hispanic people eat more healthful diets than non-Hispanic whites and English-speaking Hispanic people. In many cases, immigrant Hispanic women enjoy a health and mortality record more favorable than that of non-Hispanic women (Aldrich & Variyam, 2000).

However, research findings also indicate health behaviors and practices worsen as immigrant Hispanic women become more acculturated to the U.S. (Callister & Birkhead, 2002). Unfortunately, as they adapt to the U.S. lifestyle, many immigrant Hispanic women acquire health habits that lower their health status, putting them at risk for

increased morbidity and early death. Rates of smoking, alcohol and drug use, risky sexual behaviors, and poor dietary practices increase in direct proportion to the length of time Hispanics remain in the U.S. (Guendelman & Abrams, 1995; Mora, J., 2003; Perez-Stable, et al., 1994). Researchers are uncertain as to the exact cause of deteriorating health conditions among highly acculturated Hispanic women, but they have found a relationship between time spent in the U.S. and an increased risk for developing major chronic illnesses (Himmelgreen, et al., 2004; Norman, et al., 2004). The leading causes of death among Hispanic women in the U.S. are heart disease, cancer (cervical, lung, and breast), cerebrovascular diseases, and diabetes (U.S. Department of Health and Human Services, 2003).

Risk factors among immigrant Hispanic women

Immigrant Hispanic women experience many risk factors that can affect their quality of life and long-term health outcomes, including low socioeconomic status, less than a twelfth grade education, female head of household, poor access to health care, sedentary lifestyles, obesity, and acculturation (Barron, et al., 2004). Mexican American women have the highest rates (40%) of obesity among all subcultures of Hispanic women (USDHHS, 2003). Lack of knowledge regarding healthy food choices (versus convenience foods) and lack of exercise contributes to weight gain among these immigrant Hispanic women (Aldrich & Variyam, 2000). Unlike women in the U.S., many foreign- born Hispanic women are accustomed to walking to most of their destinations in their native country. Yet, many of these immigrant Hispanic women in the U.S. live in poor neighborhoods where it is not safe to go outside for a jog or walk (Amesty, 2003).

Social and cultural barriers such as social disadvantages, cultural health beliefs and values, discrimination, and perceived culturally insensitive healthcare providers may also serve as risk factors or may interfere with health care access (Document & Sharma, 2004). Many immigrant Hispanic women lack necessary resources to use the health care system. Some do not have transportation means to travel long distances for their appointments; others lack the financial resources to purchase health insurance. Some Hispanic women experience racial, ethnic, and gender discrimination from healthcare providers, which can interfere with receiving adequate and appropriate healthcare (Smedley, Stith, & Nelson, 2003). Researchers found that many Hispanic women are dissatisfied with the health care they receive; stating that their medical providers are cold and insensitive (Murguia, et.al, 2003; Smedley, et al., 2003). Some potential risk factors for immigrant Hispanic women may also be influenced by their cultural health beliefs and practices.

Cultural and Traditional Health Care Beliefs and Practices

Culture influences beliefs about health and wellness. Researchers have found that Hispanics believe that health is a matter of chance or controlled by God; others have learned that Hispanics describe health as a balance between mind, body, and spirit (Higgins & Learn, 1999; Mendias, et al., 2001). The influence of traditional and cultural health beliefs on health care decisions among Hispanic women in the U.S. is poorly understood. Researchers are beginning to question whether a relationship exists between traditional health beliefs and the documented under-utilization of the western healthcare system by Hispanic women (Gordon, 1994; DePacheco & Hutti, 1998; Kemp, 2001; Borrayo & Jenkins, 2001; Mendelson, 2003). Hispanic women's previous healthcare

experiences in their countries of origin may influence and even impede their health-seeking behaviors in the U.S. Examining how Hispanic women define health and what health beliefs they possess can illuminate the relationship between the perception of health and illness by revealing what motivates them to seek medical care.

The literature is sparse on the possible influence of traditional health beliefs and practices on health care decisions among immigrant Hispanic women in the U.S. The cultural health beliefs practiced by many of these women have existed and evolved over hundreds of years. Many of the current and complex cultural health beliefs among Hispanics originated in pre-Columbian times (Spector, 2004). The traditional Hispanic health belief system has been influenced by the Meso-American Indians, African slaves, Spanish conquerors, and Catholic priests who accompanied the Spaniards. The Meso-American Indians, including the Mayans and Aztecs, had a very sophisticated system for treating illnesses and staying healthy. Unfortunately, much of it was destroyed by the Spanish conquerors and priests (Spector, 2004). Hispanic health beliefs were also founded on a strong religious perspective that health was a gift from God and conversely, illness was a punishment or a test from God.

Cultural and Traditional Factors & Healthcare Decisions

The healing practices in Hispanic folk medicine are holistic in nature. The mind, body, and spirit are viewed as inseparably connected, together providing a balance within the soul or inner being of an individual (Higgins & Learn, 1999; De Pacheco & Hutti, 1998). Hispanics define *health* as a balance between the forces of nature. *Illness* is defined as an imbalance between these forces (Murguia, Peterson, & Zea, 2003). As a result of past traditions, Hispanics today often center their treatments and/or cures on

returning the body to its proper balance. They regard religious beliefs and rituals crucial to providing balance of body, mind, and spirit and to promoting the healing process (Spector, 2004; Higgins & Learn, 1999; De Pacheco & Hutti, 1998). In times of crisis, Hispanic women may turn to the familiar rituals they believe will bring them closer to God such as saying prayers, making promises, visiting shrines, lighting candles, and seeking out spiritual folk healers for strength and comfort.

Although acculturation may dim convictions about traditional health beliefs, many Hispanic women maintain portions of the cultural beliefs and traditions of their native countries (Gordon, 1994; Lagana, 2003). These cultural health beliefs are passed knowingly (or unknowingly) to their children, producing a second or third generation that is exposed to these practices and traditions. Higgins and Learn (1999) contend that much of what Hispanic women, "believe, think, and do, both consciously and unconsciously is determined by their cultural background" (p. 1107).

What we currently know about traditional, immigrant Hispanic women who have low levels of acculturation is that when they become ill they first turn to their cultural norms and familiar health care practices. These practices include seeking out family members for advice, recommendations, and/or support and initiating known home/folk remedies. From the findings in their study, Larkey and colleagues (2001) suggested that Hispanics take the following path from detection of a problem to the point of visiting a physician:

1. Self-manage the symptoms
2. Consult with family and friends
3. Consult with traditional or alternative medical resources

4. Consult Western medicine only as a last resort (p. 67).

Gordon (1994) proposed a similar pattern in the health-seeking process among Hispanic women. As the primary family caregivers, these women typically are responsible to assess illness. If they are unsure of treatment, they will consult first with someone in the family (usually another woman). Home remedies are usually attempted, followed by consultation with a folk healer (if available). The entire family is usually involved in the process. They help with the care of the ill family member, provide emotional and spiritual support, and help make major health care decisions. Gordon (1994) states, that the care-giving process among Hispanic families is "well-thought out and discussed" among all the family members. The outcomes of the home treatments are "positive" whether the results are temporary or tentative (p.317). She noted that most families are left with a relieved feeling that everything possible was done for the ill person.

Although the use of traditional healers appears to be diminishing among some Hispanic women, the use of home-based remedies to treat mild illnesses persists (Clark, 1995; Mendelson, 2003). Even highly acculturated Mexican women still demonstrate a great reliance on traditional values to maintain health and treat mild illnesses (Mendelson, 2003, p. 157). Although, there is no apparent risk to Hispanic women for maintaining and practicing their cultural health beliefs and practices, some health care professionals are concerned that utilizing traditional health remedies and folk healers may delay and affect the timeliness with which a patient enters the healthcare system. A delay in treatment may cause worsening of an illness, such as breast cancer (Larkey, et al., 2001). Although the incidence of breast cancer is low

among Hispanic women, they tend to have higher rates of later or end-stage cancer when it is finally discovered, most likely because of late entry into the healthcare system (Garbers, et al, 2003; Ramirez, et. al, 2000).

Another factor that influences health-seeking behaviors among many Hispanic women is the cultural belief that much of what happens, whether for good or ill, is considered to be "God's will" (Borrayo & Jenkins, 2001). Death and illness are part of life's journey. Fatalism, or the belief that one cannot control fate, is a prominent belief among many Hispanics. Many immigrant Hispanic women also believe in predestination (Borrayo & Jenkins, 2001). They believe that if and when women become ill, it is God's will or perhaps a test sent from God. This belief may affect how quickly they seek healthcare. Many Hispanic women turn to religious rituals to plead for comfort or relief from an illness or symptom. Because they may perceive a test, Hispanic women may seek to endure (*aguantar*) the "test" well. Only when the illness lingers or worsens do they seek assistance from a health care provider.

A third factor that influences Hispanic women's health-seeking behaviors is the traditional health belief about *when* to seek health care. Many Hispanic women are unaccustomed to seeking medical care in their countries of origin if they are *not* feeling ill (Boyer, Williams, Callister, & Marshall, 2001; Borrayo & Jenkins, 2001). Hispanic women believe they are healthy because they *feel* healthy. This belief may result in a lack of understanding regarding the need to seek regular healthcare, particularly for preventive services. An example of this was found in a qualitative study conducted by Borrayo and Jenkins (2001). They explored how cultural beliefs about breast cancer affected screening behaviors among a group of 34 Mexican

women. The major reason identified for why women did not participate in screening exams was that they felt "healthy." Because they felt healthy and did not have breast cancer symptoms, they "did not see a reason to participate in breast cancer screening" (p. 820). Moreover, these women did not participate because they did not want to "risk losing their sense of feeling healthy" (p. 821).

A fourth factor that may influence health-seeking behaviors is the cultural difference in health interactions between a client and a health provider. In their country of origin, Hispanic women are accustomed to a more personal interaction with a medical provider. Hispanics in general place a high value on interpersonal relationships (Aguirre-Molina & Abesamis, 2003). Researchers have found four important cultural values that can affect adherence and health outcomes among immigrant Hispanic groups; *simpatia*, *familismo*, *respeto* and *personalismo* (Barron, Hunter, Mayo, & Willoughby, 2004; Antshell, 2002).

Simpatia is the practice of being respectful to another person; demonstrating understanding and agreeing with the advice or information given even though they may not truly understand or agree with what is being said (Barron, et.al., 2004). *Familismo* is related to family cohesiveness and the need to consult with family over all major decisions (Barron, et al., 2004). *Respeto* (or respect) is a desired quality in an interpersonal relationship (Antshell, 2002). *Respeto* is an act of deference or respect for the person one confronts. *Respeto* exemplifies a behavior that seeks to be tactful, diplomatic, and attempts to avoid hurtful feelings. *Respeto* is exercised around persons of advanced age, authority, or elevated position in the family.

Personalismo is another value desired in an interpersonal relationship among Hispanics (Antshell, 2002). *Personalismo* is an attitude which creates a smooth, warm, and friendly relationship. Gestures, such as a warm handshake or placing a hand briefly on a shoulder during a greeting, can add feelings of *personalismo* (Antshell, 2002). Health care providers in the U.S. are often in a hurried state when they enter a client's exam room. They often do not make time to exchange pleasantries with their patients. This brusque, hurried manner may not be what Hispanic women expect or trust. The kinship aspect of patient care these women receive from folk healers places the healers in a position of respect and importance (Lopez-Rangel, 1996).

Discrimination is a fifth factor. The 2003 report from the Institute of Medicine (IOM) study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, found that consistent research findings demonstrate that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and are more likely to experience lower quality of basic health services (Smedley, Stith, and Nelson, 2003). A large body of research emphasizes the existence of disparities. For example, minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery, are less likely to receive kidney dialysis or transplants, or even to receive analgesia for bone factures. In contrast, they are more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions.

The IOM study committee reviewed over 100 studies to examine the quality of healthcare for various racial and ethnic groups (Smedley, et al., 2003) The committee found that "racial and ethnic minorities tend to receive a lower quality of care" (p. 78).

This report found that these inequities exist even when racial and ethnic minorities have the same health insurance and similar access to a healthcare provider as non-minorities.

The IOM committee also explored clinic experiences (Smedley et al., 2003). While no direct evidence exists to suggest that bias affects the quality of care for racial and ethnic minorities, significant research exists that does support that diagnostic and treatment decisions physicians make are influenced by patients' race or ethnicity. Stereotyping continues to shape our expectations and perceptions of those around us. The IOM report suggests that considerable empirical evidence suggests that "even well-intentioned whites who are not overtly biased and who do not believe that they are prejudiced typically demonstrate unconscious implicit negative racial attitudes and stereotypes" (IOM press release, March 2002, p. 4).

Discussion on the Review of the Literature

This review of the literature revealed five factors that seem to influence the health-seeking behaviors of Hispanic women. These are: (a) the use of traditional health remedies/treatments; (b) cultural and religious health beliefs regarding the meaning of illness; (c) health beliefs regarding when to seek health care; (d) interactions with health care providers; and (e) discrimination.

The studies indicate that Hispanic women are highly influenced by their culture and traditional health beliefs. Even after years of residing in the U.S. many immigrant Hispanic women turn first to their knowledge of home remedies, folk health practices, and cultural rituals *before* they seek care from formal health services. Religion and spirituality are highly valued and utilized as ways of coping with illness and disease. Studies indicate that supernatural factors such as the role of God in the developing of and

healing from illness influence how Hispanic women care for themselves in times of sickness. Most of the studies confirmed what Larkey and colleagues (2001) found to be the pattern for managing and seeking health care. Most immigrant Hispanic women (1) self-manage their symptoms; (2) consult with family and friends; (3) consult with traditional or alternative medical resources; and (4) consult Western medicine only when all other alternatives have been explored.

Several studies discovered a variety of barriers for immigrant Hispanic women in accessing and utilizing health care. Researchers found that lack of satisfaction, fear and/or anxiety, cultural barriers, language difficulties, cultural differences and perceived insensitivity, and discrimination interfere with immigrant Hispanic women's ability to develop a trusting relationship with their health care providers.

This review of the literature also demonstrated that the process of acculturation influences some immigrant Hispanic women's health behaviors. Many immigrant Hispanic women are in good health when they arrive in the U.S. Most also practice healthy lifestyle behaviors in their countries of origin. However, although the reason is not exactly clear, the process of acculturation appears to have a negative influence on their health practices, health status, and on their long term health outcomes.

A Need for Exploratory Qualitative Study

What we still do not know after this literature review is how to best educate, influence, and motivate immigrant Hispanic women about the importance of preventive care. The literature does not clearly inform us as to why efforts designed to eliminate health disparities among all groups of Hispanic women have not been more effective.

Outcomes and evaluation research is needed to provide insight on the deficiencies of these new programs and interventions.

Conclusion

Understanding the cultural context of health and health behaviors among Hispanic women is crucial in the development of interventions that will be culturally appropriate and effective in helping to improve long- term health outcomes among these women. As we know from the review of the literature, recent health promotion efforts have helped but not been enough to improve health disparities among Hispanic women. After examining the strong influence of traditional and cultural health beliefs, we can see that new interventions that will penetrate the cultural and language barriers are needed to assuage fears, create trust, and promote health-seeking behaviors. The review of the literature also demonstrates that further research which can aid healthcare providers to provide culturally sound and sensitive care is essential to create trusting relationships that will improve health screening behaviors and prevent end-stage diagnosis of breast or cervical cancers. This review also illustrates the need for exploring the development of standards of practice that allow for the combining of safe folk and alternative medical treatments which may produce feelings of social and cultural acceptance. These changes are necessary if we are going to eliminate health disparities and improve health care utilization among Hispanic women.

Further research is needed to fill the gaps of our knowledge base regarding the psychological dynamics that mediate the health behaviors of immigrant Hispanic women (Borrayo & Jenkins, 2003). Qualitative interviews (exploring the health understanding and cultural health needs) where the voice of immigrant Hispanic women is represented

are necessary to further our understanding and provide answers to fill in these gaps. The findings hold potential to provide new knowledge and directions on how to more effectively meet the health needs of immigrant Hispanic women and positively influence their health outcomes.

Theoretical Frameworks

Three theoretical frameworks were used in the approach to better understand the experience of immigrant Hispanic women's health behavior in the U.S. Each played a significant role in exploring the phenomena from its own specialized perspective. Each one will be summarized and then discussed on how it informed the research questions posed for this study.

Krieger's Ecosocial Theory

Krieger's (1994) Ecosocial Theory joins biological and social analysis of the health of a population and attempts to explain "how individuals embody societal conditions" and why social inequalities in health exist (Krieger, 2001, p. 419). It also attempts to describe who and what are responsible for social inequalities in health and who is responsible for conducting research and developing interventions to address these disparities. Krieger (2001) proposes that "people literally embody and biologically express experiences of economic and social inequality" resulting in "social inequalities in health across a wide spectrum of outcomes" (p. 693). Experiences are taken from the social and material world of an individual from birth until death. She also posits that all the aspects of a person's biology cannot be understood if the history and social circumstances under which they have lived are unknown.

Krieger's (1994) ecosocial theory is founded on the theory of social epidemiology, which is the branch of epidemiology that studies the social distribution and social determinants of health. It is believed by social epidemiologists that the social environment influences behavior by helping to shape norms and providing (or not providing) environmental opportunities to engage in certain behaviors. Social environments can place constraints on "individual choice" (Berkman & Kawachi, 2000, p. 7-8).

To help create a common understanding of her ecosocial perspective, Krieger (1999) uses the metaphor of a spider's web to explain the "web" of multiple factors involved in producing the health of a population.

> A fly, buzzing about in a sunny meadow one afternoon, veers off towards some trees and suddenly becomes ensnared in a spider's sticky web. The spider bites, paralyzes, and then eats the fly. What caused the fly's demise? Its change of course? The sticky web? The venom? The spider? Meanwhile another fly heads towards the same tree, yet avoids the web and buzzes on to another field, even as a third fly briefly stuck in a similar web frees itself--followed by another fly who dies in that same spider's web. In fact, of the 100 flies in the meadow that afternoon, 20 die trapped and eaten in the spider's web, while 80 live on for another day! What caused one-fifth of the flies to die as a spider's meal? The sum of factors leading to each individual fly's demise? The number and ratio of spiders to flies that afternoon? A decline in predators of spiders? A good growth of adjacent trees hospitable for spiders weaving webs? And why, in

> another glade, were flies more likely to perish, the ratio of trapped to free flies 1:2, not 1:4? (p. 678).

Krieger (1999) uses this story to introduce the amazing number of possibilities involved with the attempt to explain the ever-changing population distributions of health, disease, disability and/or death. Looking at only a select group of factors (e.g., the glade of adjacent trees) will not provide an accurate picture of the probable causes for the distribution of health among populations. Krieger (1994) challenges epidemiologists and researchers to consider individuals in the context of their everyday lives intermingled with their historical and social experiences and as "biological creatures that grow, develop, interact, and age" (p. 897).

Berry's Acculturation Framework

Berry (1980, 2003) posits that the acculturation process is greatly influenced by the individual's desire to maintain cultural identity and his/her level of interest in having contact with the dominant society. Berry's Acculturation Framework (1980) proposes that people who immigrate to the U.S. must eventually confront questions about how they will adapt or not adapt to the lifestyle of their new society. New immigrants must eventually ask themselves the following two questions: (a) Is adapting the new culture important? (b) Is maintaining the original culture important? Berry (1980, 2003) outlines four possible options or acculturation "strategies" as responses to these two dichotomous questions (Figure 2).

		Dimension 1: Is it to be of value to maintain cultural identity and characteristics?	
		YES	NO
Dimension 2: Is it considered to be of value to maintain relationships with other groups?	YES	INTEGRATION	ASSIMILATION
	NO	SEPARATION	MARGINALIZATION

Figure 2**.** Berry's Acculturation Questions

These four strategies are: *Integration, Separation, Marginalization, and Assimilation*. *Integration* is selected when a new immigrant answers "yes" to both questions. The new immigrant desires to adopt the cultural lifestyle of the new society, as well as maintain the original culture. This strategy offers the best choice for adaptation as it allows for the individual to combine important elements of both cultures.

Separation is selected when the new immigrant desires to maintain her own culture (Yes) and does not wish (No) to adopt the new culture. The desire to shed one's own culture (No, does not want to maintain original culture) and (Yes) adapt to the new culture is defined as *assimilation*.

The inability to adapt to the new culture (No), but not being able to maintain the original culture (No) is called *marginalization.* Assessing the option or strategy chosen by an individual offers insight as to whether favoring one strategy over another provides better adaptation or presents additional stressors. It is also a means to understand the individual's perceptions about adapting to a new lifestyle. Berry (2003) indicates that individuals may favor one strategy at work and another at home. For example,

individuals may wish to adopt the ways of a new society at work but maintain their original culture in their home life. This allows them to maintain their original cultural and health beliefs at home, yet assimilate new behaviors at work to fit in. This framework may provide insight for this study in examining immigrant Hispanic women's acculturative choices and possibly the consequent influence on health care decisions.

de Anda's Bicultural Socialization Model

Although brief and simplistic, Diane de Anda (1984) offers an intriguing bicultural socialization model that may assist researchers examine how individuals can more successfully proceed through the acculturation process. de Anda also suggests that a bicultural socialization process may help provide new immigrants with necessary skills to negotiate between and within two cultural systems. de Anda (1984) expanded upon the bicultural socialization model from research conducted with African Americans. Valentine (1971) initially developed this model and proposed a process of cross-cultural socialization in which individuals would be instructed in the values, beliefs, and normative behaviors of cultural systems for the purpose of helping new immigrants successfully adapt to their host society. Because Valentine's framework lacked specification about how this dual socialization could occur, de Anda (1984) proposed six factors or mechanisms that new immigrants can utilize to negotiate their way through the acculturation process and learn to succeed in their new host society. These factors include:

1. The degree of overlap or commonality between the two cultures with regard to norms, values, beliefs, perceptions and the like
2. The availability of cultural translators, mediators, and models

3. The amount and type (positive or negative) of corrective feedback provided by each culture regarding attempts to produce normative behaviors
4. The problem-solving approach of the minority individual and their mesh with the prevalent or valued styles of the majority culture
5. The individual's degree of bilingualism
6. The degree of dissimilarity in physical appearance from the majority culture, such as skin color, facial features and so forth

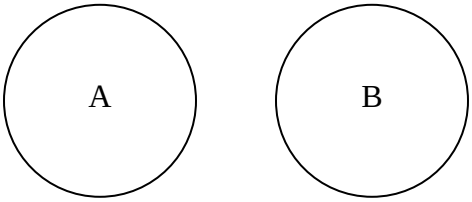

Figure 3.
A= Majority Culture

B= Minority Culture

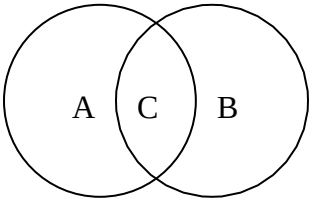

Figure 4.
A= Majority Culture

B= Minority Culture

C= Shared Values and Norms

Figure 3- Two Separate Cultures
Figure 4- Biculturalism
From de Anda (1984) "Bicultural Socialization: Factors Affecting the Minority Experience". *Social Work*, p. 102.

These six proposed factors can assist immigrant Hispanic people to acclimate to their new environment. These factors, when made available to communities where large numbers of new immigrant Hispanic families reside, can also assist them with valuable information in negotiating through the customs and mores of mainstream society. The degree or speed by which individuals become comfortable with their new society, and

learn to operate within it, is influenced by how quickly they learn the necessary skills, and is to a large degree the responsibility of the dominant society.

Applying de Anda's Bicultural Socialization (six factor model) among Hispanic women

1. Cultural Overlap

The degree of cultural overlap is represented in Figures 3 and 4. The circles represent the two separate cultures (Fig. 3) and the differing degrees by which they may overlap (Fig. 4). The overlapped section (in Figure 4) represents the shared values, perceptions, and beliefs common among the two cultures. de Anda (1984) posits that individuals are able to blend their two cultures to the degree or extent that the two cultures overlap and/or share common values and norms. The more similar the cultures, the easier it is for acculturating individuals to understand and predict behaviors in their new society, thereby enabling them to more successfully maneuver within both environments.

de Anda (1984) suggests that the dual socialization process is easier for European immigrants than for African-Americans, Hispanic, and Asian cultures because of the degree of common values and norms between the U.S. and European cultures. Figures 5 and 6 display an example of the possible fractions involved when examining the shared or common values, norms, and cultural expectations. There is a greater amount of overlap in common values, norms, and lifestyles between European immigrants and the U.S. culture than with minority groups and those of the U.S. culture. The remaining unshared area (A & B in Figures 5 and 6) between cultures can create greater differences among cultures resulting in increased levels of acculturative stress and obstacles in the acculturation process.

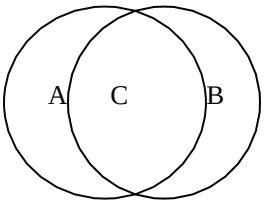

Figure 5
A = U.S. Majority culture
B = European Immigrant's culture
C = Greater amount of shared values and norms

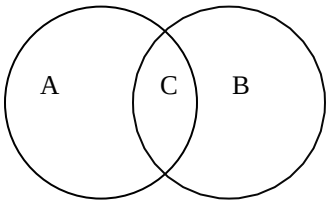

Figure 6
A= U.S. Majority culture
B = African Americans, Hispanic, or Asian Culture
C = Less shared values and norms

Figure 5- European immigration – greater degree of shared values & norms
Figure 6– Other minority immigrants--less shared values & norms

From de Anda (1984) "Bicultural Socialization: Factors Affecting the Minority Experience". *Social Work*, p. 102.

In order to provide assistance and help the adjustment process, de Anda (1984) suggests that it is important to anticipate the potential problem areas that exist in the unshared domains. Possible conflicts created by the unshared values and norms between the U.S. mainstream culture and the Hispanic culture include differences in time orientation, collective versus individualistic points of view, and family roles. The majority culture in the U.S. tends to be future-oriented. Most people are encouraged to prepare for tomorrow--today. "Time is money" is a common quote supporting this point. The U.S. majority culture is also concerned with long-range goals, schedules, and organizing events in order to be prepared for the future. The health care system in the U.S. values promptness; health care providers demand that patients arrive early or on time for all appointments. Little is said about the fact that patients are typically kept

waiting and are expected to not complain when services or providers are not "on time" for the patient's appointment (Spector, 2004). Many Hispanics and other minority cultures, on the other hand, are present-time oriented and are not as concerned with being "exactly" on time. Most Hispanics hold the belief that time is to be enjoyed (Friedman, 1998). Many Hispanics prefer walk-in clinics where the waiting is a little shorter and they can arrive "around the time" they want to be seen (Spector, 2004). Not understanding the differences in time orientation can pose problems for Hispanic women as they attempt to access the health care system or seek employment. It can also present appointment and schedule problems for those providing care or other services to Hispanic women.

Another cultural value that can cause conflict and thereby influence the acculturation process is the concept of individualism versus collectivism and subsequent family roles. Triandis (1996) has stated that individualism versus collectivism is *the* most significant cultural difference among cultures. The majority culture of the United States places a high value on individualism and individual achievement. Individualism suggests that everyone has to make it on his or her own merit. Self reliance and self-responsibility are values that are stressed and encouraged throughout life (Friedman, 1998).

Many Hispanics value collectivism. In a collective society greater value is placed on the success of the whole rather than on individual success, and family needs take precedence over individual needs. In a collective environment people are especially concerned with relationships and maintaining harmony within the group. There is more interdependence among group and family members (Triandis, 2001).

2. The Availability of Cultural Translators and Mediators

Cultural translators are defined as individuals who have successfully experienced dual socialization and can serve as effective agents in assisting Hispanic women through the process. Cultural translators can share personal experiences of things they learned in the acculturating process that were helpful in negotiating the health care system. Translators can also share experiences they have had in maintaining their ethnic values and norms while adapting to the majority host culture. Cultural mediators are individuals who serve as providers of information and guides for new immigrants.

3. Corrective Feedback

de Anda (1984) contends that corrective feedback is crucial to successfully achieving a bicultural identity. She states that it is critical that acculturating individuals receive continuous feedback on how they are doing through the adaptation process. Corrective feedback includes both the degree and type of positive and negative input received by an individual through day-to-day experiences. Acculturating individuals evaluate the worth of the feedback and adjust their behaviors to the norms of the ethnic or majority culture as they feel comfortable.

4. Problem-Solving Skills

The individual's own analytic skills are a key factor in this framework. Problem solving skills are uniquely promoted within each culture and may affect the degree of biculturalism possible for acculturating persons. Clinicians and other service providers can assess and then assist individuals to apply or develop new problem-solving skills as they attempt to change or adopt new health behaviors. Assistance can be given to new immigrants to identify challenges, assess existing coping skills, and recognize potential

resources. Evaluations and added skills can be encouraged in subsequent or future appointments.

5. Degree of Bilingualism

Bilingual individuals have the greatest potential to learn the norms of the majority culture. Language is a key method by which groups of individuals identify themselves as members of that group or community. The extent to which individuals proficiently use the language will affect the degree of dual socialization they achieve. de Anda (1984) proposes that the language of a "subordinate bilingual" is distinguished by *interference* and *dominance*. Interference is defined as mingling the elements of one language into another language, such as phonetic elements that cause an individual to have a foreign accent or using double negatives when translating Spanish phrases into English (e.g., "I don't want no more."). Dominance demonstrates the level of competence in speaking both languages. Limitations in one language or another may impede the ability to understand accurately the information being shared, and therefore influences the socialization process.

6. Appearance

The physical appearance of ethnic individuals can strongly affect the socialization process. deAnda (1984) suggests that the greater the difference in physical appearance (e.g., skin color) the greater the chance for difficulties and conflicts to occur among acculturating individuals or groups. She states that it is easier for European immigrants to come to the U.S. and blend into the mainstream culture because their appearance is not dissimilar to the majority culture. However, some minority immigrants are notably different in their appearance and sometimes in their dress. These differences can impede

the socialization process by making it more difficult for new immigrants to become "one of us" in the majority culture.

De Anda (1984) offers suggestions to examine the impact of the six factors "to determine whether they facilitate or impede the process of bicultural socialization" (p. 107). These suggestions include:

1. Determining areas of interface between the two cultures that can serve as "doorways" between them.
2. Noting the major points of conflict between the two cultures and the negative consequences for the client.
3. Searching out and providing translators, mediators, and models that can offer guidelines for dealing with such conflicts and offer critical experiential information.
4. Arranging when possible for increased corrective feedback for the client in the environment.
5. Working to expand the client's repertoire of problem-solving skills; particularly those that are the least context bound, and helping to develop a larger repertoire of context specific problems-solving skills.
6. Educating people of the majority culture about the significant characteristics, values, and needs of minority cultures as well as advocating flexibility and adjustment in the mainstream culture's institutions (p. 107).

These components are recommended as interventions to assist acculturating individuals through the process of bicultural socialization. Minority immigrants can then maintain their cultural identity in addition to learning to successfully function in their new society.

Application of Theoretical Frameworks in This Study

These three frameworks offered specific strengths to assist in examining the literature and the collected data from this study. The concepts of the process of acculturation, the process of bicultural socialization, and the embodiment of our environment are intimately related to the transition immigrant Hispanic women experience as they acclimate to a new society and a new lifestyle. Understanding the assumptions of these conceptual perspectives allowed for a deeper exploration and perhaps a more global perspective when analyzing these women's stories and interpreting the meaning of their narratives.

Krieger's (1994, 2001) ecosocial perspective provided an expansive theoretical guide to reflect post analysis the many factors that influence health practices and health outcomes among this group of immigrant Hispanic women. Her theory provided sensitivity in examining social determinants such as culture, ethnicity, discrimination, class, and gender bias that immigrant Hispanic women experience.

Berry's Acculturation Framework (1980, 2003) addresses the uniqueness of the acculturation process and yet proposes some commonalities regarding these preliminary attitudes and values about maintaining one's original culture and desiring to participate in a new culture. Berry presents the four possible decision outcomes in an easy 2 x 2 format that presents the strategies simplistically and clearly.

Although Berry suggests that the integration mode may be less stressful for acculturating individuals, he does not emphasize one strategy over another. It is extremely beneficial to understand that Hispanic women may favor one mode (integration) in one area of their lives, such as at work where the expectations to "fit in"

may be socially significant and important. Yet, at home these same women may prefer another mode (separation) where they can live their more comfortable or familiar lifestyle.

de Anda's (1984) model of bicultural socialization provides excellent factors to consider in assisting immigrant Hispanic women through the immigration and acculturation process and thereby influencing positive experiences that will contribute to better health outcomes in the long term. Because research does indicate that a bicultural perspective is less stressful for most acculturating individuals, it is beneficial for researchers to consider these factors as they develop interventions to assist desiring individuals with helps to successfully ease them through this socialization process (LaFromboise, Coleman, & Gerton, 1993).

Research Questions

The review of literature and theoretical frameworks suggests knowledge and theoretical gaps on how immigrant Hispanic women negotiate their existing cultural health beliefs and behaviors with the health beliefs and customs practiced in the U.S. Consequently, the following research questions were identified.

1. What health-protecting behaviors and health-promoting lifestyle behaviors are practiced by foreign-born, immigrant Hispanic women of reproductive age?
2. How do foreign-born immigrant Hispanic women of reproductive-age negotiate their original cultural health beliefs and practices obtained in their country of origin with those they encounter in the United States?
3. How does time lived in the United States influence health beliefs and practices among foreign-born immigrant Hispanic women?

Definition of Terms: The following list of definitions was used to clarify terms used in this dissertation.

1. Hispanic women - An ethnically diverse group of Spanish-speaking women of any racial background. Hispanic women can be from any of the following ethnic sub-groups: Mexican-American, Central American, South American, Puerto Rican, Cuban, and Spanish.
2. Health - A state of physical, emotional, and spiritual well-being.
3. Health-protecting behaviors - the use of health care screenings and exams to prevent and detect illness & disease (i.e., prenatal care, screening exams, contraception, and abnormal lab follow-ups, etc.).
4. Health promoting lifestyle behaviors - Behaviors that promote health and well-being (i.e., healthy diet, exercise, annual physical exams, etc.).
5. Culture - The "sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals . . . that we learn from our families during the years of socialization" (Spector, 2004, p. 9). Culture influences our thoughts, our decisions, our actions, and our expressions of self.
6. Acculturation - A process that occurs when individuals or groups of individuals having different cultural backgrounds come into continuous first-hand contact with subsequent changes to the original culture patterns of either or both groups (Redfield, Linton, & Herskovits, 1936 p. 6 as cited in Berry, 2003, p. 18).
7. Ethnic identity- The sum total of an individual's feelings, perceptions, values, and attitudes about belonging to a particular ethnic group (Smith, 1991, Phinney, et al., 2001; Yeh, & Hwang, 2000).

CHAPTER THREE

Methodology

The Need to Be Heard in Their Own Voice

Although qualitative studies have been conducted to explore Hispanic women's health care beliefs and practices, none have given voice to the experiences of immigrant Hispanic women learning to live within two cultural perspectives and how that process influences their health care decisions and behaviors. Three assumptions undergirded this study in the process of capturing individual Hispanic women's voices and the need for this qualitative project: (1) Immigrant Hispanic women come from a variety of backgrounds and subgroups, (2) Immigrant Hispanic women are in a time of transition, (3) Immigrant Hispanic women face stressors from their new society as well as from their unique cultural background, and (4) Immigrant Hispanic women have unique health care needs.

Immigration is a time of transition and a time of vulnerability. According to Meleis, et al., (2000) transition is a vulnerable time in which, individuals are "exposed to potential damage, problematic or extended recovery, or delayed or unhealthy coping" (p. 12). Obviously, it would be difficult to quantify the transition time for each Hispanic woman because it would be different for each one. Consequently, the conduct of investigations must work for the assumption that all immigrant Hispanic women are in a time of transition. Care must be taken to insure that each woman in transition is represented individually and not based on where she falls on a standardized measurement tool or acculturation scale. The concern raised is that these tools may replace the individual meanings and significance of the experiences lived by these women during this

process of transition. An explanation for why health deteriorates to a greater degree in some Hispanic subgroups (i.e., Puerto Ricans) remains elusive (Cervantes, et al., 1999; Landale, et al., 1999). This presents some difficulty for researchers who attempt to understand how populations of immigrant Hispanic women manage their health.

As mentioned before, immigrant Hispanic women come from a variety of backgrounds and subgroups, in which there are as many in-group differences as between-group differences. Although there are many similarities in values and beliefs among all of the Hispanic sub-groups there are also many societal and environmental differences that influence the day-to-day lived experiences among these women. From Spain to Cuba to Puerto Rico to Central America and down to the Andes Mountains of South America, Hispanic women live and raise their families with local cultural values and beliefs.

Meleis (1991) posits that immigrant women are threatened with a "two-edge sword" (p. 366). On the one hand, immigrant women have added stress imposed upon them by the expectation of the societies in which they reside to not only live in but to thrive in two worlds. Their manner of acting and reacting are not always understood by members of their new society. The demand for assimilation and *blending in* is great in a society that values conformity. However, Meleis (1991) adds that members of a society "do not usually support newcomer's attempts to cling to their own values and mores" (p.366).

On the other hand, additional distress can be caused by the cultural expectations from members of the immigrant women's own country of origin. Meleis (1991) states, that immigrant women are scrutinized by members of their own country of origin and "judged as fit or unfit to belong to that group based on whether or not they are able to

maintain and guard their original identity" (p. 366). In most Hispanic sub-groups, a woman is primarily responsible for the health and well-being of her family. Her role is typically performed behind the scenes at home and not out in society. Consequently, the influences on this tug-of war are often hidden in Hispanic women's health care decisions, practices, and behaviors. What is known is that in the United States their long term health outcomes are not favorable. A qualitative approach such as interpretive narrative analysis offers an opportunity to collect data reflective of individual women's voices and experiences.

Research Design

A Qualitative Perspective- Narrative Analysis

The major goal of most qualitative methods is to open up a deepened and more reflective understanding of the phenomena of interest (Van Manen, 1990). Josselson, Lieblich, and McAdams (2003) state that narrative research is a "subcategory of qualitative research" and it is "inherently inductive and rooted in phenomenological or hermeneutic forms of inquiry" (p. 3). The use of *interpretive narrative analysis* can be useful in giving voice to immigrant Hispanic women, a population of women whose feelings, thoughts, and lived experiences are not commonly transmitted in research. Additionally, it can provide valuable answers to questions on how immigrant Hispanic women negotiate their original cultural health beliefs with those they encounter in the U.S. Equally, it can provide knowledge on the factors that affect whether immigrant Hispanic women adopt new health beliefs and practices, relinquish others, and/or combine complex systems of health beliefs and practices. The process of collecting, interpreting, and analyzing personal narratives can offer a "personal, collaborative, and

interactive relationship," one that can unveil their voice and their concerns (Ellis & Bochner, 2000, p. 744).

The Meaning of Narratives

Narratives are stories about events or moments in time. Sandelowski, (1991) states, "A narrative is a representation of a life at a given moment rather than the life itself" (p. 163). Narratives can be used to represent the character or lifestyle of specific subgroups in society, defined by their age, gender, race, ethnicity, and/or religion (Lieblich, et al., 1998). Narratives can also be used to share "a social, cultural, or ethnic point of view that can sometimes represent unheard voices due to discrimination or racism" (Lieblich, et al., 1998, p. 5). Narratives are oftentimes referred to as stories but they can also be found in life histories, case studies, journals, conversations, field notes, personal letters, and biographical materials (Lieblich, et al., 1998; Holland & Kilpatrick, 1993). Stories or narratives can order and orient events in the context of our lives; they can also solve problems as we come to understand their meanings (Priest, Roberts, & Woods, 2002).

Narratives are often retrospective and reflective. Many times experiences are not understood during the living of them; it is only after there is time for reflection that they develop meaning (Van Manen, 1990). Narratives are therefore, ways in which to explain or interpret meaningful events in people's lives (Cortazzi, et al., 2001). Historical details of the event may be remembered differently by different participants, but what matters is how the person remembers an event with all its emotions, colors, and leftover meanings attached to it (Lieblich, et al., 1998).

Sharing narratives or stories is a natural event for many people. Frequently, a person comes to understand the self as the self is revealed to others by the narratives we share with them (Lieblich, et al., 1998). Folk stories and bedtime stories can often be full of personal narratives about meanings learned through life's experiences. Storytelling holds a special place in the Hispanic culture; some narratives called *corridos* are occasionally developed into a song or ballad. Narratives are often passed on among friends and family and down through generations from parents to children and grandchildren.

Holistic-Content Model

Although there are many different approaches to the analysis of narratives, Lieblich, Tuval-Mashiach, and Zilber's (1998) model for the classification and organization of narrative research is helpful in guiding new researchers through the process of reading and analyzing narratives. For this reason, the model was selected for this study. The model offers four different modes for examining narrative text. These modes focus on a holistic versus categorical approach and content versus form approach. The four modes include: (1) categorical-content, (2) categorical-form, (3) holistic content and (4) holistic form. Categorical approaches are similar to content analysis where sections or single words belonging to a defined category are collected from the entire text of many narrators.

Lieblich and colleagues' (1998) holistic-content model has been used to investigate individual and group narratives and has also proven to effectively examine narratives from multicultural populations. The holistic-content model for reading and analyzing narratives utilizes the whole narrative of the informant and focuses on the

content relative to the phenomena of interest. The focus of one part of the narrative such as the beginning or end is analyzed in context of the whole narrative. The analysis can also focus on one major theme, and the theme is examined in context of the whole story. The holistic content model can be utilized to examine the phenomena of interest with individual informants and groups. Similarities and dissimilarities may be discovered using this approach.

Lieblich, et al., (1998) eloquently describe the process of working with narrative data; they state,

> Working with narrative material requires "dialogical listening" . . . to three voices (at least): the voice of the narrator, the theoretical framework, which provides the concepts and tools for interpretation; and a reflexive monitoring of the act of reading and interpretation; that is, self-awareness of the decision process of drawing conclusions from the material. In the process of such study, the listener or reader of a life story enters an interactive process with the narrative and becomes sensitive to its narrator's voice and meanings (p. 10).

In the process of interpreting and analyzing narratives, the researcher diligently seeks to find the voice of the informant within the experience and in the time and setting of that experience.

The step-by-step process of reading for holistic-content as described by Lieblich (1998) begins with reading the material thoroughly several times for familiarity and until patterns begin to emerge. The focus of attention is given to parts of the narrative that feel significant in context with the entire story. Secondly, an initial and global impression of

the narrative is written. Third, special foci of content or themes are selected that appear repetitive or of special significance to the narrator. The fourth step involves reading the selected sections separately and repeatedly. Finally, selected themes are followed throughout the context of the whole narrative, and special conclusions are noted. In this final step selected themes are examined, noting where and how often they appear in the text; relative salience is also noted. Special attention is paid to episodes that "contradict the theme in terms of content, mood, or evaluation" by the informant (p. 63). Discussing the narrative with others may also be helpful during the reading and interpretive process.

Sample

A convenience sample of 20 immigrant Hispanic women between the ages of 20 – 45 was recruited for this study. The purpose of this study was to assess the health practices of immigrant Hispanic women during their reproductive years. Gathering information on health care practices during this time, when many women are more likely to be motivated to live a healthier lifestyle, offered the investigator a more accurate picture of their health promoting/protecting behaviors.

Inclusion Criteria. Healthy English and Spanish-speaking Hispanic women between the ages of 20 and 45 were invited to participate in this study. In order to examine the influence of acculturation on their health beliefs and behaviors, foreign-born, immigrant Hispanic women who have lived in the U.S. for greater than three years were selected.

Exclusion criteria. Women with a history of thought disorders, chronic illnesses (e.g. CA, HTN, and DM), physical handicaps, terminal illness, and active drug/alcohol abuse problems were excluded from the study, because their behaviors may be different

from the greater population of immigrant Hispanic women. Women who were currently pregnant were also excluded, because they were more likely to be actively seeking preventive health care. Immigrant Hispanic women with health limitations would have special health practices, behaviors, and needs that would not be representative of the healthy Hispanic population and would be outside of the focus of this study. A screening form was developed to direct the inclusion/exclusion questions (Appendix A).

Description of Research Setting

Two community health centers were approached for permission to recruit participants for this study. The sites were selected for the special services they offered to underserved populations, specifically, low-income Spanish-speaking patients. Both health centers offered bilingual low or no-cost health services. Each reported approximately 2,000 patient visits a month. The staff at these sites expressed enthusiasm about participating in a research study and having the opportunity to receive a copy of the results which concerned their patients.

Human Subjects Assurance

IRB approval was requested and received to conduct this study by the University of California San Francisco. A letter of approval was obtained from both community health centers as assurance of access to appropriate and adequate participants (Appendix B). All women were given a consent form in their preferred language (Appendix C). Confidentiality and the right of refusal were also stressed with each participant. All participants received explanations of the purpose of the study, procedures for conducting the study, compensation, risks and benefits, how to contact the investigator, and their

right to withdraw at anytime. There were no risks to participating in this study. Pseudonyms were used to protect the identification of the participants in the field notes, memos, audio-taped interviews, and transcripts. All forms with participant information were kept separate from the audiotapes and transcripts.

Methods

Recruitment

Women were informed of the study by poster/ flyer advertisement (Appendix D) and by personal invitation by the nurses and office staff of each of the health centers. Posters were displayed in the reception areas. All potential informants were informed that participation was optional and their decision to participate would not have any effect on the treatment they received at the clinic. All of the women who participated in this study were referred to the investigator by nurses or front office staff at the health centers who met the women individually and discussed the details of the study. If the women were still interested in participating in the study after listening to a brief description, and if they met the inclusion criteria, they were invited back to a conference room designated for the use of this study. There were 28 women referred during the recruitment process. Of these, four declined to participate because they did not have time or said they would return another day and then did not. Four women did not meet the inclusion criteria because of varying health reasons. All of the women who participated in the study were compensated for their time with a stipend of $20.

Data Collection

The data collection procedures consisted of in-depth one-on-one interviews, extensive field notes and memos. The in-depth interviews were conducted by the

investigator who is a bicultural and bilingual women's health nurse practitioner and is fluent in reading, writing, and speaking both Spanish and English. A bicultural, bilingual research assistant was also in attendance at most interviews and assisted with the paperwork, audio-taping, and participants' children. The women were asked to participate in one initial interview lasting approximately 1-2 hours. Although it was expected that all of the interview questions would be addressed during the first interview session, if the interview was not completed or if the information collected in the first interview needed clarification, a second "clarification" interview was scheduled.

Instruments

After giving consent, the women were asked to complete a demographic data form (Appendix E). Participants were queried for their demographic information such as age, place of birth, education level, number of years in the United States, occupation, income level, etc. This questionnaire took approximately five minutes to complete.

Participants were asked to fill out the Short Acculturation Scale for Hispanics (Marin, et. Al., 1987), which allows researchers to identify low or high levels of acculturation. The scale (Appendix F) consists of 12 questions related to the language in which a participant speaks, reads, and/or thinks while at home or within social interactions with family and friends. The three-part questionnaire examines Language Use and Ethnic Loyalty, Media Use and Preferences, and Ethnic Social Relations. The responses are a 5-point Likert-type scale where 1 = Only Spanish; 2 = More Spanish than English; 3 =Both Equally; 4 =More English than Spanish; and 5 = Only English. The responses provided by each respondent can be averaged across the items. An average of 2.99 was used to differentiate between low and high levels of acculturation. Higher

scores (greater than 2.99) indicate higher levels of acculturation. Alpha coefficient for the 12 items was .92. This scale has been utilized numerous times in studies with Mexican-Americans, Central and South Americans, Cuban Americans, Puerto Ricans, and Dominicans. The responses took approximately 5-10 minutes to complete.

The first semi-structured, audio-taped interview was then conducted. Appendix G contains the interview questions to guide the first interview. These questions were developed and utilized to provide both narrative and reflexive data from pilot work in 2003. Open-ended questions allowed the women to express their feelings in their own voice and also permitted them to explain and elaborate on their answers as they wished. Most of the women spoke English and Spanish, interchanging from one to the other to more adequately express themselves. The questions were aimed at learning about their definition of health, their cultural health care practices, their health care experiences and other health-related issues. They were also asked questions regarding the influence of the U.S. culture on their own cultural beliefs and health care practices. This interview took approximately 90 minutes. All of the interviews were audio-taped. Detailed observational and field notes were kept by the interviewer about the context and process of the interview. Follow up interviews were scheduled to clarify data, and/or pursue questions that arose during the analysis. All tapes recorded in Spanish were translated to English by a bilingual, bicultural research assistant. The investigator and a third bilingual volunteer read and listened to the translated tapes to confirm the accuracy of the translation. All materials containing research study information were kept in a locked, fireproof file cabinet.

Data Analysis

The process of reading for holistic-content as described by Lieblich, et al. (1998) began with reading the material thoroughly several times for familiarity and until patterns began to emerge. The focus of attention was given to parts of the narrative that felt significant in context with the entire story. Secondly, an initial and global impression of the narrative was written. Third, special foci of content or themes were selected that appeared repetitive or of special significance to the narrator. The fourth step involved reading the selected sections separately and repeatedly. Finally, selected themes were followed throughout the context of the whole narrative, and special conclusions were noted. In this final step, selected themes were examined, noting where and how often they appeared in the text; relative salience was also noted. Special attention was paid to episodes that "contradict the theme in terms of content, mood, or evaluation" by the informant (p. 63).

The Analysis

The analysis for each interview required in-depth immersion in the details and specifics of each narrative. The steps included the following: 1) reading and listening to the transcripts, 2) analyzing the text, 3) identifying the predominant story lines, 4) global summarizing of each interview in a memo format, 5) line by line reading and re-reading and reflection, 6) reading and listing key themes or patterns, 7) searching for unspoken or missing details, 8) writing memos regarding key phrases in the story, 9) reviewing and discussing narratives with dissertation committee members, 10) identifying themes for individual and group findings.

Interview transcripts were cleaned, prepared, and linked to Atlas ti (Version 5), a qualitative software program. The program provided an organized approach to data management and analysis. Additionally, it permitted the investigator to share the analytic process easily with long-distance committee members.

Evaluation

Key to any research study is the clear description of how the reliability, validity, or credibility of the study will be evaluated. Lieblich and associates (1998) present four criteria for evaluating the quality of a narrative text (Table 1). These four criteria were used in the analysis of this study. They state that this guideline proposes a process of consensual validation–namely, "sharing one's views and conclusions" and making sense in the eyes of a community of researchers and interested informed individuals (p. 173). They pose that including "numerous quotations in reporting narrative studies" will provide evidence of the quality of the interview and enhance the credibility of the investigator's observations and subsequent interpretation and analysis (p.173). Providing a substantive amount of quotes would also provide the reader with enough information to be able to judge the evidence and comprehend the researcher's alternate proposals and conclusions.

Table 1.
Lieblich, et al., (1998) Guideline for Evaluating Narratives

Criteria	Description
1. Width: The comprehensiveness of evidence.	This dimension refers to the quality of the interview or the observations as well as to the proposed interpretation or analysis. Numerous quotations in reporting narrative studies, as well as suggestions of alternative explanations, should be provided for the reader's judgment of the evidence and its interpretation.
2. Coherence: The way different parts of the interpretation create a complete and meaningful picture	Coherence can be evaluated both internally, in terms of how the parts fit together, and externally, namely, against existing theories and previous research.
3. Insightfulness: The sense of innovation or originality in the presentation of the story and its analysis.	Close to this criterion is the question of whether reading the analysis of the life story of an "other" has resulted in greater comprehension and insight regarding the reader's own life.
4. Parsimony: The ability to provide an analysis based on a small number of concepts, and elegance or aesthetic appeal	Relates to the literary merits of written or oral presentations of the story and its analysis

The first criterion in their guideline is termed Width: The comprehensiveness of evidence. The authors pose that including "numerous quotations in reporting narrative

studies" will provide evidence of the quality of the interview and enhance the credibility of the investigator's observations and subsequent interpretation and analysis. Providing a substantive amount of quotes would also provide the reader with enough information to be able to judge the evidence and comprehend the researcher's alternate proposals and conclusions. Numerous stories and quotes in the women's actual words guided the analysis of this study. Narratives and quotations were discussed repeatedly with experienced researchers regarding the meaning of the stories to the study participants. Alternative explanations were discussed and considered.

The second criterion is referred to as Coherence: The way different parts of the interpretation create a complete and meaningful picture. This criterion addresses an internal and external examination of the text. Internally, it examines how well the "parts fit together" to present the story provided by the informant. Externally, this step addresses how well the text supports existing or related research and theories. In the analysis of the data, themes were examined and reanalyzed with the women's stories to insure that they represented each woman's experience.

The third criterion is called Insightfulness: The sense of innovation or originality in the presentation of the story and its analysis. This criterion suggests that the analysis of a quality narrative would provide insight or added comprehension for the reader regarding the meaning and significance of the lived experience of the "other" or the informant. This new insight or comprehension would serve to enhance "the reader's own life" (p. 173). An exemplary narrative of how the salient themes fit within one woman's whole story was used to illustrate for the reader how the selected themes gave meaning and significance to the lived experiences of the woman, as well as experiences the other

women shared in this study. The fourth and final criterion is termed Parsimony: The Ability to Provide an Analysis Based on a Small Number of Concepts, and Elegance or Aesthetic Appeal. Discussing the stories and quotes with a few expert qualitative researchers throughout the process of the analysis provided feedback to assess the tightness of the fit between the narrative text, the interpretation, and the analysis.

Lieblich and colleagues' (1998) guidelines are clear and helpful for new researchers to methodically plan and incorporate each criterion throughout the research process, thereby providing for a higher degree of confidence in the findings. The guideline encourages the presentation of the informant's own voice to avoid issues of representation. The guideline also offers a way to present the results in such a way that readers may participate in the evaluation of the researcher's process of interpretation and analysis.

Credibility, dependability, confirmability, and transferability of the evaluation and data analysis process in this study were established by the use of Lieblich, et al.,'s guideline throughout the analysis process. Additionally, at least two expert qualitative researchers and members of the dissertation committee were involved in reading, discussing, and analyzing the transcripts. They assisted with the examination of the narratives and provided input regarding the described experiences of many of the narratives as interpreted by the researcher. They provided feedback regarding the tightness of the fit between the narrative text, the interpretation, and the analysis as conducted by the researcher. They also confirmed the "voice" of the women in the representation of the findings.

CHAPTER FOUR

Results

This chapter will present a description of the sample and the qualitative findings of this study on the factors that influence health promotion practices among immigrant Hispanic women. Descriptive statistics will be presented to describe the sociodemographic and acculturative characteristics gathered by the Demographic Data Sheet (Appendix E) of the study sample. Thematic findings from the narratives analysis will support the themes presented. Each participant was assigned a pseudonym to protect confidentiality.

Description of the Sample

Twenty-eight women were initially recruited to the study. Four women were excluded for health reasons and four others did not attend their interview. Two women were interviewed a second time. All of the women were interviewed at the recruitment site. Several employees of the community clinics who became acquainted with the study asked to participate. Seven employees who met the inclusion criteria were included in the study. All of the women were foreign-born with varying reasons for immigrating to the U.S.

Sample Characteristics

Twenty immigrant Hispanic women participated in the current study, ranging from 21- 44 years of age. The mean age for these 20 women was 29.9 years. All of the women in this sample were born outside of the U.S., with 40% of them born in Mexico. There were nine different Latin American countries represented in the sample (Table 2).

Table 2. Sample Demographics

Characteristic	N (%) 20	M (SD)	Range
Age (years)		29.9 (6.36)	21-44 yrs
Marital Status			
Married	13 (65%)		
Single	5 (25%)		
Divorced	1 (5%)		
Widowed	1 (5%)		
Children			
No children	7 (35%)		
One child	3 (15%)		
Two children	5 (25%)		
Three children	2 (10%)		
Four children	1 (5%)		
Five children	2 (10%)		
Education			
>6th grade	3 (15%)		
High School	4(20%)		
College	13 (65%)		
Employed			
Yes	13 (65%)		
No	7 (35%)		
Country of Origin			
Argentina	1 (5%)		
Bolivia	1 (5%)		
Chile	1 (5%)		
Ecuador	1 (5%)		
El Salvador	2 (10%)		
Mexico	8 (40%)		
Peru	3 (15%)		
Puerto Rico	1 (10%)		
Venezuela	2 (10%)		
Years in the U.S.		12.9 (6.98)	3-33 yrs
Health Insurance			
Yes	13 (65%)		
No	7 (35%)		
Annual Income			
$5-9K	4 (20%)		
$10-19K	6 (30%)		
$20-39K	6 (30%)		
$40-59K	3 (15%)		

Many of the women came to the U.S. as young children with their families. The years lived in the U.S. ranged from 3-33 years. The mean age of years lived in the U.S

since immigration was 12.9 years (SD, 6.98, Median = 12.5; Mode =12). All of the women were first generation immigrants. The majority of the women (65%) in this study were married, and 13 were mothers.

The highest year of school completed ranged from junior high to one or more years of college. Only three of the women (15%) had six years or less of education. Most of the women had at least a high school education (N=17). Thirteen of these women (65%) reported that they had at least one year of college/allied health technical school. One reported having 19 years of school. Fourteen women (70%) were employed outside of the home. The main areas of employment were office staff or medical assistants. One reported having her own business as a housekeeper. Ten of the women (50%) had annual incomes below $20,000/year. One woman did not report her income.

Spanish was the primary language spoken in the homes of these women. Thirteen women requested to be interviewed in Spanish. Those preferring to be interviewed in English used Spanish from time to time in the interviews to clarify their thoughts or describe details in their stories. Even though most of the women asked to be interviewed in Spanish (N=13), all of the women knew some English. A couple of the women asked for assistance with the forms even though they were written in their requested languages. When asked if they had difficulty reading or understanding the questions, they replied that they wanted to make sure they answered the questions correctly.

Acculturation Level

Scores on Marin's (1987) Short Acculturation Scale for Hispanics (SASH) were summed and averaged to calculate a general acculturation score. The degree of acculturation for this sample was 2.53 (SD, .61). An average of 2.99 was used to

differentiate the less acculturated (average score between 1 and 2.99) participants and the more acculturated (average score of 3.00 or higher). Minimum and maximum total scores were 1.33 and 3.58 respectively (see Figure 7).

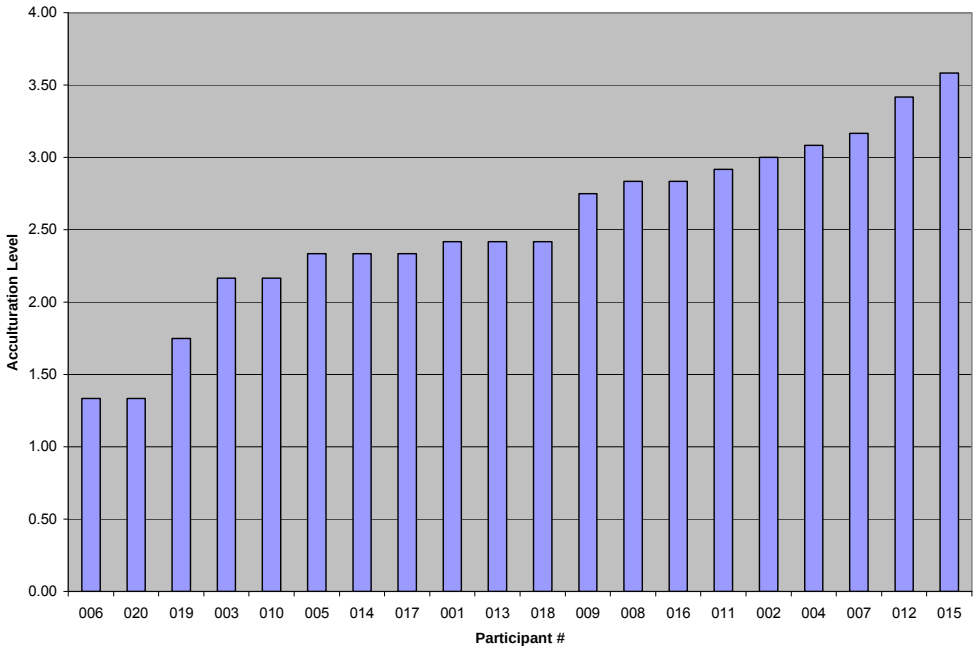

Figure 7. Sample acculturation totals in ascending order

The SASH has three subscales that measure personal language use (5 items); preferred language in the media (3 items); and preferred language use for socialization (4 items). According to the SASH scale, 15 (75%) of the women in the current study would be categorized as less acculturated. Three women had very low scores of 1.33 and 1.75. Only five women scored 3.00 or higher (see * in Table 3). As noted in Table 4, most of the women spoke Spanish rather than English in their homes, preferred Spanish programs in the media over English ones, and preferred Latina/Hispanic persons for socializing. All but two of the women responded that if they could choose their children's friends they

would want them to be “about half Latino/Hispanic and half American” rather than all Latino/Hispanic or All American.

Table 3. Sample acculturation scores

Participant	Acculturation Level
1	2.42
2	3.00*
3	2.17
4	3.08*
5	2.33
6	1.33
7	3.17*
8	2.83
9	2.75
10	2.17
11	2.92
12	3.42*
13	2.42
14	2.33
15	3.58*
16	2.83
17	2.33
18	2.42
19	1.75
20	1.33

Table 4. Marin's Short Acculturation Scale Sample Group Findings

Item/Subscale	M	SD
Language Used in Personal Life		
Language for reading and speaking	2.65	.988
Language used as a child	1.2	.410
Language spoken at home	2.25	1.12
Language used for thinking	2.65	1.18
Language spoken with friends	2.8	1.00
Preferred Language Used for Media		
Language on television	2.9	1.12
Language on radio	2.7	1.22
Preferred language for movies, TV, radio	2.85	1.31
Preferred language used for ethnic social relations		
Preferred with close friends	2.8	.69
Preferred at social gatherings	2.35	.58
Preferred in visits with friends	2.3	.80
Preferred for children's friends	2.9	.30

Major Findings/Themes

This section presents the results obtained from the qualitative interviews with twenty foreign-born immigrant Hispanic women. Most interviews were 90 minutes in length. Several women were invited to return for a second interview; two follow-up interviews were conducted. The participants in this study shared their thoughts on a variety of questions about their immigration experience, their perceptions regarding the challenges of acclimating to a new culture and environment, their early memories of health care practices in their country of origin, and their present-day experiences with health care in the United States.

Using Lieblich and colleagues' (1998) step-by-step holistic-content model to read and analyze the data, the whole narrative was utilized to identify major themes. Each interview was read thoroughly several times. Special attention was given to parts of the

narrative that appeared to be significant to the woman in context with the entire story. An initial global impression of the narrative was written. Special foci of the content were selected that appeared repetitive or of special significance. These sections were highlighted and read separately and repeatedly. Finally, selected themes were followed throughout the context of the whole narrative and conclusions were noted. There were several patterns that emerged throughout this process. These repeated patterns evolved into themes and were color-coded and given names to represent the content or foci of these given patterns found in most, if not all the interviews (Table 5). Themes that reflected the research questions were also identified. The specific research questions were:

1. What health-protecting behaviors and health-promoting lifestyle behaviors are practiced by foreign-born, immigrant Hispanic women of reproductive age?
2. How do foreign-born immigrant Hispanic women of reproductive-age negotiate their original cultural health beliefs and practices obtained in their country of origin with those they encounter in the United States?
3. How does time lived in the United States influence health beliefs?

Extensive memos on each theme, using numerous quotes, were written and shared with members of the dissertation team. Sharing views and conclusions allowed for discussion and solidification of the researcher's judgment of the evidence and its interpretation. This step also enhanced the process of examining the tightness of the fit between that narrative text, the interpretation, and its analysis.

Thematic Analysis

This section will present the themes identified in the analysis. Salient quotes will be included to illustrate and give meaning to each theme and to represent the voices of the women who participated in this study. A summary including a synthesis will be provided following each theme. One exemplar narrative that reflects a general experience for most of the women, and that reflects many of the themes, will be presented at the beginning of this section.

Table 5- Major Themes

Theme One	"Things Are Different Here" - Perceiving a Degree of Cultural Overlap
Theme Two	"We Still Keep All The Same Traditions" - Maintaining Cultural Heritage"
Theme Three	"It Was Really Hard!" - Adapting To a New Culture
Theme Four	"I Get Treated Different" - Perceiving Discrimination
Theme Five	"My Mom Taught Me to Be Healthy"- Examining Health Care Practices
Theme Six	"Sometimes You Can Take Things That Are More Natural" - Using Home and Herbal Remedies
Theme Seven	"They Might Be More Advanced Here"- Accessing Health Care in the United States
Theme Eight	"We Need More Education" – Accessing Community Resources

An Example-- One Woman; Many Voices

Yasmina is a 25-year old Hispanic woman from Peru. She has been living in the U.S. for 17 years. She is married and has two children. She and her husband both work

full-time, and their annual income ranges between $40,000 and $59,000. She graduated from high school and currently works as a health educator. Yasmina is a soft-spoken, well-dressed young woman. She expressed great interest in participating in the study because she "wants to make a difference in helping other Hispanic women."

Yasmina shared her immigration story, one filled with fear, sadness, and hope. Yasmina remembers fleeing from Peru with her father at the tender age of eleven. She recalls the sounds of *"bombs going off in the neighborhood where we lived."* It was a year to elect a new president and her country was at war. Her mother and two siblings remained behind for another four months – until it was safe to come to the U.S. Yasmina had aunts that lived in Utah, so this is where they came to live. Her father, a banker in Peru, found menial jobs and was able to support them for a time. He later found a better paying job in New York. Yasmina stayed behind with her aunts. She found the U.S. very different from home.

Yasmina struggled to acclimate to her new environment. Similar to other study participants, elementary school was extremely difficult. *"I was the only Hispanic person in the whole . . . school"* she said. *"There was a lot of prejudice…a lot of racism."* Yasmina said that there was racism because people had not met anyone *"that spoke Spanish."* The prejudice and racism were made more difficult later for Yasmina when it was directed at her younger siblings. *"It was just horrible!"* said Yasmina. The racism became so unbearable that Yasmina and her siblings vowed to not let on that they were Hispanic. *"I did not want to be known…as weird."* They were careful in how they talked, dressed, and behaved. At the end of the first year, Yasmina's father passed away of cancer. They were left to fend for themselves and life became even more difficult.

Yasmina's mother took on three jobs to support the family; it became Yasmina's job to look after her siblings. Eyes filled with tears, she shared painful memories of growing up with loneliness and discrimination. More tears were shared when she expressed that despite her best efforts she was unable to protect neither her siblings nor her own children from it. After many years, Yasmina now embraces her cultural heritage. She wants to teach her own children to maintain their cultural heritage and learn to speak Spanish. She said, *"I made it so that they would not feel ashamed, but now they don't really know much about it. And so now we . . . are trying to teach them."*

Like many of the women in this study, Yasmina learned from her mother how to care for herself and her family. She was taught to use home and herbal remedies to care for illnesses. When asked if she believed in home remedies she said, "*I think it does [work], on some things."* She said that she is grateful her mother lives close by. She shared, *"I take their temperature and then I usually call my mom and let her know the symptoms to see if there is something that she recommends"*. She admitted that she uses herbal teas to treat minor illnesses like colds or stomach aches at home. Yasmina also learned from her mother to eat a healthy diet (fruits and vegetables) and to exercise daily. Since her mother developed diabetes a year ago, Yasmina is even more careful with their nutrition.

She admitted she needs to be more diligent about her women's health screening exams. She had a difficult experience with a health care provider who, even though she was the first patient of the day, "*made me wait over an hour in the waiting room and no one came to tell me anything."* When she finally saw the gynecologist, Yasmina said the doctor "*did not take the time to explain what she was going to do, or even introduce*

herself . . . and when she was done she just walked out!" Because of this experience, Yasmina waited a couple of years before having another exam. Yasmina shared that she knows that because her mother was diagnosed with ovarian cancer three years ago, it is *"important for me to do it."* Yasmina explained why she is hesitant to see a provider. She said, *"I want someone that sits down and looks at you and actually talks to you and treats you . . . someone that uses your name and treats you as an individual not just as a symptom or a number . . . We need more providers that speak the language. We need more of them!"*

Yasmina's story includes examples of all eight themes identified in the stories of 20 immigrant Hispanic women. All of the women were born in different places in Latin America, yet they all shared a common element in their lives, that of immigration. These women brought with them their own cultural perspectives, beliefs, and values. Many of their cultural beliefs, traditions, and practices shared common threads. These eight themes represent some commonalities among these women and demonstrate how they negotiated their cultural health beliefs with those of their new society in the U.S.

Eight Major Themes

Theme One - "Things Are Different Here"- Perceiving the Degree of Cultural Overlap

When asked about their experiences with adapting to the norms of their new society in the U.S., many women talked about the differences between cultures. Women in this study found positive and negative differences between cultures including family/friend relationships, lifestyle, food, relationships with health care providers, feelings of safety and security, expectations and interactions among parents and children, and lack of respect among young people. For many of the women, the differences in the

social structure of their new environment were the most difficult to understand. Amanda attempted to articulate this difference.

> *Well, it is very different from here! Here it is not like I can go to my neighbor and say, "Let's go outside and talk!" In Latin American countries you can go to your neighbor and chit chat outside of your house and enjoy just talking!. . . culture-wise it is just very different from here in the U.S. I think it's got to be in the lifestyle there . . . your life is a lot more busy than in Venezuela. I don't know… Latin countries are . . . I don't know why, but they are different, way different than here. Everybody rides the bus over there. You get to know more people when you are riding the bus than you know riding in your own car. . . Little things like that make things different.*

Sylvia commented on the differences between social contacts and open expressions of affections among her people of Peru and those she has encountered here in the U.S. She stated,

> *I would say the language and the love that we have as Hispanics. It is very different from the Americans; we are more expressive in our feelings! Not everyone-- but the American is more reserved. I can give you a hug, and it's a sincere greeting! But I cannot do that with all Americans.*

Paola shared similar sentiments. She expressed concern that people from the U.S. might feel uncomfortable with the customary display of affection found in daily greetings among friends and family typical of Hispanic people. She stated the following:

Hispanics, I think are more loving! They're more touchy-feely or more, I don't know how to explain it. I am not saying Americans are cold-hearted or anything like that! But I mean that way they are a little bit different. You know when we say "Hi"…we always kiss each other on the cheek. Americans don't do that! Obviously, they would take it like "whoa" or "what?" I don't know…but it seems like Hispanics…we are always very close to the family and we always have big families! There are tons of cousins and uncles and… [laughter], kind of like the Greeks, they have big families too!

Erika shared that the lack of social interaction caused their family to create an imaginary shell around them, perhaps a shell where inside they felt united and safe.

Here the Hispanic has to live his life a little bit apart, how do I say this… more withdrawn. For example there is not, how do I say it? Here you don't socialize a lot. Right? We have created like a shell around us as a family and everything.

Yolanda had difficulty voicing the differences in cultures. She struggled with the words to adequately express what she felt. She stated,

*You feel like something that you don't feel here anymore! You can have everything here but you don't feel the unity in people. The people are like…here you become more like... different than in Mexico, you become more "seco" [*dry; without expression*]. I don't know... like if you were more distanced from people and in Mexico it is not like that. In Mexico you feel like... for example when there are parties... the environment is*

different, everybody gets together, they make a party…and the food… and you dance and you spend time and interact with your family and friends.

Esther expressed feeling a difference in the way people support each other. She voiced that her friends and family in Mexico had developed a close relationship. The closeness of their relationship allowed her loved ones to know when she was in need and this created a strong bond between them. Esther has not been able to find or develop a friendship with anyone here in U.S. She shared this narrative,

It's different, it's still like a different feel, you know, and you just feel you can like ask for anything and they will do it for you, because you don't even need to ask for things, they just know what you need, and how you need it, and when you need it, and you just feel that kind of bonding.

Serena shared Esther's perspective on the support she feels from her friends and family back home in Mexico versus what she has experienced here.

I have a friend who was born here, she's an American. She's …she has a lot of problems with her sister. Her sister didn't help her or even show interest to helping her. When my sister has a problem, you know, I'm always there! So money or whatever she needs…we are always there for each other. Yes, we let them live with us if they don't have a place to live. I don't think the American people do that. I don't think they are as close as we are with our families. You don't hear about them doing things like that for their families.

Maricella was concerned about the differences in what parents teach their children. She verbalized a worry that her children would not learn respect for others as was strictly taught to her as a child in El Salvador. She also expressed uneasiness about the materialism emphasized today in the American society and its effect on her children. She stated,

> *They get used to the American lifestyle or they adopt cultures that aren't from us. It is not from this culture to teach the things we teach. So our children grow up a different way not from like us--our way. I think that the families are very close there, but it isn't like that here. They haven't kept that here. They tend to go toward more material things than respect. Here it is important to have many things. It is not that way for us, we teach other things. We teach respect and family closeness; not like material things. That is not so important.*

Dolores shared her feelings about something else that is different here in the U.S. She discussed the disparity with the sense of time. She expressed concern for the fast pace of her life in the U.S. She stated,

> *I think here they live life at a really, really fast pace! It seems like years go by really fast! When you are in Mexico, I guess you have less to worry about because when I was down there…I never had to worry about 'Oh I need to be here at this time or I have to be there at this time.' It was just worry-free! Here it is, 'You need to be there at this hour'…'You need to be in this place.' I think it's just really fast pace here! They don't really take time to slow things down and live life! Time was not an issue.*

Some of the differences in cultures were not at odds with the values held by a few women in this study. Vickie verbalized her appreciation for the abilities and knowledge she gained here in the U.S. She described her acculturation process as a time of growth and progression, even as "an awakening." She said,

> *In Mexico it is different from here because in the first place there is more machismo and less liberty because your parents were strict...I grew up in a world where they hide liberty; your mind is not developed. When I go there to see my mom and my brothers and my family and friends I say to myself, 'It's been 10 years and I come back and as soon as I get back I see the same ignorance and they haven't progressed at all!' I see myself so awake, so developed! I think I grew up as a human being! I grew up as a woman and I can only achieve that here* [US] *because there* [Mexico] *they continue…they keep covering people's minds! They cover something that is so normal… hat is natural and I say 'Wow, I am glad I learned it there* [US] *because if not, I would be another woman here and I would have the same ignorance!'*

Yolanda expressed greater feelings of safety and security in the U.S. than she did in her own country. She shared,

> *It is more secure here…well in my country there's not that much security. Policemen…over there… it is very different…there's more corruption. Here there's not. Here if you miss a stop sign, they give you a ticket and you have to go and pay it. In Mexico you don't, in Mexico you can give*

money to the policemen…They can ask you for any amount of money and then you can leave!

Serena voiced that she appreciated the freedom of being an "equal" with her husband here in the U.S. In her country of origin (Mexico) it was the woman's job to stay at home and do the cleaning, the cooking, and caring for the children. In Mexico, she did not feel an "equal" with her spouse. She said,

I am equal with my husband…I work as much as he does and we bring… both of us bring money in to the home. So if we are going to be doing something in the house, he is going to be helping! In Mexico, the woman stays more at home… home with the kids. It is not equal there.

Only one woman said that she did not feel there was a significant difference between her cultural norms and values in her country of origin (Argentina) and those of the U.S. Gloria voiced that although they, as a family had to adjust to *"new schedules, the way of living, the times we had to go to school, the times we ate, the times we get up,"* she did not find it difficult to adjust to her new environment. Gloria shared,

That hasn't been hard for me to adjust to because we had our values as a family when we moved here and the values are the same. There are a lot of good values in the American family as there is in the Hispanic family, so that wasn't much of a change for me.

All of the women in this study reported small degrees of similarities or cultural overlap between their native countries and the U.S. The majority however, talked about the differences. The most notable difference reported by the women was the reserved or less demonstrative nature of North American people. Women talked about the warmth

and familial-like affections they shared with their family, friends, and neighbors in their native countries. These shared experiences of "missing something" in their new communities relate to the Hispanic cultural value of family cohesion or *familismo*.

Familismo refers to family connectedness or family unity. This family attachment expands to extended family, friends, and neighbors (Antshell, 2002). Familismo involves emotional support, generosity, respect, loyalty, and reciprocity (LaRoche & Shriberg, 2004). Many of the women acknowledged this difference in cultures and appeared to see this as a barrier in accessing their neighbors and potential friends. One woman said that as a result of this "difference" she felt, Hispanics have to be more "withdrawn." Another woman described creating a "shell" around her family. This perceived difference caused many of these women to feel unable to share of themselves with those in their neighborhoods as they "naturally" did in their native countries. Most of the women, talked about feeling that things were different in the U.S. Perhaps this caused them to perceive themselves as different too. Despite length of time in the U.S., the majority of the women continued to prefer their social, familial-like customs over the more reserved lifestyle they noted in the U.S. They maintain their cultural mores and values in the home and live a more integrated or bicultural life at work.

For a few women the benefits of living in the U.S. outweighed the differences. One woman voiced that she was able to progress in a way that she would not have in her country. She felt that the U.S. opened her eyes to new understandings that are kept hidden in her native land. Another woman expressed appreciation for being an equal with her husband. Because they both needed to work to provide for the family, she was able to share a more equal footing with her husband. Another woman shared that she felt

freedom and security from corruption and oppression in the U.S. that she had not experienced in her own land. Despite the benefits, most women did not express a desire to fully assimilate to the culture and lifestyle of the U.S.

Theme Two- "We Still Keep All The Same Traditions- Maintaining Cultural Heritage

"My children are growing up with a mixed blood, so we want them to follow my culture, to follow the ways of my country." –Sylvia

When asked about what things were important for them to maintain about their culture, many of the women in this study mentioned language, family traditions, cultural identity, family cohesiveness, and respect (for family members and others). All of the women reported that they felt it was important to adapt to the lifestyle of the U.S. in order to be included and be happy here. However, most of the women expressed a desire to maintain their cultural heritage as well. All of the women voiced their desire to retain a strong sense of ethnic identity regardless of the length of time in the U.S. or the level of education attained.

Several of the women voiced that regardless of the length of time they have been in the U.S., their cultural identity remained tied to their country of origin. Sylvia expressed it this way; *"Now I am an American citizen, but my blood is Peruvian!"* Gloria shared a similar sentiment. She said,

> *I have most of my family here, so there's not really much to go back for. I still like the culture, I still like the food, I still have all those things in my house…but I don't necessarily have to go back to feel… in my heart I'm Argentinean and I always will be.*

Many of the women commented on their desire to maintain the family and holiday traditions they experienced in their country of origin. Gloria expanded on this, by sharing the following,

"We still keep the same traditions here, because my whole family is here. So for like birthdays we are all together. For holidays we are all together. Yes, for anything, you know we are supporting each other and that's a big thing in our family…and it's always been like that.

When asked what was important to her about her culture, Paola from Venezuela said,

Being involved with my family and doing all the things that we used to do there! Celebrating all of the holidays that maybe aren't celebrated here but are celebrated there…we have our get-togethers. Christmas! Just try to…we still keep in contact with our family down there, or they come and visit us here once in a while.

Saray shared a narrative about a discussion she had with her son about cultural heritage. In this conversation with her son, we see her son's struggle to define his own cultural identity.

I love my country! I am very proud to be a Mexican, to be Latin, to speak my language! I treasure it and I feel very proud to be a Mexican… So I see the Mexican flag and I say 'Wow, this is me!' My oldest son says, 'Mommy, I am a Latin. I was born here… American, but my blood is Mexican. I am Mexican.' And I say, 'Yes, but your flag is this and my flag is this.' He says, 'No mommy, I can also have the Mexican flag.' 'Yes, you

can have the Mexican flag, but you were born here and this is your patria, like mine is the Mexican patria.'

Sonia stated that she was taught as a child by her parents the importance of maintaining her cultural heritage. She teaches her children in the same manner. She relates,

Yes, well we have always been Puerto Ricans [laughter] that's a big part of it! Like I said my mom always spoke Spanish to us. In our house we weren't allowed to speak English and so we've always spoken Spanish to my parents. And also just the holidays, you know traditional holidays, and whatnot, stuff like that! We have always been Puerto Rican even if we live here. So, we still try to keep it that way!

Several women shared their efforts to pass on to their children a desire to maintain their cultural traditions and beliefs. These women talked about teaching their children about the history of their people and of the country of origin. Iliana said,

The family values there I feel are very important. I try to teach them (my children) a little bit of the history of Mexico, even though they are not that interested. I try to teach it to them.

Erika, a woman from Peru also shared her desire to teach her children to appreciate the family values taught in her country. She shared the following narrative,

I can teach them the values, the traditions of Peruvians, even though they are here or they are growing up here they still live under our rules and our traditions.

Maintaining the Spanish language within the family was extremely important to many of the women. They all discussed ways in which they encouraged their children to speak Spanish in the home so they would not forget it. Maricela voiced that teaching her children Spanish was so important to her she taught them to use it daily. She stated, "*The language is important. They have the language…they have it because they even read and write in Spanish*." Erika shared how they speak mainly Spanish at home. She said,

> *"Yes, definitely the language! We have kept that in our home and in our family. My husband tells my kids, "We speak Spanish and Spanish is the main language in our home." I hope it will be with them forever, because even when they grow up it will help them a lot to be bilingual.***"**

Several women related that they spoke only Spanish to their children from birth until their children began elementary school. Now that her daughter was starting school, Gloria was concerned that she would learn English and forget her Spanish. Gloria said,

> *The language is really important. I really taught my daughter so that she only speaks Spanish at the house. And I try to speak only Spanish to her. Sometimes it's hard because she started school now and she's learning more English and so it is becoming easier for her to speak it.*

Iliana also shared concern that her children would lose their Spanish speaking skills. She shared,

> *"The language is another thing. I don't want them to lose it, and it is getting harder now because they are getting older and they are in school and it is easier for them to speak in English. I would like to keep that--the language –so they can read it and write it.*

Serving traditional food was another important cultural value held by several of the women as a way of maintaining their culture heritage. Erika and Esmeralda shared the following sentiments about food.

> Erika*: And also the food! I continue to cook the same as when we were in Peru. For example, we don't go to Peruvian restaurants because we don't need to. We always eat Peruvian food at home. We continue to eat the same thing.*
>
> Esmeralda*: To this day we only eat food from Bolivia. Not Mexican, not anything else, only from Bolivia.*

Iliana and Dolores shared two other cultural values they wanted to maintain. Iliana mentioned respect for others. This trait was important to her; it was strongly emphasized to her as a child by her parents and by her teachers at Catholic school. She expressed concern that it was not strongly emphasized in the U.S. culture. She said, *"I think there's a lot of respect… for your grandparents, uncles, aunts. There's a lot more respect and a lot more communication."* Dolores added religion to the cultural values she wanted to maintain. She explained,

> *My family and my grandma, and my aunts, they are all very religious! So I've kept that with me! I don't know what else…well maybe I could say the culture and just how our lifestyle is down there! We…my family…we try to keep it as close as possible here to how the lifestyle is there down there! We like how it is down there.*

Saray voiced what many of the women expressed. She said,

You never lose the most important things from your culture, but you are living in another country, there are also other cultures here, you mix them and you teach your kid both of them, Mexican and American. Yes you can mix them and you can have success.

Several women mentioned that family cohesion and family support were very important to them. The special nature of family gatherings and family traditions were listed as cultural values they wanted to maintain and pass on to their children. Language appears to be a very important factor for these women as well. All of the women expressed a desire that their children maintain their ability to speak Spanish. Many of the women described activities they perform at home to encourage their children to know and desire their cultural heritage.

Ethnic identity seemed salient in these narratives. All of the women voiced a strong attachment to their identity from their countries of origin. A desire to keep their ethnic identities was strengthened by their family ties and maintaining cultural practices. Some of the women reported that they believed they could successfully acclimate to their new surroundings while maintaining their cultural heritage and traditions. While it is understandable to want to cling tightly to their cultural identity and traditions, it may also create obstacles for them and their children. Immigrant Hispanic women may not comprehend the need to assimilate, to some degree, in order to learn how to successfully navigate in the U.S. culture. This includes high proficiency in English and knowing how to negotiate the U.S. infrastructure (health care systems, education system, and government services).

Theme Three -"It Was Really Hard!" - Adapting to a New Culture.

You don't speak English, and then you get put in a handicapped class, it just makes it hard and I hated it! I hated every minute!" –Yasmina

When asked to share stories about the process of adapting to a new culture and the U.S. lifestyle, many women shared heart-wrenching stories of the difficulties of this process. Language difficulties appeared to be the single biggest reason for the hardships in acclimating to the U.S. Not being able to communicate with others was extremely distressing for most of the women regardless of age. Amanda and Yasmina shared similar stories of what it was like to begin attending elementary school shortly after arriving in the U.S.

> Amanda*: Oh it was horrible! Not being able to communicate, like the first probably, month or so, I would come home crying and tell my parents "I can't understand anything!" "I can't ask any questions or anything!" It was hard! I remember there was like probably five Latinos in my class, five or six of us in our elementary school. It was hard for us to not understand anything that was going on; real hard!*
>
> Yasmina*: Nobody spoke Spanish and so I felt completely out of place trying to learn the language. There was no ESL back then, and so it was just…being in third grade and you have to pretty much figure it out on your own! Because they didn't have a program for Hispanics to learn English, my aunts would try to teach me at home. My mom didn't speak English when she came here and so…she couldn't help me with the homework and you fall behind. I remember my brother and my sister when they came here, there was no ESL and so they put them in classes with*

handicapped children because they were "behind" which they weren't you know! I… we knew all the math, we knew all that stuff coming from Peru. We just didn't speak the language which made it really hard for us to try to get ahead and try to fit in with the kids.

Esther expressed similar challenges in middle and high school. She discussed the challenges of being among a small group of students who were Hispanic and who also did not know how to speak English. She did not find the English as a Second Language (ESL) classes to be very helpful or supportive:

Esther*: When I came here, I went to high school and it was totally different, like at first it was really hard. I didn't speak English. I remember I used to sit there crying, like what are they talking about? And people would ask me things and I would be like, "Oh, my gosh!" I remember going back home and trying to do homework and… but what was I going to do? I didn't even know what kind of homework we had and my mom would be so sad, like she would just sit there and cry.*

Sylvia shared how burdensome it was to find a job because she could not speak English. She needed a job to help support the family. She finally found employment where she was not required to speak English. She said, *"A lot of the Hispanics here don't speak the English language, so we simply work in a job that…how do I say…where you don't need English, only hands."*

Vickie expressed feelings of frustration at not being able to communicate her basic needs. She admitted that she is studying English but finds the process slow because

of work and caring for her family. She shared this experience about her attempts to fill a prescription;

> *I don't speak it very well. I don't understand very well at all the English. For example, when I had to go get a prescription and they spoke English. I could not understand. I could have called it in ...but since I don't speak English, I didn't do it. I got frustrated because my conversation would be too short and in the end they would not understand everything I was saying. I am trying to learn; it is just slow. And meanwhile, I cannot speak it and they don't understand me. This is frustrating!*

Several women discussed other hardships with acclimating to their new society. They talked about the loss they felt at leaving all they knew and loved behind. Many women came as small children and did not have a say about the process of immigrating to the U.S. Nevertheless, they were still faced with the challenges of acculturation. Esther felt strongly that she should have been allowed to stay behind with family members. She said, "I didn't want to come here, I mean I have a good life and everything, but I wanted to stay there and every day that I wake up I wish I could go back and never come here." Paola, came here as an eight year old child. She also shared her sadness at leaving all she knew behind in Venezuela. She stated,

> *At first, you know as an eight year old, you have all your friends that you've grown up with, your whole childhood and then to have to come here and leave all that behind, that's hard! Especially getting used to new people and a new climate, everything, language and stuff like that!*

Yasmina shared how her father passed away shortly after they arrived here from Peru. As the eldest, she was given responsibility to take care of her younger siblings. This was a task she felt was too difficult for a child so young.

So after a year that we were here, he passed away. And so my mom had to get three jobs to support all the three kids! She didn't speak English and so…she had to start just from the bottom, just cleaning stuff and um… working…taking care of elderly people. So it was…that's when we were really left alone at home. And I was the oldest and so I would take care of my brother and my sister.

Maria missed her family mostly. She felt lonely and isolated after arriving here from Bolivia. Money was scarce and so a trip home was not possible when she learned that her brother had passed away. She shared her feelings of loneliness,

But not being able to speak or communicate your feelings with others… that nobody could compensate. Because my husband worked all the time, and the children were too young to talk to about my feelings; that was the hardest thing! Then, my brother died three months after we moved here and I was pregnant with my boy and so that was hard…a hard time for us.

Erika found it difficult to adapt to her new lifestyle. She missed all that was familiar; all that to her represented home. She commented,

The food, the traditions, and the people are more like…how can I explain? The people are more because everyone speaks their own language you know, and you're in your own country, and it's easier. For example you get together on the weekends and everyone is there! For example, at my mom's

house, we could get together-- all the family. For instance, on a Saturday or Sunday all my brothers and their kids, and everyone, would get together! And we used to have a good time, and here, we can't do that.

Esmeralda admitted that although she was excited to come to Canada first and then to the United States, she did not expect to feel the deep sense of loss for home and for her family. She found acclimating to her new society much more difficult than she thought possible. She said,

I believed in that image that I was going to find everything easier and I didn't! The first barrier was the language. They don't understand you, they reject you because you don't speak the language correctly…that you don't know how to communicate...Even though I was 26 years old when I left my country, my house, even though I was an adult, I had always lived with my parents. So coming to a foreign country, without your parents, without your friends, without your language, being alone, it was very shocking for me! I mean, it was very shocking! I cried almost every day!

A few women shared how they coped with the difficulty of acclimating to their new environment. Gloria shared a narrative about how as a young girl she tackled the challenge of attending school, not knowing how to speak English. She said,

It was hard…it was hard but I kept telling myself, okay, I can stay home and feel sorry for myself and not go to school and not get an education or I can get out of bed and get to school and learn and so that's how I got over that.

A few women had a strong support system here in the U.S. They had family or friends to help them transition to their new culture. Cynthia came here to attend a university. She lived with a sister who also attended the university and who had a vast group of friends. Cynthia shared,

> *My sister had already lived here for a year, so she was showing me where everything was and where I had to go if I needed something. She was teaching me everything. I think I was here for about four days before school started. And then school started and I liked it, it was nice! I began to meet people and there was more activity and so it was better. It was hard at first but being in school and meeting people and talking to everyone, that was all good! We had Spanish-speaking friends so that made it easier.*

Sylvia expressed feeling excited to come to the U.S. She first came for vacation to visit family. Later she decided to stay. She now has all of her family here. She stated that she loves living here. She said,

> *I've been in this country for almost thirteen years. My father was the first that immigrated to New Jersey, and then I came. I decided it, I chose to come and I loved it! I decided to stay in the United States. Eventually my father was able to bring my entire family here! Thanks to God, we are all here now. From New Jersey I came here to study college at UVSC eight years ago! After this, I met my husband and now all my family has decided to move here also! So I have my parents, my brothers, brothers-in-law… everyone! Thanks to God!*

Maricela moved here from El Salvador. Two years after she moved here her mother came to live with her. She has not returned to visit El Salvador because she said she has all her family here. She shared, *"Unlike other people that come here…they don't have any relatives and it is an adventure for them! But thanks to God I had my brothers here. I have five brothers here and we are seven in my family."*

Although she does not have family here, Francisca moved to Utah to be closer to the headquarters of her church. She feels she has more opportunities as a woman here in the U.S. than she would have in her country of origin. She is actively involved in the activities of her church and has several friends. She states that she has a strong support system and feels happy to be here. She shared,

> *As women we are taken into account here, no? We can have participation in any service here. We are accepted in. There is also more access to health care and English language preparation. Sometimes if you cannot communicate well in English, they try to help you and understand you. Also, they help you so that you don't feel bad and feel supported and protected. That's why I have been living here foreight years; otherwise I would have gone back to Mexico.*

When asked to share their stories of coming to the United States, most of the women described it as a very difficult experience. Many women came here as children because their parents chose to relocate. Almost half of the women came to the U.S. as children under the age of 14 (45%). For these women, acclimating to a new culture appears to have been more difficult because of language barriers,

ethnic differences, and a lack of awareness among members of the dominant society regarding the needs of new immigrant Hispanic children and families.

Most of the women reported that after they learned to speak English they were able to adapt more readily to their new life. Women who came to the U.S. as adults and were able to develop a support system early on (such as, friends, family, or church associates) reportedly had an easier time adapting to their new lifestyle, although many still experienced challenges because they did not know how to speak English.

These narratives highlight the tremendous need for new immigrant Hispanics to have resources available to become proficient in English as quickly as possible. Many of these women suffered greatly because there was not a system in place to assist them or their parents in developing the basic and necessary skills to negotiate through the mainstream culture. Several women voiced the importance of family support to help them through the acculturation process. Adult women who immigrated to the U.S. and came to live with or near family voiced that this was significant for them and aided them through the hardships of acclimating to their new environment.

Theme Four - "I Get Treated Different" - Perceiving Discrimination

"Sometimes it is very hard because they see you… and they see your Hispanic appearance and they suddenly stop what they are saying or doing and look at you. I notice the difference in the treatment. It doesn't bother me like I told you…it bothers me at the moment. But it doesn't bother me because I say to myself I'm not going to deprive my kids…to live in a better country. So I tell myself well nobody is perfect. They have their own ideas but I am not going to let it matter. And it doesn't." -Erika

Several women shared experiences with perceived discrimination. Most of the women described perceived discrimination as "being treated different." Dolores, a 21 year old Hispanic woman, expressed it as being treated differently and being "set aside". Some discrimination came from members of the dominant white population, some came from other Hispanics, and some came as a result of differences in religious beliefs. Women shared examples of both personal and family experiences with discrimination directly related to their ethnicity. One woman felt so much discrimination in elementary school that it caused her to put aside her culture, identity, and language. She felt it was necessary for her survival in her new society to not be different or "weird." She experienced "horrible things" and she "hated it." Yasmina, a 25 year old Hispanic woman from Peru shared the following narrative:

> *Once we learned English, we wanted to stay away from Spanish, and we wanted to stay away from anything that would cause people to point fingers at us and stuff. It was just horrible trying to hear you know… hearing all that stuff that they would say to my brother and my sister! I hated every minute until I started…until more Hispanics started coming and… I think that's why I tried to stay away from anything that had to do with the culture and anything that had to do with the food and anything that had to do with the language and I did not want to be known as you know…'weird'.*

She was mortified when she saw the same things happening to her younger siblings and later to her own children. She expressed feelings of anger and desperation as

her attempts to shield her children from the discrimination she once experienced were thwarted by new standards set for the school system in her area. She shared,

> *Because of that, I didn't speak Spanish to my kids when they were born. I think it's just because I didn't want them to have a big sticker on their heads that said, 'I'm weird" or 'I speak Spanish and that's my first language!' I remember when I enrolled my son in school, he was… they gave me a form to fill out and they asked you know, his heritage and I wrote Hispanic, and then they asked what language do you speak at home and then I put English. But they put him in an ESL class! When he doesn't speak Spanish at all! I was so upset and I went to the school and you know I went to scream at the lady, the ESL teacher! And I'm like…'He doesn't need any of these classes! He doesn't even speak Spanish, he speaks perfect English! He reads in English!' And I guess just because of his last name, you know they assume that he doesn't speak and they need to check him. Which is by law what they have to do, but I have all these memories from me and my brother and my sister being pushed away and I'm like, 'Oh, I don't want that for my kids!' So that's why they don't…yeah, it's the reason why they don't speak Spanish now…which I regret doing but you don't want them to be treated different because of their heritage or their language.*

In this study, perceived discrimination was highly associated with appearance and language. Esmeralda, a 37 year old Hispanic woman from Chile, expressed her feelings about feeling rejected because of her Hispanic or "Latina" appearance. She stated,

With certain Americans I feel rejected. There are certain people that look at you like "Okay, you are Latina." They see that you look Latina and they try to talk to you, like they try to talk to the Indians [laughter] slow--so that you can understand. And you are like "I speak English, so don't worry!" But they see you and they reject you!

Several women shared stories of perceiving discrimination or racial/ethnic bias because of their inability to speak English. A few women shared that even though they could speak English, they did not want to speak it because they could not speak it well. They perceived that they received more discrimination if they could not speak English well versus not at all. Some women perceived discrimination by feeling "ignored" when they were not able to express themselves in English. These incidents of being ignored occurred as children in school classrooms and as adults in the waiting rooms of health facilities. One woman stated that she was made to wait a long time before being attended to because of her Hispanic appearance and poorly spoken English.

Teresa, a 30 year old Hispanic woman from El Salvador, expressed confusion about the source of discrimination she felt from teachers and others regarding her use of the English language. She said,

Some teachers and stuff…they wouldn't speak to you in Spanish. Just because you are Latino and stuff like that! I think sometimes they have like racism. But I guess that when you speak a little English or so, they don't discriminate as much as if you just speak Spanish. I didn't want to speak it until I could speak it better. Now, it is okay because I can speak English.

Because her parents did not speak English, Esther, a 21 year old Hispanic woman from Mexico was responsible for scheduling appointments for her younger sister with cerebral palsy. She recounted memories of not knowing how to appropriately ask for or schedule an appointment. She also remembers being set aside and asked to wait while others were helped first. She stated,

> *I kind of have to fight more to get an appointment than other kids that were not Hispanic because we didn't know how to ask for the appointment or we didn't know exactly how to do it or anything. People would say to us, 'Yes, I will help you in a minute' and they would go help everybody else first. I used to like just explode. I used to cry and make a huge drama but that's just something that is part of the United States and not only Hispanic people but to others too.*

Serena, a 34 year old Hispanic woman from Mexico expressed feelings of impatience with those she perceived demonstrated bias towards her because of her Hispanic ethnicity. She said,

> *Well, as a Mexican, like everybody, I'm sure we have all experienced some racism…and…but being here most of my life and understanding English I was able to defend myself. I've been able to do that… defend myself… like I will confront the people if I hear them talking about me and they don't think I understand English…but hey, I don't know why they think that…they look at me and they think I don't speak English. I heard them the other day at a supermarket in Oregon, this lady was standing in front of the express line with a cart full of groceries and she (the clerk)*

said, 'These people should learn how to read and learn English cause this is the express line!' That really made me angry, so I went and told her… 'For your information, I know how to read and speak English and I'm not even trying to go into your lane". That didn't do anything for me…I had to do something about it, so I talked to her supervisor. Because I mean, in Oregon about 50% of their business is from Hispanics that don't speak English! I think they should show a little more respect.

Two women in this study expressed feeling discrimination for reasons in addition to their being of Hispanic ethnicity. One woman expressed feelings of perceived discrimination from people of her own ethnic background. Esther shared an experience where she felt she was being treated badly by her Hispanic employer. She shared her feelings of frustration and embarrassment that led her to quit her job.

I have noticed that by being Hispanic, I get treated different. I worked at a fast food place and I didn't speak English at all. I was back helping in the kitchen and the manager called me to work in the front on the registers. I told him, 'No, I don't even know how to say Hi.' He just put me to work there and he was making fun of m,e and he was Mexican too! I couldn't stand it! I just walked out! I have pride! If they are going to make fun of somebody…well it won't be me.

Another woman expressed feeling religious discrimination as well as racial/ethnic discrimination. She is Catholic and lives in an area where there are many members of the Church of Jesus Christ of Latter-day Saints (LDS). Iliana, a 28 year old Mexican woman

and mother of two stated she felt that her children were left out of activities because they were of a different religion.

> *It's been hard…especially here because of religion. I really have felt that you are just like an outcast here. People don't include you. In our neighborhood, we are the only Catholics and the only Hispanics. Kids don't come over a lot, so my kids end up playing by themselves. It has been hard! It has been hard! Which I think is a shame because it shouldn't matter, but unfortunately that's the way it is!*

Current immigration reform movements occurring during data collection was reflected in one woman's comments regarding discrimination. Yolanda, a 32 year old woman from Mexico said,

> *It is hard to be a Latina in this country. I would like an opportunity! For example, right now with the immigration issue and all that, they don't accept you in every job! It is very complicated for us to find a job! People don't want to give you a job-- only in the agricultural fields. Things are very hard! Hard jobs that people don't want to do…Americans leave that up to us! For example, jobs in different businesses don't accept you because they have fear of what's happening right now. There are fines for hiring Hispanic people for jobs.*

In the interviews where the study participants shared experiences with discrimination, some of the women appeared to minimize the acts or effects of it. Maria's comments are representative of the comments women made regarding perceived discrimination. She stated,

If there has ever been discrimination I take it as a…I don't know how to say it in Spanish…it's a challenge for me, it's like a goal, and I don't take it as discrimination… I say, "Okay, it's okay, if you don't like me because I don't know how to fill out an application, I am going to give you more information, and I am going to do it better…if you need more information about my income, I will get it!" They just need to let me know what they want from me, so that I can get it, because I have nothing to hide. I don't take it as discrimination, I haven't felt it, but my husband says he has at work. I don't work a lot, and if I work, I haven't felt it as discrimination. Giovanna, my oldest, she says that when she first began school, she felt that, but it can also be because of the language.

Seventy-five percent of the women expressed feelings of perceived discrimination. Many of them perceived discrimination as a result of their Hispanic appearance. These women shared that their physical appearance caused people to treat and talk to them differently than those who did not look Hispanic. The majority of women perceived that in addition to their physical appearance their inability to speak fluent English caused them to be treated differently or to be set aside or ignored. Most of the women expressed feelings of sadness and frustration with their many obstacles in learning a new language. The majority of women who came to the U.S. as children experienced discrimination in the schools from teachers as well as from other children. One woman expressed feeling discriminated by an employer and a member of her ethnic group because she did not speak English.

A couple of women mentioned feeling like "outcasts" because they were Hispanic and because they belonged to a different religious faith than the dominate culture. Only a few women denied feeling bias from anyone but expressed that their family members had. The subject of perceived discrimination did not come up in two interviews.

Again, these narratives illuminate the hardships these women experience because of "difference." From these stories, we see that new immigrant women face many "differences" in their transition experiences to the U.S. lifestyle; from differences in social customs to differences in religious beliefs to differences in appearance. In many cases, feeling different led to feelings and experiences of perceived discrimination. Perceived discrimination was experienced by these women in a variety of locations (schools, grocery stores, ball games, work, and health care facilities). The experiences shared by these women were traumatic and stressful. The exposure to perceived discrimination was long in duration for many of the women, especially for those who came to the U.S. as children. These narratives call attention to the possible long-term exposure to stress immigrant Hispanic women experience. This theme also highlights the potential for harm that bias and racial/ethnic discrimination might have on new immigrant Hispanic women's access to health care.

Theme Five- "My Mom Taught Me to Be Healthy- Examining Health Care Practices

"Healthy means to be able to walk up the stairs and not be out of breath…and to be able to have fun with your kids…to be able to run with them and ride bikes and do stuff like that with them and to be active. If you can't do these things than you are not healthy."
-Serena

Women were asked the following questions about what it meant to be healthy: (a) Tell me what it meant to you to "be healthy" when you lived in (country of origin), and

(b) Tell me what it means to you to" be healthy" since you moved to the U.S.? The women shared a variety of stories from their childhood about what they were taught at home about being healthy. Many of the women shared the health teaching they received mainly from their mothers. For most women, eating well (fresh fruits and vegetables) and moderate exercise were the two health activities most emphasized at home.

> Vickie*: My mom especially taught me to value fruits and vegetables a lot. When I was little, I didn't like them very much but now I do! I know that the most important things are vegetables, iron, protein for the body, and also exercise.*
>
> Amanda*: Well, my mom always taught me to be healthy. We rarely ate outside of the house- everything was homemade. It had to be like a special event or something going on for us to go out and eat. She would always tell me 'Mija, it's good to eat "arroz con frijoles" [rice and beans].' She has always taught me to be healthy…to try not to eat out too much and to exercise.*

Breakfast was an important meal for Yolanda. She said that she was taught to eat three meals a day. Sometimes there was not enough money for all three meals. In that circumstance, breakfast and dinner meals were emphasized. She stated,

> *More than anything else breakfast over there…they would tell you that you should have breakfast because your stomach is like a machine that is working and if the stomach is empty, then you get diseases. Breakfast is very important in Mexico, when you get up you go and get breakfast right away…early around 7:00 or 6:00.*

Teresa, from El Salvador shared how her mother taught her the importance of hygiene in maintaining health. She was taught the importance of boiling water before drinking it and washing all food items before cooking because of the possibility of ingesting parasites.

> *Well, I remember my mom used to take me to the doctor just to get my shots and stuff like that. Even though you know, like in the house… we didn't have filtered water or stuff like that. So still we could get sick because of the parasites. You know, they are in the water. So if you don't boil it or do stuff with it….They teach you to boil the water, so you don't get sick and to wash your fruits and vegetables and your food before you cook it…or cook it really good so you won't get sick.*

Francisca's mother played an important role in teaching her about staying healthy. She shares how she learned about health care practices from her mother regarding safe cooking tips. She shared this narrative,

> *For example, she taught us to wash the vegetables and disinfect them. To taste the food that you are cooking but not with your mouth; always with a spoon, without sticking your hands or spoon back inside the pot or pan in which you are preparing the food. And for example, if the food is frozen or cold we should not leave it out for a long time. We always cooked just enough food, when we were less in my family, because we were always used to cooking more and so sometimes my mom would have some leftovers and we would not want to eat it. So we learned…we would say*

'We are going to cook less food so we don't have to put it in the refrigerator.'

Francisca mentioned that her mother also taught them that to be healthy, they needed to be physically active.

Over there in Mexico, there aren't any gyms or anything like that. We did go swimming and we did play with the rope, the swings, and she would also play with us with whatever she had available. She always tried to keep us exercising or going to picnics or pools. We did not swim very often because the pools weren't that close, but we did all of these things to exercise.

Two women voiced how their mothers, in addition to a balanced diet and exercise, included daily vitamins to keep themselves healthy.

Iliana*: My mom would give me vitamins every day! I hated taking them. They were so gross! She made sure I ate breakfast. She would tell me to "eat breakfast so that you can learn. Your brain needs food". Those are the kinds of things that she would tell me.*

Esther*: You know basic things like, wash our hands before we had dinner and brush before bed, in the morning and right after meals… wear a sweater when it was cold time. She would give us like teas, I don't know, these weird teas, and vitamins. Oh! Vitamins, my mom would always give us vitamins!*

Another woman shared how her mother taught her to stay healthy while at play. She also shared what her mother would do to care for minor illnesses. She said,

She would also teach us that we were going to get an earache if we went outside right after we got out of the shower. She would tell us, "Don't be out there without shoes, your tonsils are going to start hurting; don't be in the water, don't play in the mud, you are going to get…what is it called "lombrices" [worms], *parasites…stuff like that. So yeah, I do remember all that she taught us about staying healthy. My mom would always put Vicks on our chest and in our nose… like if we had a stuffy nose or a cough. If we had a fever, she'd give us Tylenol and that's all, put us to bed, she would never cover us. She would if it was cold, but not if we were sick with a fever.*

Most of the women shared that their childhood consisted of trips to the doctor for immunizations and to the dentist for dental exams. The majority of the women were not accustomed to receiving annual physical exams. Cynthia said,

I think my mom used to take us to the doctor when we were newborns and children and we had our own pediatrician. But then, as we grew up… into our teens, we never went to the doctor regularly like every year or every six months, unless we needed to go for some reason. My parents didn't go to the doctor either, except when they needed it or when they were sick.

Cynthia mentioned that hearing and vision screening exams were not done at school as they are frequently done in here in the U.S.

They didn't have exams at school either, except for immunizations. They didn't encourage eye exams at school. Here I've seen that they do. But in Mexico they never did eye or hearing exams at school. At home, we did go

to the dentist when we had to go. We didn't go regularly, but we did go when we needed to go. But we never went for annual physicals or checks.

When asked to compare the health care they received from their mothers in their country of origin to what they experience in the United States, many of the women shared that things are very "different" here. In most cases, it was their mother that taught them what it meant to be healthy and how to stay healthy in their environment. It was also their mothers that took care of them when they became ill. Several women admitted that they learned more about the reasons for health care practices (such as well-balanced diets and moderate exercise help to improve health) after they moved to the U.S. Cynthia stated that she learned about the concept of preventive screening and mental health for the first time here in the U.S. She said,

As we moved here, we learned a lot about prevention and why people need to go to the doctor at least every year. Here at school,l I have learned that you don't go to the doctor just when you are sick. But that you should go at least every year to know if you're doing well and if you are healthy. So, I learned a lot about health prevention and how to get certain health checks as a woman; that every person should go to the doctor.

Cynthia shared that the perception of mental health is different in her country than it is here.

Another thing, I think is different here from Mexico is how we see mental health. When we were in Mexico, nobody sees a psychologist, if you're not crazy, you don't have to go. And here I have learned about the people and how everyone is aware of many diseases that exist, mentally and

physically, and that they need to have regular visits with their doctor to make sure they are doing well.

Maria expressed that she has a better understanding of the reason for the health care practices she was taught as a child in Bolivia. She said,

Here they focus a lot in the fact that you have to eat foods low in fat…and that you also have to exercise a lot. Those are things that I would do in Bolivia but I never knew they would do so much for my health. I thought they were only to maintain a good shape, but now I know that they are for my health.

Iliana discussed how she is exposed to much more information about health now. Her work at the community health center allows her to learn more about keeping her family healthy. She shared,

It's very different. There's a lot more…I guess awareness of it. Just to keep active you know, yourself and with your family. There's a lot more recreation centers that are available, that are not expensive. The whole family can go too. There's a lot more advertising…a lot more out there. There are a lot of things out there, TV and radio. There is a lot out there… It has helped me view it differently.

When asked to share their current health care practices, all of the women reported that they still focus on eating a balanced diet. They also make time to exercise at home or at a local gym. Gloria's and Amanda's comments are representative of what many women reported regarding their patterns of nutrition and exercise.

Gloria*: I have a balance. I have a good breakfast. I have a small lunch. I have a balanced dinner. I have snacks in between. I try to stay as healthy as I can with the snacks and the dinner. Now I eat more vegetables in my house than before. I do eat meat and chicken, but I try not to eat much in a day. I said my mom would have us drink a lot of water, and she would always cook with a lot of vegetables more than meat. I have now learned more about diet going to school here.*

Vickie, who was taught by her mother to "value fruits and vegetables," expressed frustration with the challenges of teaching her children to eat a well balanced diet. She voiced,

American food… nutrition and the American food… I don't think they are the same thing. Well, for example, for my son at school he gets desserts and candy and that's lunch for them! For me, it is not a good plate if it does not come with a combination…with vegetables, salad, protein, iron. It is not lunch for me. It is a little contradictory. I teach my son something and my son learns other things at school. The things I teach him is contradictory to what he is learning at school.

Maria explained that living in the U.S., she is more aware of how to keep herself healthy. She also shared that now that her father has developed cancer she is making more of an effort to live a healthier lifestyle. Maria voiced how she takes her of herself so that she can be and stay healthy. She said,

I need to avoid getting sick. I know there is a possibility to get cancer, because my dad has cancer. My father's cancer is not hereditary, but I

know that if someone in the family has had it, anyone can have it. The same with asthma, diabetes, but with exercise and a good nutrition… I know that some diseases can be prevented. I try to have my regular checkups with my gynecologist.

Yasmina's mother was recently diagnosed with diabetes. She discussed how she has adapted health care practices to protect her family from this disease. She shared,

My mom has diabetes; she was diagnosed just about a year ago. That's a big huge thing in our life, in our kids' lives. We watch our carb portions and we make sure that we are exercising everyday, even if it means just going out for a walk with my kids. We exercise four to five times a week or something like that. I cut out the fat whenever I cook anything at home, just because I took that from my mom and just being careful…with the sugar that we intake. I know that we don't really drink juice. We have sodas very rarely, there's a lot of water or a lot of things with no sugar added to it. I am just careful in that aspect.

All of the women reported that they did have annual women's health screening exams. Three women were single, twenty-one years of age, and not sexually active. These women had not had pap smears yet; however, they had visited their providers and had a physical exam which included a breast exam. Many of the women shared that their mothers played a big part in reminding and encouraging them to get their exams done yearly. Gloria said, *"My mom is always telling me, 'Mija have you had your exam, have you had it done?'"* All of the women appropriately described the reason and need for doing pap smears and mammograms on a regular schedule. Amanda has always had

normal pap smears. She shared, *"Yes, yes, I do it every three years for my category. I don't want to have cancer; and if I did, I would want to be able to treat it, and so I get it done."*

The majority of women reported that spirituality plays an important role in the things they do to keep themselves healthy. Seventeen women (85%) reported using prayer to help them stay healthy and to assist them through life's difficulties. Erika uses prayer to guide her "make good choices and decisions." Cynthia shared how she uses her belief in God to help her make healthy life choices and to minimize stress.

> *I know God wants us to be healthy and eat right. I have learned that I have to take good care of myself and eat right. I shouldn't smoke or do drugs or drink alcohol; that is how my beliefs have helped me be healthier in every aspect. I believe that when I get sick, I can pray to God for strength. I just feel like I can pray and ask for comfort and He'll make me feel better. So, I do think prayer is important-- always.*

Several women shared how they utilize their belief in God to assist them through stressful events. Their religious beliefs aid them in times of stress to feel a sense of peace. Sylvia shared how her belief in God helped her through her young son's surgery. She said,

> *When my son had surgery…he fell off the monkey bars. He had major surgery in his arm for that. They had to use general anesthesia, and because of the time when he had eaten, he had to wait. There was the risk that he would try to bring all that out with the anesthesia. So there are moments that… you turn to your Heavenly Father. And you beg him to*

help you, to give you patience, to give you peace that he can help the doctors to do what they need with your child, or with a loved one. I can testify that you feel satisfaction. I feel spiritual peace. I felt peace when I was going through that with my baby, with my little son. You pray to God, and he gives you peace, and calm and that helps you.

Women in this study admitted that although they have strong religious convictions about the power of faith and prayer, they also believe that they need the assistance of the health care system to complement and aid in healing and maintaining health. Sonia shared, "I think that they kind of go together, you know, you can't expect God to do everything, you have to do your part!" Francisca shared the same sentiment. She added,

I know that faith can make mountains move but you do have to complement it with the medical aspect. Not only with…well, sometimes you ask for a blessing to have health, but even though you have a great faith, sometimes it is necessary to have health care. Because we know that God can make great miracles happen but we can't leave it all to faith and not do anything, because it is also known that faith alone cannot do anything.

All of the women reported an awareness of a healthy diet and exercise program. Many of them had been taught these principles at home in their countries of origin. The majority of the women shared that in their native countries it is more common to eat more fruits, vegetables and grains. Many of the women also shared that it is customary to walk to their various destination

instead of riding in a car; they pointed out that it was often their daily exercise. Most of the women shared stories of being encouraged by their mothers to run and play outside. In fact, many of the women's mothers acted as role models and played outside with their children. Spirituality also played a role in the way the women in this study kept themselves healthy. Religious beliefs such as prayer was said to bring feelings of calm and peace and a reduction of daily or acute stress. Spirituality was utilized by these women as an intervention to reduce stress. This theme highlights the important role that mothers played in teaching the concept of health. Most of the women in this study voiced that they continue to call upon their mothers during times of family illness. Mothers also play an important role in the lives of these women in maintaining health. Several women reported that their mothers are the key support person in encouraging them to schedule their breast and cervical screening exams on a regular basis.

Theme Six – "Sometimes You Can Take Things That Are More Natural"- Using Home and Herbal Remedies

"When I get sick or when any of my little siblings get sick my mom always says "Oh, drink this tea" or "This tea is good for you!" Like chamomile tea and there's a whole bunch of herbs that I don't even know all their names. My mom would say, "Oh you know, this works for a cough" or "This works for menstrual cramps" or something like that! That's usually what my mom would do! - Dolores

When asked to describe how they took care of themselves, many women mentioned the use of home and herbal remedies. The majority of the women in this study had been taught by their mothers about the use of home remedies. Mothers were taught by their mothers and so on. Although about half of the women had lived in the U.S. most of their lives, today as adults they still believed in these remedies. Even the women who

worked as medical assistants and health educators reported that initially their common health care practice was to call or ask their mothers about home remedies before seeking formal health care. When asked to share if she still uses the home remedies taught to her by her mother, Esther replied, “Yes! I give them to my husband before I send him to a doctor; I try to fix it at home.”

Sylvia shares another example of her mother’s influence on the use of herbal remedies,

> *Yes, the herbs, the teas, the lemon with garlic, and they are remedies that really work, and even now my mom makes them for my kids. I don’t know how to make them because I have her here, so she always makes them, but they are natural remedies, and they are a lot better than a prescription by a doctor, because eventually that won’t be effective anymore, because your body will adapt to it; and then you are going to need a larger and larger dose. But yes, we keep the traditions with the home remedies. My mom went recently to Peru and she brought some herbs for the stomach, for headaches, for different things and you make them, the herbs, and you really feel better.*

Even in the cases where the mother was not physically present, many of the women maintained their belief in the effectiveness of their traditional remedies. Many women admitted that they did not know how these treatments and/or remedies worked – just that they did. Iliana shared that sometimes these home remedies helped to comfort her.

They drink a lot of teas, sort of like herbal things, like people grow in their gardens and they'll have a number of herbs. They'll give kids the mint tea, the Yerba Buena for anything…"If my stomach hurt, I would get the tea". They would give me vitamin C if I got a cold. Mostly I remember drinking the teas for everything, or if my legs hurt, my grandma would mix all this stuff and rub it on my legs and, that's all I remember. I didn't get sick a lot but when I did, they would give me teas.

When asked if these remedies really worked she said,

You know, I don't know. Sometimes they did, sometimes… maybe it would just comfort me, but you know, I remember if they didn't, my mom would take me to see a pediatrician.

Dolores shared that she feels comforted with the use of herbal remedies.

I don't know. Maybe it's just a comfort food or something but I know like my mom usually gives me for when I have like really bad menstrual cramps, it tends to help…It's called "Epazote" and it works! You know it doesn't cure it but it helps alleviate the problem. For example, like with the cough that does help with a cough! And like when your throat is really dry…when you have a cough there is a tea that helps that too! So I guess to a certain point it does help!

It was interesting to discover that women who stated that they did not continue to believe in home and herbal treatments did in fact use some of the childhood remedies taught to them by their mothers. In doing so they were continuing this

cultural practice and passing it on to their children. For example, Maricela stated that she did not believe in all the treatments her mother gave her as a child to treat her illnesses. She said that she had learned to do things differently in the United States, yet when asked about teas she admitted the following:

> *Sometimes we take tea, but not other things like that! My husband, when he has a cold, he likes to make a fruit tea, with cinnamon, milk, ginger, and apple, and it helps him!...There are Hispanic stores, you can find small bags of Manzanilla, the black pepper. I think they use it also for colds or something.*

She later also admitted that her daughters have learned about the teas.

> *… Because they see us and they ask and they want to take the teas too. They say, [laughter] "Give me some of that… that tea that you make daddy!*

Yasmina was in conflict about the home treatments and teachings her mother gave her as a child. She believed in some things but others she thought were superstition. When she became a mother, she would hear her mother's teachings in her mind and heeded them; although many times reluctantly.

> *My mom uses Manzanilla a lot for stomach ache and colicos for the baby, anything like that…agua de arroz also… for babies that have colicos or if you are not able to keep anything down, you can give babies the agua de arroz and they should be fine. For like if you have a sore throat, she would do a mix of limonada caliente with some honey and mix that up and you would drink it and gargle with it. Other things, you*

know if you are sick you don't go outside, you never go outside with your hair wet because you are going to catch something.

She also described how she gives these same remedies to her children.

I give some honey to my kids, when they need it. I don't want to give them just some regular medicine. I would prefer to give them you know a tea de Manzanilla.

Interviewer*: Does it work?*

Yasmina*: I think it does, on some things, like a stomach ache or stuff like that. I don't like my daughter to go out with her hair wet. I guess I learned that from my mother. And going outside with bare feet I really don't care if they are like out in the street, but I do care about the wet hair. You know, I think about it and I think there's no scientific proof that it would happen, but it's just something that we just do because, we just do it! I just think back at what she would tell us you know, and I remember… okay one day I did go to bed with my hair wet, and then I woke up estaba ronca!* [I was hoarse] *You know, so maybe it has something to do with it. So yeah…it does come to mind the things I was taught.*

By far, the most common home remedy mentioned by the women was the use of herbal teas. Most of the women mentioned the use of teas such as "Manzanilla," "Yerba Buena," "Malba," and "Garlic and Honey" for a variety of ailments. They also used folk treatments such as poultices and massages. Most of the women combined the use of these traditional remedies with Western medicines. The use of home or herbal remedies were thought to be more "natural" thus protecting the body from the possible harmful effects

of the strong medicines prescribed by their doctors. Evelyn shared the following narrative on the importance of complementing prescribed medicines with more "natural" products to keep her body healthy.

> *Yes, for example there's a shake that helps burn fat, with nopal [cactus], grapefruit juice, oatmeal, celery, parsley, and that also helps…I drank it a lot in Mexico and here too. There is another tea for the kidneys and also remedies that I know are good. I also come here to receive health care, but sometimes I mix them when it is possible in order to control my health better. Sometimes you can take things that are more natural and that aren't harmful. Because sometimes medications can cause complications like gastritis; the medications are very strong. You have to also complement with yogurt for example, if you already know that the medications are strong. They give a lot of sábilla* [nutritious beverage] *to drink too…and herbs like that. They help you to have good health like a medication. You have to use both things to complement; one for the other.*

Evelyn further described how she managed complementing prescribed medications with home remedies.

> *I read the information that comes on the medication; it shows all the possible complications. If it is a strong medication I am going to take it to get better. I have to take it, but I also have or also take some alternative so that the medication can't harm my body as much-- if it's strong! For example, if I need to take a medication, I try to take it after I*

eat so that I don't have any digestive problems. You have to know how to take care of your body like that in natural ways.

For Evelyn this was not done in isolation, but rather in consultation with her provider.

When I come to the doctor… I tell him… what I am taking. I also ask him "Can I combine this with that? Or can I take this?" I always tell him for example… things… for example, vitamins, teas, garlic pills, pills made out of Linaza [seeds], *fish pills and other things like that. I tell the doctor "can I do this?" and he said, "Yes, this can help you also for your cholesterol, to lower your cholesterol and all of that." So I always mention the things that I take or ask if I can take it or not. So that I don't finish up with problems caused by combining things, because we know that if we combine things that we could have problems and I always try that the things that I'm taking complement each other and don't affect me.*

According to the women in this study, pharmacists in most Latin American countries can dispense medications including antibiotics. Doctor visits or appointments at clinics and hospitals are sought only after home treatments and pharmacists have been consulted and the illness has not improved. Many of the women described using herbal treatments at the first sign of illness but if they or their family member did not recover or improve quickly (within a couple of days) or if they developed worsening symptoms than they would seek the help of the local pharmacist.

Sylvia*:First you try to use the remedies that you have. Over there* [country of origin] *if you have insurance… well I had insurance over there for hospitals and everything, but I have never been in the hospital; except when I was born* [laughter]. *We always try to take care of things naturally. Or you can go to the pharmacy, the pharmacist will tell you "take this and this and it's going to help you." Whenever you need to, you go to the hospital. But most people go only when they are really sick and nothing works.*

Yolanda used several folk treatments and healers in caring for her family's health in her native country. She shares this narrative about utilizing the assistance of a bone setter and herbalists.

Over there you can go… for example, if you fracture your hand… you get an x-ray. Or if you have the bone dislocated, you can go to the hueseros [bone setter]. *They are people that give you massages and they put the bone in place and you don't have to go anymore to have surgery. So they put the bone in place, they give a massage and give you a drink of papaya water with the seeds. The seeds you put them in the water and you drink them and it gets rid of the swelling. Because it becomes swollen and the blood capillaries…and then you get really well. And you get better really fast and the bone gets back in place and you don't need to have surgery; only if you have a broken bone for example, here* [pointing to the forearm]. *If not, you can go to the huesero and they don't charge you that much…I miss things like that!*

Yolanda explains how she learned about these home remedies.

> *They are people from little towns that come to the cities. They teach the people from the capital…I live in the city. They are people from little towns and they have more contact with nature and all that. Since there aren't any centers or hospitals near them, they learn with herbs and then when they come to the capital they teach us! That's how I learned.*

Women in this study described several options for caring for the health of their families. These options include the use of home and herbal treatments; consultations with their mothers or other family members, friends, or neighbors, seeking assistance from the local pharmacists and receiving treatment from local healers. Only after these options were tried did they seek health care from a physician. When someone in the family became ill, most of the women in this study used some type of home remedy taught to them by their mothers.

Some women admitted to using the exact same treatments on their family members as their mothers gave to them as children. Other women did not use home treatments but continue to drink herbal teas for common respiratory or gastrointestinal ailments. The strength of the relationship and continued presence of the women's mothers in their lives seemed to encourage the continued use of these home treatments and remedies.

This theme highlights the cultural health belief that "natural" medicine is better for the physical body than chemicals or man-made medicines. Most of the women, regardless of time spent in the U.S., were more likely to perceive that it was safer to

use a natural treatment over prescribed medication in treating illnesses. They were also more likely to use home and herbal treatments along with their prescribed medicines. Many of the women stated that they would prefer a clinician that shares the same cultural background, not only because of the ease with communication, but also because the provider would be familiar with the use of herbal and home remedies. Several women wanted to be able to consult with their providers about the safety in using complementary folk medicine with their prescribed medications.

Theme Seven- "They Might Be More Advanced Here"- Comparing Health Care

"I think both places have their own pros and cons."- Cynthia

When asked the question, "What kind of differences do you see in your experiences here in the U.S. versus those in your country of origin in seeking health care; the women in this study shared a wide variety of experiences. Some women preferred health care in their country of origin, while others felt more confidence with the level of sophistication they perceived in the training and technology available in the health care system in the U.S. Cynthia shared an eloquent narrative that captures the voice of the women regarding their view of healthcare in the country of origin versus the U.S.

> *When I was in Mexico I felt comfortable because I had my mom and she was with me all the time. Here, when I have been to the doctor, I have gone by myself, so it is different. I did feel comfortable there because my mom was with me and she knew the doctor, so I didn't have to worry about if he was a good doctor or not. My mom did that for me. I've seen here in the U.S. that they have more technology; more tools. Sometimes*

the doctors are better trained and know more. When I went to the doctor in Mexico, I never felt scared. I felt comfortable because the doctor was friendly and he explained to me and my mom what was wrong. He would talk to me and make me feel comfortable even though I was a child. I think it is important even as a child to feel comfortable with the doctor that is going to examine you. I did feel like the doctor was nice in Mexico.

Cynthia compared the health care she received in Mexico with what she experienced in the U.S.

Here, when I have been to the doctor I've seen a little bit of a different experience. There's always a schedule. You get to the clinic, they get you in and see you and you're out. And they don't always ask you if you want to know something else. I know I could ask questions, but sometimes I feel like there is no time. You don't feel like you have the opportunity to talk more to the doctor. He doesn't take time to just get to know you and be friendly.

When asked if it was the health care provider that made things feel rushed Cynthia replied,

Sometimes it is the whole staff. Sometimes when you get in, the secretary tells you to fill out a form and you don't know what it is. Then you turn it in. Then, the nurse comes to get you. And she starts checking your blood pressure and your temperature. They don't do that in Mexico. You go in directly to the doctor's office and you don't see a nurse and they don't check you. Here it is a whole new thing, and when you get to the doctor

you have already been there for two hours before he sees you. He asks what's wrong and gives you a prescription and you can go home. The whole thing is different in Mexico. Because there, you talk more to the doctor and he spends more time and explains everything to you. Here in the U.S. you spend more time with other people from the staff than with the doctor.

A few women shared that they preferred health care in their country of origin. The reasons given for this preference was cost, patient satisfaction, and a wide variety of options in treatment modalities. When asked about why women return to their country of origin to access health care, Erika shared,

Yes, they go [back] *because it's cheaper. Because for example, with the money that I make here, I could go to a clinic over there with a good doctor! That's why I would do that, and here it would be much more expensive to have surgery.*

Sylvia reported that she was more satisfied with the care she received in Peru. She expressed feeling more confident with the recommendations and care offered by the doctors and dentists in her native country. Sylvia told of a traumatic experience with her four year old son who lost a tooth due to what she perceived was slow, uncaring treatment by a dentist and his office staff. She said,

Yes, for example, here I took my son to the dentist; they put a crown on his tooth. The crown fell off! I took him back so that they would put it on again. He did not have any type of infection then but three hours later, the baby was completely crying! They told me 'Give him this medicine'

and sent me with a prescription to the pharmacy. Okay, it calmed him. A week later, I saw that he started getting some white things around his tooth. The baby didn't complain but I took him in and they told me that he had a strong infection and the tooth had died, and that this was normal! But how did that happen? How did his tooth die? I am really mad, because something like that wouldn't have happened in my country! In Peru, doctors and the medicine…whatever they give you, it helps you! These things wouldn't have happened there! In that sense, here they are more…slow… they don't care enough. I don't know, maybe I shouldn't think that way, but I feel that's how it is. It takes longer to get to the problem here.

Serena expressed that perhaps patients get better care in the private hospitals in Mexico. She shared,

My husband's niece had her baby in a really cool hospital! They took really good care of her! It's just different…like there at the hospital she got this real chicken soup, but it was like a whole drumstick and vegetables, you know…homemade! But here they give you just the canned chicken soup. I think here you get more processed stuff.

Esther works as a medical assistant at a nearby clinic. She said based on her experiences working alongside health providers here in the U.S. she knew she could get more individualized medical care in her native country.

"I think it is better, somehow I think it is better! I just see that when patients come here and they ask for something all of them get ibuprofen

and amoxicillin. That is what everybody gets 'Take ibuprofen, take ibuprofen.' I mean in Mexico, I don't know about some doctors, but the ones I went to, if you have something, they'll fix it for you! You know they'll give the right medicine and they'll treat it for you and tell you 'come back in a couple of days to see how you are doing.' If you are not doing better, then they'll give you something to cure it. Here, seriously, I see patients that come over and over for the same thing and they just get ibuprofen and amoxicillin!

Esther shared some personal experiences with health care in the U.S. and compared them with care she received in Mexico.

I had a problem with my shoulder and I work here [clinic] *and nobody has done anything for me. They just… they sent me for some x-rays but they couldn't find anything and that's it! They just said, 'Take ibuprofen.' I seriously don't think they know anything… I had an allergy really bad, during winter. I guess I was just allergic to the winter weather or something and I went to a private place for a dermatologist, and of course, I had to go there like three or four times, pay $60 each visit and they just didn't find anything. The guy finally is like, 'You know what, I just don't know what's wrong with you…I don't know what you are allergic to.' I'm like, 'Well then give me my money back.' I went to Mexico like a month ago, and I got treated for it in Mexico and it disappeared! I went to a natural medicine place that we've been going to, for like forever. He gave me these little drops and it worked.*

Francisca also felt that she could get better health care in Mexico.

> *When I had surgery there, I got good care. I got over it quickly. I had all the studies done. If you have money, you have access to everything! Yes it's the same, because there are prepared people. There are people who are educated and trained well and so it is possible to get good care.*

Saray expressed confusion and uncertainty about where she would prefer to receive medical care. She said that in Mexico the medicines are more "natural" and therefore harmless compared to the medications given in the U.S. which tend to cause more danger and harm to the recipient. She stated,

> *Science is more advanced here but there are things…for example stronger medicines that are made based on drugs…sedatives that are very strong and all that- harms you! Even though the doctors try to do everything to prevent the harm, there are things that do. Your nerves can be harmed and obviously natural medicine is not going to harm you. It's going to help you, and that's why I think that nature is always important, a lot more important.*

Saray also said, however, that medicine was more advanced here in the U.S. and for this reason she felt safer here.

> *Well, right now if I go to Mexico, I know they are going to treat me, but the equipment there is different than here... it's a lot more advanced and lot faster here than there. And maybe where I live there, there*

wouldn't be enough doctors or enough medical equipment. For that reason, I am safer here, it is more advanced.

Erika and Paola also voiced that perhaps health care was more advanced in the U.S.

Erica*: It would be maybe a little better here, because it is more advanced, as I said, more modern right? If it was only the money, you could go there. But I think here it would be a little better in that sense, right? Because it is more modern and more advanced. So maybe things would be a little better here?*

Paola*: I would say here, just because there's more technology. We are more advanced here. There are other diseases and stuff like that that we know better here than they would know over there … we have a lot more research and technology and equipment that we can help those that need help.*

Several of the women shared the perspective that they could receive good quality health care here in the United States but that they had to choose wisely for a health care provider. Many had at least one negative experience. Maria waited many years to see a doctor for her ears. Her parents did not trust doctors; consequently, they treated her repeated ear infections with home remedies. When she came to the U.S., she immediately sought out an ear specialist.

When the doctor looked at me… I didn't speak English very well but I had an interpreter with me. The doctor looked at me and he didn't want to answer all the questions that I had. He would only say, 'Don't worry,

you are going to be okay and that's it!' I didn't like that, and I was scared. We found out about two or three people that did not do well after their surgeries. So I stopped seeing that doctor. Later, I found another doctor. The doctor explained everything I wanted to know. He told me what it was, what it wasn't, the possible consequences and he told me that nothing was guaranteed. He said, 'I can do my best, but I cannot tell you that everything is going to be okay.' He told me that there is always a risk, so I had to take a risk. I really liked what he told me, because he didn't tell me everything was going to be okay, and I really trust doctors here. I have noticed that always with my dad's experience; they have treated him really good.

Dolores shared the important qualities she expected from a health provider. She said,

I'd want someone that can speak my language! And I want someone that I could talk to and someone that wouldn't just dismiss my questions or someone who would kind of discourage me from asking questions. I want someone who would say, 'Oh, do you have any other questions or any other concerns?' Not just someone who would say 'Oh thanks!' and would just kind of send me away. That is what is important to me.

Maricela voiced that she was happy with her health care here in the U.S. She works as a health educator in a local community health center. Like several other women in this study she said that she feels fortunate to have a Hispanic health care provider that speaks Spanish. She explained,

I have a good relationship with him. He understands me. He speaks Spanish because he is from Nicaragua. It is important for me… Yes, so that he can understand me. The Hispanic ones can understand you better. They come from the same place and they understand.

Many of the women expressed a preference for health care services in their native countries. Most claimed that if one had money to pay for private care, they perceived that they would get excellent care "there." Some women expressed that in their native countries they had more options for health care utilization. They could consult herbalists, curanderos (folk healers), bone setters, pharmacists, as well as mothers, friends, and neighbors. It was the customary practice to do as much at home to care for the ill before going to a hospital. In many cases, it was a financial decision that motivated them to care for the sick at home because medical costs were beyond the family's means.

Some women perceived that because of the potential for advanced research and technological opportunities in the U.S., health care should be better "here." Yet, many of the women were not satisfied with health care services they had experienced. Several women shared negative experiences accessing health care in the United States. Barriers to access included language difficulties, perceived discrimination, lack of trust, and dissatisfaction with care received. Much of the complaints had to with relationships with their health care providers. Several women shared stories about their relationships with doctors in their native countries. In these stories, women expressed trust and confidence in the care they received from their doctors. They also perceived that their doctors were providing personal individual care and that the doctors had concern for them.

Several women reported that they would prefer a health care provider who speaks Spanish, is familiar with Hispanic health modalities, and displays personal attention and concern. Most of the women expressed satisfaction with the health care they had received at the community clinics where many of the staff and providers were Spanish-speaking. *Personalismo* is a term that describes a personal relationship or interaction. It can be translated as "formal friendliness" (Flores, 2000). Personalismo would lead Hispanics to expect a warm, personal, yet formal relationship with their health care providers. It is another important cultural social approach valued among Hispanics, and it was missing in their experience with health care providers in the U.S. Consequently, even though they perceived that health care should be better here in the U.S., it was lacking the personal touch many women were accustomed to and continued to desire. A perceived lack of personalismo would lead immigrant Hispanic women to hold back information, not adhere to prescribed therapies, feel dissatisfied with health care, and not return for follow-up (Flores, 2000).

Theme Eight - "We Need More Education" – Accessing Community Resources

"This one lady she came… and she was telling me how she had her tooth-- one of her molars or something… was hurting and she didn't go in. She finally got the nerve and when she finally decided to go in, she had had cancer or a tumor that was eating up everything! She didn't find out because she just felt like she didn't need to go and so…I think people aren't aware of things that they need to get taken care of. They don't realize how expensive something can be and what help that they can get, and that's why they don't go." – Sonia

When asked to share what resources they would like to have in their community to help them with their health care needs most women requested education. Many women voiced a need for educating new immigrant Hispanics on the basics of the U.S. health care system. Women requested classes where new immigrants may be taught such things

as: how to make a medical appointment, how to understand and use insurance programs, how to arrange for payment plans, and how to maintain or improve their health. Sonia shared an experience at the clinic where she works regarding this need for educating patients regarding insurance and payment plans.

> *They get insurance and since they've never had it, they don't know how it works. They think, "Oh I can go and I don't have to pay because I pay at work, so I don't need to pay when I come here." I don't think they really understand that type of thing. So they come here to the clinic and they… they didn't know and they are freaking out and they say "I have insurance, what happened?" "How come I have to pay again?" Because we have a deductible and then a co-pay too! And stuff like that is different. They don't understand because they weren't told. They were just given this card and told, "Here you go" and so they think, "Okay I can take my kids to the doctor" and they think "This is a great thing!" And then later on they get the after price of the bill and are shocked.*

A few women suggested that health care providers should gear their teaching to the level of experience and understanding of each individual patient. For this to happen, women suggested that clinicians carefully assess how much each patient understands regarding treatments plans before allowing them to leave. Clinicians should also offer the opportunity for the patient to ask questions before terminating the visit. Cynthia addressed this concern,

> *I think the nurses and the doctors are nice when you go to a visit. But they should give the patient more information to make the patient comfortable.*

They should ask if you understand or if there is something that you would like to know. I think when they give you a prescription here in the U.S. they assume that you know what they are giving you. They assume you know how to take it. And sometimes, they don't explain the side effects, food interactions or drug interactions. I don't feel like they teach you more than they think they should. As long as they are covered, they teach you the basics and assume you understand the rest. And what they teach you is because they want to be protected as doctors, but they don't seem to care if you really understand or not. They don't ask you if you have ever used this drug or if you are taking something else.

Some of the women requested education for themselves on women's health issues. Several women requested that these classes be offered in the evenings and on Saturdays when they would have available transportation. They also requested that these classes be offered in Spanish.

Maricela*: I want to know more of the things that happen inside the body. That's what I know only a little bit about. The breasts for example, how do I take care of them and why? What happens to them…what changes occur? Also, when should I go to the doctor? Do I go because of what is happening now or what is going to happen in the future or what? I want to know more about that in Spanish. I want someone to explain it to me in Spanish. I can understand better that way.*

Serena requested information regarding weight loss plans.

Like me…I'll just start a diet and I don't even know about it. So, you're just getting started because everybody else is doing it and it works. But you don't know what you're doing or why it works.

Several women requested information on illness that their parents or other family members had developed. They requested more education on the nature of chronic illnesses, for example, diabetes, hypertension, heart disease, and cancer. Teresa explained,

People that are sick with diabetes or high blood pressure they don't know. They just eat and eat and eat and they don't exercise. So if they would have more information, then they would be able to…be healthier. But I guess you know…there are not really a lot of resources or programs or things that teach people how to eat and how to maintain a healthy life. Then you know they just eat whatever, and they don't…look at what they eat. They just eat it. I think education is the most helpful because a lot of people are really sick and they need more than just a doctor's visit.

Yolanda shared a desire to learn English. She has not been able to afford the classes offered in her community because of the cost and because she does not have a state ID card.

I would really like to learn how to speak English, and here I don't know of anywhere where I can go. Well, close to where I live there isn't a school where I could learn how to speak. There are some, but it's just that they ask you for so many things. They ask for an ID and here I don't have an ID, and that's why I can't learn English. The ones that ask for an ID are

free, they don't charge you. But the ones where they don't require it, they charge too much! They charge like $35 a week! $35 a week! You can eat with that! But here I don't have an ID. A lot of people have it, but they took them away. They are not here anymore.

Some of the women in the study offered suggestions for improving health education materials. These suggestions included the use of more pictures in reading materials, such as pamphlets and brochures. Maria said,

The fliers are good, but we are very lazy to read them…if they had pictures it would also help. People like that, at least Latin people, they love to see pictures, with different shapes and things like that, but almost nobody likes to read. In public restrooms there could be signs with pictures and small phrases, where they could get a better idea of what needs to be transmitted to the people…but I think for people like my mom… she doesn't like to read. She understands better with pictures, so if you give her a booklet to knit, she can look at the pictures and she can do it! But if you tell her in words to do one to the right and one to the left, forget it, she couldn't do it! But if you give her a picture, she can tell you how it is done.

Iliana suggested using simpler language and terms in written material.

Simple terms, because a lot of our patients don't have an education. And they don't understand a lot of…we'll give them handouts and…a lot of them can't read or can't write. So simple terms, more education in the

evenings, weekend, and Saturdays; many women have to wait for their husband to get home with the car.

Yasmina requested more education for adolescents to be offered at their schools.

Maybe having that in schoo…having things available for them to educate themselves,s because a lot of them come in, and they are pregnant. They don't really know what happened, they know what happened, they know how they got there, but it could have been prevented if the right education was given out. Resources should be available in school and outside of school.

Even though many of the women in this study were educated and some worked in the health care arena, the community resource they most requested was health education. Some of the women requested this information for themselves; others requested it for family, friends, and patients. Women wanted to have a better understanding of the need for screening exams, even though they reportedly had these done on a regular basis. Several women reported having a relative with a chronic illness such as diabetes or hypertension; they wanted to better understand how to care for their family members and how to avoid developing the illnesses themselves. Classes in Spanish and at convenient hours (late evenings and Saturdays) were requested. Several women offered suggestions to improve health education materials so that they were more culturally appropriate.

This group of women demonstrated an active interest in being better informed about their own health. They appeared somewhat educated in healthy behaviors but desired more in-depth knowledge about health and illness. Many were accustomed to caring for themselves and being able to access a variety of health care modalities to treat

illness. This theme highlights the expressed desire of this group of immigrant Hispanic women to be informed and involved with the health prevention and health promotion needs of their families.

Chapter Synthesis

This chapter has presented the results obtained through a narrative inquiry study. Demographic and acculturation data were statistically analyzed and presented. An exemplar narrative was provided to illustrate the themes in context of one woman's story. Major themes were presented as they provided insight, awareness, and salience to the research questions. Meticulous attention was given to the themes and the numerous quotes and narratives presented to adequately represent the voice of the women in this study. Hispanic cultural values of family cohesion (*familismo),* respec*t (respeto),* personal relationships *(personalismo),* the use of "natural" remedies, maintaining ethnic identity, language, and heritage were all salient themes in this study.

The women in this study described their families as a close-knit group and a very important social unit. Most of the women described strong family ties despite being separated by many miles. The term *familia* usually went beyond the nuclear family. The Hispanic "family unit" included not only parents and children but also extended family. All of the women described a traditional expectation of a Hispanic family as one that gathers often to celebrate together or to spend time with each other. Emotional support, expressions of affection, willingness to provide assistance, and respect (*respeto*) for one another were highly valued cultural norms. Hispanic women shared the importance of instilling in their children good manners and respect for parents, authority and the elderly.

This strong sense of family unity and support system among Hispanic families has been documented in other studies. In research literature it has been described as *familismo*. It is a feeling of connectedness or collectivism within a family group which might also extend to a neighborhood and outranks the need of the individual (Flores, 2000). Many of the women voiced this connectedness or *familismo* was lacking in their relationships with persons of the U.S. Some of the women responded to this by "withdrawing" or creating a "shell around them and their families." Other women responded by increasing activities within their own family groups to create and maintain family cohesion. In either case, the women searched within their own culture and family groups to meet their needs.

Warm personal relationships *(personalismo)* was another Hispanic cultural value women perceived as missing from many encounters with people in U.S. communities, specifically health care providers. Several women described feeling more at ease with health care providers in their native countries because they felt that their providers cared about them on a personal level. Several women perceived that they could receive better care in the U.S. because of advanced knowledge, research, and technology; however, many of these same women voiced dissatisfaction with past visits to their health care providers. Health care in the U.S. conflicted with what many of the women experienced in their native countries. The U.S. health care system tends towards shorter office visits and maximizing the number of patients seen in a day. Consequently, these women felt the impact of providers having less time with each patient. For many women, understanding that they would have less time with a health care provider might have encouraged their health belief of doing all they could at home first (i.e., home treatments and herbal

remedies) before seeking health care. Delaying health care visits holds potential for long term health consequences.

The significance of the maternal role in health care decisions was an important finding in this study. All of the women shared that it was their mothers who taught them the definition of health and instructed them on how to maintain their health. It was also their mothers (or other women) who provided initial care when they became ill as children. This is the pattern they experienced in childhood and that they took on as adult women themselves. Many of the women stated that they were healthy as children; this may have added confidence to the teachings and health care methods used by their mothers. This may also support why most of the women felt confident calling their mothers for advice with health care concerns before seeking a health care provider. In most cases, mothers responded by encouraging home remedies to treat minor illnesses. Herbal and home remedies were taught by and encouraged by mothers as safe methods to treat many common illnesses. This finding adds to our knowledge on how immigrant Hispanic women might adhere to a personal hierarchy in making health care decisions.

Language was a significant construct in this study. Preserving the Spanish language within the family was important to all of the women. Several women referred to this as a way to maintain their cultural heritage within the home. Others saw it as a way for their children to develop bilingual skills that would help them get ahead in the future. Language barriers presented obstacles early in the immigration experience. Women were negatively affected by their inability to speak or understand English in school, at work, or in accessing health care. Parents were unable to assist their children with homework or help children get ahead in school because of language difficulties. Some of the women

expressed limitations in their opportunities for work. Several women were not able to access health care because they could not ask for an appointment or fill a prescription. Many women expressed feelings of perceived discrimination because they were not able to speak English well. Language proved to be a salient theme, even a doorway, for this group of women in their ability to acclimate or socialize in to the lifestyle of the U.S. as children and as adult women.

Discrimination was another salient theme in this study. Most of the women shared experiences with perceived discrimination that diminished their ability to find success in school, work, and/or access to health care. Most of the women voiced confusion and surprise with their feelings of perceived discrimination. Several women were unsure why their appearance or inability to speak English would cause others to treat them differently. Perceived discrimination appeared to more negatively affect the women who came to the U.S. as children.

This chapter presented the findings obtained through a narrative inquiry study. Narrative data were analyzed using Lieblich's (1998) approach to narrative analysis. Demographic and acculturation data were statistically analyzed and presented. Eight themes were identified, presented, and discussed in great depth. Numerous quotes were provided to give voice to the stories presented by the women in this study. An exemplar narrative was provided to illustrate the themes in context of one woman's story. Chapter Five will discuss the implications for the findings for health care and future research.

CHAPTER FIVE

Discussion

Statement of Purpose

The overall purpose of this study was to explore and understand the factors that influence the health promotion practices and health care decisions among reproductive-age, foreign-born immigrant Hispanic women in the U.S. The specific purpose of this study was to explore the traditional culture-related factors practiced by these women in their country of origin and to examine how these practices are influenced or changed with time and exposure to health care in the U.S. The women's knowledge, experiences, perceptions, and attitudes were illuminated through their personal narratives. Commonalities among the women's stories were thematically organized and presented as they related to the study research questions. This chapter will present (a) a discussion of the study findings as they relate to the research questions, relevant literature, and theoretical frameworks, (b) the strengths and limitations of the study, (c) implications for health care and nursing practice, and (d) recommendations for future research

Research Questions and Study Findings

First Research Question and Findings

This study's first research question asked, "What health-protecting behaviors and health-promoting lifestyle behaviors are practiced by foreign-born, immigrant Hispanic women of reproductive age?" In an effort to identify perceptions and attitudes about health care practices, the women were first asked to define what "being healthy" meant to

them. They were also asked to share stories of how they kept themselves healthy. Women in this study defined being healthy as "not being ill" and "being active" and "not being short of breath while exercising or playing with the kids." Most of the women described their current health-protecting behaviors and health-promotion practices as:

1. A balanced or healthy diet-defined as fresh vegetables and fruits, small amounts of meat and bread products, plenty of water, and small frequent meals
2. Regular weekly exercise
3. Abstinence from smoking and alcohol use
4. Regular annual exams-- even those who were young and not sexually active had at least a breast exam.
5. Minor illnesses such as colds and stomach aches were treated with home remedies. Mothers were also consulted regarding treatment options.
6. Acute illness defined as fevers, infections, and those not helped by home remedies were referred to doctors and emergency room personnel.
7. Spirituality which provided peace, comfort, and strength. It allowed the women to decrease stress in their lives replacing it with faith and belief in God's good will.

Findings in this study regarding definitions of health and health-protecting and health-promoting behaviors that included good nutrition, being active, promoting healthy self-care practices, and spirituality are consistent with the literature (Hartweg & Isabelli-Garcia, 2007; Higgins & Learn, 1999; McCarthy, Ruiz, Gale, Karam & Moore, 2004). Researchers have found that similar populations of Hispanic women perceived health as being within the woman's control and included healthy diets, exercise, annual exams, and spirituality as healthy practices to maintain good health.

Health Promotion, Health Protecting Practices: Healthy Eating

When asked to share stories about what they learned about health in their native countries, many women shared that they were taught the meaning of being healthy by their mothers. They often said, *"My mom always taught me to be healthy."* Being healthy included eating well. Many of the women shared similar examples about how they were taught that fruits, vegetables, plenty of water, and smaller food portions were important for a healthy body. Studies indicate that low acculturated immigrant Hispanics have healthier dietary patterns than their highly acculturated counterparts. This was true of this group of women; the majority of the women (75%) in this study reported low levels of acculturation (according to the SASH scale). Congruent with the literature, low levels of acculturation were associated with healthy diets (Aldrich & Variyam, 2000). Contrary to most studies, the highly acculturated women also reported that they tried to eat healthy, well-balanced diets. There was no difference in reported dietary patterns between the women with low and high acculturation levels in this study.

Health Promotion Practices: Physical Activity

The women in this study reported that they were physically active, unlike many current research reports on physical inactivity among Hispanic women (Crespo, Smit, Andersen, Carter-Pokras, and Ainsworth, 2000; Keller and Fleury, 2006; Sanchez-Johnson, Stolley, & Fitzgibbon, 2006). The women reported active lives which included moderate amounts of weekly exercise. Most of the women also reported that they believed exercise was essential to staying healthy. Women reported exercising with family, friends, and children. Few women reported exercising alone; those who attended

a gym usually did so with friends or family members. One woman reported exercising with a group of Hispanic women in a local church building in her community. Social support was an important factor for many of the women. They exercised more regularly if they had a support group to help motivate and encourage them.

Relevant to this study were the similar findings of Voorhees and Young (2003). They found higher levels of physical activity among young Central and South American women who reported regular religious attendance and belonged to community groups. Arredondo, Elder, Ayala, & Campbell (2005) also found an association between religious practices and increased healthy dietary behaviors and physical activity among a group of Mexican women. Study participants who attended church regularly were more likely to include more fiber in their diets and report thirty minutes or more of physical activity on most days of the week. Arredondo and colleagues (2005) explain that one possible reason for this association may be that religious institutions may encourage healthier diets and abstinence from substance abuse (alcohol, tobacco, and drugs). Keller and Fleury (2006) also found that women were more likely to report increased physical activity if they had social support and community or neighborhood resources.

Health Protecting Behaviors: Cervical Cancer Screening

Hispanic women are more likely than non-Hispanic women to develop cervical cancer (Pinzon-Perez, Perez, Torres, & Krenz, 2005). Immigrant Hispanic women in the U.S. report underutilization and greater barriers to cervical cancer screening than non-Hispanic women (Boyer, Williams, Callister, & Marshall, 2000; Owusu et al., 2005). Women in this current study reported that regular annual exams were not part of their health care experience in their native countries. Some of the women explained that it was

not customary to get physical exams; people went to see medical providers primarily for illnesses. Many of the women reported that as children they went to the doctor or local clinics mainly to receive immunizations. Several women mentioned that they did receive regular dental exams. Contrary to many studies, when asked about women's health screening exams, all of the women expressed awareness of these exams and voiced that they understood the need for them (Borrayo & Jenkins, 2003; Larkey et al, 2001). Additionally, all of the women reported that they had their breast exams and/or Papanicolaou (pap) smear done on a "regular" basis. For some women regular exams were done every year; for others it was every two to three years. There were no differences in the use of cervical cancer screening between the women who worked in health care and those who did not. Many of the women reported that their mothers were extremely influential in reminding and encouraging their daughters to get their exams done annually.

Women in this study reported that barriers for annual screening exams included lack of insurance, inadequate access to health care, language difficulties, and negative past experiences with health care personnel. Most of these reasons are consistent with findings in the literature. Boyer and associates (2000) reported similar barriers to cervical cancer screenings identified by women, which included inadequate access to health care, financial barriers, lack of access to female Spanish-speaking providers, and lack of knowledge. Similarly, Pinzon-Perez, and colleagues (2005) reported barriers to cervical cancer screening, including long waiting periods, lack of continuity of care, lack of quality care, language differences, and lack of knowledge accessing the health care system. De Alba, Sweningson, Chandy, and Hubbell (2003) found that in addition to

income, usual source of care, and health insurance, less proficient English speakers were less likely than highly proficient English speakers to have received cervical cancer screening within the last three years.

Healthy Lifestyle Behaviors: Mind, Body, and Spirit

Women in this study defined "being healthy" and "maintaining health" as holistic in nature. It involved the physical, emotional, and spiritual self. Higgins and Learn (1999) also found that women in their study perceived health as a balance among the mind, the body, and the spirit. Similar to the present study, they found that spirituality and religious practices were used as methods for stress reduction.

Spirituality was a modality that many women utilized as a way of keeping themselves healthy and minimizing stress. Although the women were not asked about their religious affiliations, four volunteered that they were LDS, and two were Catholic. Most women reported that they were taught by their mothers to include daily acts of worship as a means of receiving strength, direction, and peace in their lives. All of the women voiced utilizing some form of spirituality to produce feelings of "peace," "calm," "patience," and "comfort." Most of the women listed prayer or personal worship as the most common spiritual practice. Several women stated that including God in their lives would help them "receive blessings" that would help them feel healthier. The importance of spirituality among Hispanic women has been documented in the literature (Higgins & Learn, 1999, Musgrave, Allen, & Allen, 2002; Napoles-Singer, Santoyo, Houston, Perez-Stable, & Stewart, 2005). Unlike some reports, the women in this study did not emphasize health as controlled by God; rather they voiced a "partnership" relationship with God in their personal and health care needs.

Women mentioned praying to God for peace, comfort, and blessings, but they did not state that they felt that God's will or fate determined their health outcomes. One woman explained that God would do his part and expected that she would do hers by consulting with health care professionals. Napoles-Singer and colleagues (2005) also found that younger Hispanic women (age range, 18-92, M= 52.2, SD, 20.1) in their study reported that they were taught to ask God for help for minor health problems and seek care from doctors only for serious illnesses. More research is needed to better understand how spirituality or religious affiliations and/or beliefs are associated with health care access in younger immigrant Hispanic women.

Barriers to Healthy Self-Care Practices

Immigrant Hispanic women in this study who were employed tended to have more struggles with eating balanced meals and making time for exercise. Some of them shared that at times they were so busy at work they did not have time to sit and eat the healthy meals they prepared. According to some of the women it was more difficult to follow a healthy diet while living in the U.S. because of the "fast-paced" lifestyle. Several of the women who were employed mentioned the temptation to stop at a fast-food restaurant at the end of the day to feed their hungry, waiting families. Women who worked outside of the home also reported that it was often difficult to exercise when they got home. Many of the women shared that they solved this problem by exercising with their children. A few women mentioned that they felt their exercise programs were effective at helping them control their weight. Most of the women said that exercise helped them feel healthier.

Second Research Question and Findings

The second research question asked, "How do foreign-born immigrant Hispanic women of reproductive-age negotiate their original cultural health beliefs and practices obtained in their country of origin with those they encounter in the United States?" Most of the women in this study sought to maintain their cultural heritage. All of the women claimed their ethnic identities as "Hispanic" or "Puerto Rican", or "Mexican" or "Argentine" or as a person from their native country and did not identify with the "American" culture.

Maintaining their Cultural Heritage: Negotiating a New Culture

All of the women expressed a desire and sought methods to maintain their language, family traditions and celebrations, *familismo* or family cohesion, respect for parents and elders, and memories of their native countries within their current family groups. As noted in Chapter Four, women devoted family time to teaching their children customs and norms of their country of origin. Several women shared that they would not allow their children to speak to them or their grandparents in English so that they would not forget to speak Spanish. Many women told stories of how they celebrated Christmas just as they had done as children in their native countries. Most of the women regularly prepared traditional home-cooked meals and planned family gatherings with extended family members to maintain their cultural practices.

Several women also voiced appreciation for their new culture. They talked approvingly about the wide, clean streets of their new community in the U.S., the freedom from strict male/female roles, greater equality between husband and wives, better educational and employment opportunities, safety and security, and access to more

advanced medicine and technology. Many women expressed appreciation for the opportunity of being in the U.S. and expressed desires to blend the two cultures successfully.

A few women expressed concern about their children's exposure to the U.S. lifestyle and customs. Many of the women wanted their children to adhere to the traditions of their native country regarding morals and values. Other women were anxious that their children would lose their training regarding showing respect for their parents, people of authority and the elderly. Some women reported that they preferred their own cultural beliefs and hoped that their children would never adopt the ways of mainstream society.

Dual Health Perspective: Integrating Health Care Practices

Similar to many studies, most of the women in this study maintained a dual health perspective (Davis, 1997; Lopez, 2005; Mendelson, 2003). They maintained their cultural health beliefs and practices and combined them with those they valued from the U.S. One woman explained, "You have to use both things to complement; one for the other."

All of the women in the current study reported the continued use of traditional health care practices, particularly the use of herbal and home remedies. They also used folk treatments such as poultices and massages. One woman lamented the unavailability of alternative healers such as a bone setter or herbalist in this country. These finding are consistent with recent studies. Mendelson (2003) reported that the highly acculturated group of Mexican women in her study also blended the use of hot soups, teas, and massages with readily available over the counter medications. Lopez (2005) found that many of the 70 highly assimilated Mexican women in her study persisted in their

knowledge and use of traditional folk medicine and practices. Years in the U.S. caused some women to report that they felt cautious about using all the home treatments and remedies they experienced as children. These women expressed being more selective in the use of home or herbal remedies, but all of the women acknowledged using at least one herbal remedy.

Mother's Influence: Cultural Tradition

Most of the women in the present study reported a strong influential relationship with their mothers that affected the way they made health care decisions. Many of the women remained in contact with their mothers especially during an illness, which seemed to influence the continued use of home remedies. Few studies have reported the influence of women in immigrant Hispanic women's health care practices. In this study, many women reported seeking their mother's advice regarding health care decisions. In most cases, mothers instructed the women to use home remedies and treatments to treat common illnesses.

Sanchez (2007) also found that Mexican-American women in her study sought their mothers frequently as their lay health care providers for health advice or treatments. This author reported that the women in her study were also treated by grandmothers and maternal aunts, especially during pregnancy and childbirth. Davis (1997) found similar results in her research with Puerto Rican and African-American women. Women in her study reported that the primary caregivers in their lives had been "mother figures." Health care, home remedies/treatment, and advice were commonly given by their mothers, grandmothers, aunts, and other female friends or close neighbors. In most cases, mothers were consulted before formal health care services were sought. These studies are

consistent with the findings in the present study regarding the salient role of the mother in health care decisions and practices.

Negotiating the U.S. Health Care System: Frustrating Barriers

Despite their perceptions that health care systems and health care providers were more advanced in the U.S., many of the women in this study shared unhappy experiences and barriers in their attempts to access health care in this country. Some of the frustrations cited were language barriers, perceived discrimination, feeling ignored or dismissed, lack of knowledge regarding the use of insurance, lack of knowledge in how to access the health care system, lack of respect and *personalismo* from health care providers, lack of cultural sensitivity or knowledge by health care providers, and poor quality health care. Many, if not all of the barriers and frustration reported by these women are consistent findings in the literature (Cain & Kinton, 2003; Coffman, Shobe, Dmochowski, & Fox, 2007; Mayo, Sherill, Sundareswaran, & Crew, 2007; Lauderdale, Wen, Jacobs, & Kandula, 2006; Tortulero-Luna et al., 2006).

Most of the women reported fewer barriers or access problems when they were able to see a provider of their same ethnic background. This preference for ethnic and language-concordant physicians among culturally diverse patients has been cited in the literature *(*Napoles-Singer et al., 2005; Schneider, Strecker, Promecene, & Monga, 2005). Many of the women claimed that clinicians from their native countries "spend more time and explain everything to you" compared to those from the U.S. They also claimed that in the U.S. "You spend more time with other people from the staff than with the doctor." Several women explained that a Hispanic health care provider would be more sensitive to cultural mores, beliefs and customs.

Napoles-Singer and colleagues (2005) reported similar findings in their study with White non-Hispanic, African-Americans and Hispanic patients. They found that Spanish-speaking participants' greatest fear was being cared for by a non-Spanish-speaking physician. They felt that they received poorer quality health care than English-speaking patients and that medical office staff was usually less willing to assist them because they were Spanish-speaking. Participants in their study also cited discrimination based on ethnicity, social class, health insurance, and immigration status as barriers to health care access. Findings in this study support the research that ethnic disparities may be associated with the quality of health care services Hispanics receive when they attempt to access health care in the U.S. (Cain & Kington, 2003; Coffman, Shobe, Dmochowski, & Fox, 2007; Napoles-Singer et al., 2005; Smedley, Stith, & Nelson (2003)

Third Research Question and Findings

Finally, the third research question asked, "How does time lived in the United States influence health beliefs?" Unlike many studies, time in the U.S. did not appear to substantially change health beliefs among this group of women (Guendelman & Abrams, 1995; Mora, 2003; Perez-Stable et al., 1994). Most of the women in this study desired to maintain their traditional cultural health beliefs and selectively blend in U. S. health customs. Many of the women continued to care for themselves as they were taught in their native countries and by their mothers. These health care practices included healthy diets, physical exercise, appropriate rest, and stress reducing measures. Most of the women preferred natural and fresh foods as is customary in their native countries. A few women complained about the practice in the U.S. of refrigerating or freezing food, stating that the flavor of the food was not good the next day.

Many women in this study abstained from smoking, alcohol and drug use. Most of the women were married, had children, and participated with their families in regular church attendance and community activities. All of the women voiced a preference for their cultural lifestyle of maintaining close knit family groups and familial-like relationships with friends and neighbors.

Few studies have examined the health promotion beliefs and practices among immigrant Hispanic women. Berg (2003) conducted a study to assess Mexican American women's desire to engage in health promotion behaviors. She found similar results to the present study regarding healthy diets and exercise. Berg reported that women were willing to adopt health promotion strategies such as taking daily multivitamins and calcium supplements, modifying to a high fiber, low fat diet, engaging in moderate exercise, and doing stress reduction breathing exercises. Hartweg and Isabelli-Garcia (2007) also conducted a study to examine the health perceptions of immigrant Hispanic women from Mexico and Central America. Women stated they felt healthy care practices included good nutrition and physical exercise. The women also stated that they felt they received better nutrition in their native countries, because foods such as vegetables were different here and they were not sure how to cook them. They also did not like their flavor. These findings were similar to the findings in the present study. Some of the women also stated that they preferred the food in their countries of origin, especially the variety of fruits and vegetables. However, none of the women reported that they felt nutrition was better in their native country.

A unique finding in this study and one way that time in the U.S. did influence health beliefs for several women was an expressed desire for more education. A few

women admitted that through classes, workshops, and information on the Internet they had a better understanding of why healthy diets and exercise help to keep them healthy. Several women stated that there is more awareness and encouragement of health promotion practices in the U.S. and more research and evidence of the benefits of these behaviors. They stated that they heard about these practices on the radio, on television, and at work.

More education was requested in women's health issues, the care of chronic illness, and negotiating through the U.S. health care system. Women suggested changes to existing health education classes and teaching materials. They encouraged less reading, simpler language terms, more pictures and diagrams, and more time allowed for discussion. Women requested classes where there would be interaction and more time allowed to ask questions. Several women requested that these classes be made available free or low cost, with no ID card requirements, during evening hours and/or on Saturdays, and in Spanish. A report on the assessment of the readability of Spanish patient education materials by Horner, Surrat, & Juliusson (2000) suggested increasing font size to 14 or 18, decreasing reading level to fifth or sixth grade, including more illustrations, adding short direct sentences, and simplifying key concepts and complex terms. These recommendations coincide with the suggestions offered by the women in this study.

Application of Theoretical Frameworks to the Findings of this Study

Chapter Three described the concepts of the three theoretical frameworks used in this study which allowed for a deeper exploration in the analysis of these women's stories and interpreting the meaning of their narratives. The process of acculturation, the actions of bicultural socialization, and the embodiment of their immigration experiences and transition to a new environment are intimately related to the way immigrant Hispanic women learn and choose to negotiate between both cultures. They also influence these women's health care decisions and behaviors.

Berry's Acculturation Framework

In this study, women were asked if it was important to them to adapt to the U.S. lifestyle. They were also asked if maintaining their cultural heritage was important to them. All of the women answered "yes" to both questions. These two questions were proposed by Berry's Acculturation Framework (1980) as crucial questions that indicate the ways in which an acculturating individual wishes to relate to their dominant society. Answering "yes" to both questions indicates that they selected the integration strategy or mode of acculturation. The integration mode signifies that these women are open to participating as members of their new society while at the same time maintaining some degree of cultural integrity. Women in this study had varying levels of acculturation across the domains of home, work, and social life. Most women demonstrated the integration mode for their work or social life and yet practiced a degree of separation in their home life. They reported a variety of ways in which they sought to strictly maintain the Spanish language, family traditions, and cultural teachings (i.e., respect for elders) in

the home. In this area, these women desired to hold on to their original cultural traditions and beliefs and resist adapting to the customs and values of the U.S.

For example, Yasmina's choice of acculturation strategies fluctuated over time. Because of her experiences with perceived discrimination as a child in school she chose not to maintain her culture and instead assimilated more fully with the U.S. lifestyle. Later as an adult, she regretted her decision and desired to re-adopt her cultural traditions and beliefs and to share them with her children. She switched from assimilation to integration mode and began her attempts at blending both cultures. Yasmina admitted that she wanted to create a strong cultural environment in her home so that her children would come to know the traditions and beliefs of Peru. Her strong determination to maintain her cultural heritage at this point in her life would be classified to some degree as separation mode in Berry's framework. She is placing a stronger value on holding on to her original culture and less effort in developing her interactions with her new environment. Yasmina's story exemplifies how the strategies are employed in the life of one individual through the acculturation process.

Some of the women who shared stories of perceived discrimination experienced barriers to adapting to the host society. Because of language difficulties or racial/ethnic bias, they were "set aside" or ignored by members of the dominant culture. Berry's (1980) framework suggests that all acculturation strategies are not always available to new immigrants. The dominant culture also bears some responsibility for how it responds to new immigrants and how it will allow new members into its environment. Berry suggests that the dominant culture may deny selected rights or opportunities to some acculturating groups while granting them for others. In this case, acculturating

individuals remain segregated and are unable to participate as they wish in mainstream society. One woman from Mexico voiced anxiety at the increased difficulties of undocumented individuals to find employment because of the recent marches against illegal immigration. Another woman talked about raids in her neighborhood at homes of families that were thought to be illegal. Experiences with racial or ethnic discrimination affected or limited the acculturation strategies some women were able to select or apply in their acculturation process.

Berry's Acculturation Framework was helpful in guiding the interview questions to examine the acculturation process for each of the participants. It was also helpful in analyzing how these women chose (or were not able to choose) an acculturation mode to help them negotiate through or between cultures. Berry's framework was helpful in understanding the acculturation process of new immigrants and those women who had been in the U.S. for several years.

de Anda's Bicultural Socialization Model

Bicultural socialization is a process by which new immigrants learn to function between two cultures-- their traditional culture and the culture of the U.S. de Anda's Bicultural Socialization Model (1984) is described in detail in Chapter Three. de Anda's model addresses the possible explanations for why some immigrating individuals remain differentiated from the U.S. Several factors are described by de Anda as influencing the process of biculturalism in new immigrants. Three of the six factors were mentioned by women in this study; these three included the degree of cultural overlap or commonalities between cultures, the degree of bilingualism, and the degree of dissimilarity in physical appearance from the majority culture. These three factors influenced the degree of

biculturalism experienced by the study participants. They negatively influenced many of the women in their motivation and opportunities to "fit in" successfully into the mainstream culture of the U.S.

As mentioned before, most of the women preferred their cultural customs over those of the U.S. They also preferred their own customary social interactions with family, friends, and neighbors over what they gleaned from the interactions they perceived among North Americans. Many of the women voiced that there was minimal overlap between cultures. de Anda (1984) proposes that disparities in values, beliefs, perceptions, and norms can create conflict in the process of adapting or socializing to a new culture.

Some of the women in this study struggled with the English language. This proved to be a tremendous obstacle for these women in successfully negotiating through the U.S. culture. Women shared various experiences with their challenges to access the health care system and/or accomplishing tasks such as shopping, riding a bus, or asking for directions. Several women perceived discrimination or felt "othered" because they could not communicate well in English. de Anda suggests that proficiency in the English language may enhance or limit new immigrants' opportunities in becoming bicultural or learning to negotiate successfully between their two cultures.

de Anda's (1984) model states that physical appearance can be a challenge to the socialization process. She proposes that the greater the difference in appearance the greater the chance for difficulties and conflict to occur for new immigrants. In this particular study, perceived discrimination was highly associated with physical appearance. Several women voiced that their Hispanic appearance would elicit discrimination or bias among people of the U.S. Some women shared stories noting that

when they entered the room “people would stop talking and stare.” Another woman from Puerto Rico mentioned that her hair, “tells everyone that she is not white.” The degree of dissimilarity in physical appearance from the majority culture appeared to create conflict in the socialization process for some of these women.

de Anda’s (1984) bicultural socialization model was significant for understanding the specific factors that may enhance or interfere with these new immigrant Hispanic women’s process of becoming part of their new society. As mentioned above, several factors interfered with the process for many women; however, the degree of social support from friends, family, and members of the mainstream culture appeared to facilitate the socialization process for a few of the women. These women spoke English well enough or had family with experience in the customs of the U.S. to assist them to successfully negotiate through the various systems.

Krieger’s Ecosocial Theory

Examining the research questions through the lens of Krieger’s (1994) ecosocial theory directed the analysis of the data to look at how these immigrant Hispanic women biologically embodied their lived experiences since immigration to the U.S. Krieger (1994) proposes that every individual biologically embodies and expresses all of their social experiences (from birth to death) in a manner that influences their health, illness, and well-being.

Many of the women in this study shared stories of healthy childhood experiences. Only two voiced having a childhood illness that required hospitalization. Most of the women reported that healthy behaviors (eating nutritious meals and exercising) were practiced in their homes and encouraged by their mothers. Women shared happy stories

filled with memorable experiences of family celebrations and get-togethers. Life experiences changed when they came to the U.S. for all of the women. Many are adapting "well" to their new lifestyles yet many stated they are happiest when functioning in the same manner they did before they came to the U.S.

Differences in cultures, inability to speak English, and perceived discrimination appeared to be the major factors that influenced their social experiences and that affected their health care decisions and behaviors. In most cases, these factors created negative or stressful experiences for the women in this study. Exposure to these new stress-causing experiences was greater for women who came to the U.S. as children. These women lived longer with the day-to-day experiences of feeling "othered" and with the embodiment of the label of an "ethnic minority." When asked how they responded to these stressful experiences, most of the women reported that they were "angered," "frustrated," and "confused" by them. They also stated that it did not deter them from participating in the "blessings" of living in this country. Some women voiced a greater determination to learn to speak the language as a way of negotiating their way through the mainstream culture. Krieger postulates that these daily experiences with feeling different (or "othered") can most likely affect the health of these women. She states that our social experiences and our biological history are inseparably connected with how we "develop, grow, age, ail, and die" (2002, p. 39). Understanding the stressful events many of these women experience will be important to future research efforts in the development of appropriate interventions.

The use of these three theoretical frameworks was important in guiding the analysis and understanding of this researcher of the process and strategies of

acculturation, the factors that might influence the development of a bicultural perspective, and the possible health effects of biologically embodied social experiences lived by the women in this study. Although no one theory can provide all the insights for studying a phenomenon of interest, these three together were extremely supportive and provided valuable guidance.

Implications for Health Care and Nursing Practice

Insights gained from this study have significant implications for our knowledge of immigrant Hispanic women's health beliefs and behaviors. This work helps further the understanding of what health care practices are important to immigrant Hispanic women and how this group of women negotiates their traditional cultural beliefs with those they encounter in their new environment in the U.S. This study also adds to the body of knowledge regarding the effects of perceived discrimination on the access to health care experiences of foreign-born immigrant Hispanic women who are Spanish-speaking.

Maintaining Cultural Heritage

This study sheds greater light on the desire of immigrant Hispanic women to maintain their cultural heritage and traditional health and social practices. Most women in this study reported that they preferred to selectively blend the U.S. culture into their existing cultural norms and values. Sonia expressed it this way, *"We have always been Puerto Rican even if we live here."* Saray added, *"You mix them and you teach your kid both of them, Mexican and American. Yes you can mix them and you can have success."* Women expressed and were committed to the importance of maintaining their cultural family traditions (holiday, special celebrations, and get-togethers); their strong desire to maintain the Spanish language; and their desire to keep their cultural health beliefs and

practices regardless of time spent in this country. Several women shared things they did at home in an attempt to safeguard their cultural heritage.

According to the findings of this study it would be a mistaken perception on the part of health care providers to assume that the more (outwardly appearing) acculturated individuals are no longer utilizing traditional health practices at home. All of the women in this study regardless of acculturation level, years in the U.S., age, country of birth, place of employment, level of education, and use of insurance utilized one or more traditional folk medicine practices. Even highly acculturated women in this study believed that "natural" home remedies would protect their bodies against strong harmful prescribed medications. Several women voiced concern about the potential damage synthetic pills or "chemicals" might do to their bodies. Many women reported they believed that "natural" medicines such as herbs were more healing to the body than prescribed medicines. Because traditional health care practices comprise natural herbal remedies and folk treatments, including safe herbal remedies in patient treatment plans may be a way of drawing immigrant Hispanic women into professional care and improving adherence. Research is needed in herbal practices so these can be prescribed with full awareness of risks and benefits.

The Significant Role of Mother in Health Practices

An additional implication of this study's findings is the importance of the maternal role in defining health, teaching health care behaviors, encouraging health care practices, and influencing health care decisions. All of the women reported that they were taught by their mothers how to care for themselves in times of health and illness. Most women called their mothers for health care advice before seeking formal health care.

Understanding the significant role of women as traditional caregivers and healers can assist nurses and clinicians to include the mother and other female family members in health care plans to improve adherence and health outcomes. One possible method of accomplishing this may be for health providers to ask patients if they have explored relevant health issues with family members and friends and explore what was discussed.

Perceived Discrimination

Another significant finding for health care and nursing practice was the amount of perceived discrimination experienced by these women in their daily lives. Many of the women reported experiences with discrimination at school, at work, at church, in the grocery store, and in health care centers. They experienced bias as children and as grown women. Several women shared stories of discrimination from people of their own ethnic groups as well as from members of the mainstream culture.

When discussing health care in the U.S. many women said they would prefer a Hispanic provider because she/he would be aware of their cultural health practices and therefore would be more understanding and accepting of them and their beliefs. Several women voiced that they had not received appropriate care from health care providers in the U.S. As mentioned in Chapter Four, many women expressed feelings of perceived discrimination in the health care setting from staff members and health care providers. Women in this study shared experiences where they were asked to wait until all the English-speaking patients were registered or were ignored because they could not speak their requests in proper English. A couple of women reported that they were treated rudely by physicians during a routine physical or screening exam.

These findings raise the question of whether health disparities are due to racial or ethnic discrimination in our health care system. This study provides personal examples and stories in women's health which add to the growing body of research that supports that Hispanic women, especially those who are foreign-born and not fluent in English, are less likely to receive adequate or equitable health care (De Alba et al., 2003; Lauderdale et al., 2006; Smedley, Stith, & Nelson, 2003; Williams, Neighbors, & Jackson, 2002). The variety of growing evidence provided in the literature and supported by this study of the reality of bias among health care providers suggests that training of health care professionals is needed as an intervention to eliminate health disparities related to racial/ethnic discrimination.

Integrating cultural competence training programs in health care provider education such as the cultural humility approach would enhance patient care, cultivate self-awareness, and enlarge provider belief systems. Cultural humility is an approach that allows clinicians to become consciously aware and respectful of each patient's culture and uniqueness (Tervalon & Murray-Garcia, 1998). It also enhances patient care by increasing provider's awareness of the belief systems and cultural values they bring to each client visit (Juarez et al., 2006). The Health Resources and Services Administration Bureau of Primary Health Care Office of Women and Minority Health define cultural competence as, "having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities (Retrieved July 26, 2007 from http://bhpr.hrsa.gov/diversity/cultcomp.htm).

Measuring and evaluating patients' perceptions of the quality of health care visits and overall patient satisfaction may increase office versus emergency department visits, adherence to treatment plans, and improve patient outcomes. Provider bias and implicit and/or explicit stereotyping can negatively influence interpersonal interactions and can create complex situations which increase health disparities. Improving training and preparation of all providers of care in self-reflection regarding their own personal beliefs, cultural values, and humility and respect for other cultural values may reduce provider bias and more importantly decrease health disparities.

Callister (2001) posits that cultural competence is a dynamic process that evolves over time and includes acknowledging, respecting, and building upon ethnic, cultural, and linguistic diversity. She adds that cultural competence must include a holistic approach. Cultural competence programs at individual institutions should reevaluate their existing philosophy and training programs of health care personnel to incorporate methods that are holistic in nature and that include methods such as the cultural humility approach to facilitate the elimination of health disparities found in provider bias and health care service inequality.

A unique finding of this study regarding perceived discrimination is important to highlight. Most of the women who came to the U.S. as young children reported high levels of acculturative stress as they entered the school system. Many of these women reported experiences of perceived discrimination from their school teachers and other students. Many women were held back or set aside because of a lack of Spanish-speaking or culturally-prepared teachers and/or available materials in Spanish.

Women reported that they were set aside and given picture books to look at or a Spanish-English dictionary to review during class. They were not expected "to do anything in class." The women reported that in many cases they were not even "required to do the homework." These women commented that as they sat there observing in class, they understood the math that was being taught, but they were not required to participate in the learning. When asked how long it took them to understand and speak English, many of the women reported that it took about six months to a year. It is likely that these women remained a year behind in school by the time they were fully socialized into the school system.

It was not the purpose of this study to assess the effects of immigration on the early educational experiences of these women. But it is important to note that only one of the women who came to the U.S. as a child and graduated from high school went on to attend a university. All others who studied beyond high school attended technical schools (i.e., medical assistants or medical receptionists) and earned annual incomes of less than $20 thousand a year. This finding is troublesome because it has serious implications for the U.S. educational system and the treatment of immigrants in this country, but more importantly on the lives of immigrant Hispanic women and their families.

New Hispanic immigrants are being shaped by their experiences and opportunities in the U.S. Considering their explosive growth in numbers in the last decade, these Hispanic immigrants will highly influence the future of this nation. The children of these women are the adults of the future who will provide continued growth for the U.S. economy. It is crucial that these new Hispanic immigrants improve their educational achievements, increase their fluency in English, and thereby raise their socioeconomic

positions permitting them opportunities for a brighter, healthier future. A recent report published by the National Academies' National Research Council (2006) stated,

> The importance of education for Hispanics' economic success, social integration, and political participation cannot be overstated. Despite continued temporal and intergenerational gains in educational attainment, Hispanic students lag well behind both whites and blacks in years of school completed, but especially in their representation among the college educated. They face multiple risks in U.S. schools that stem from their delayed acquisition of preschool literacy; their parents' limited familiarity with the U.S. education system; and, for large numbers of second-generation youths, delayed exposure to English. Failure to master English before leaving school represents a formidable risk because English proficiency is absolutely necessary for success in the labor market, and it is vital both for navigating health care systems and for meaningful civic engagement (Retrieved May 1, 2007 from http://national-academies.org/ Press Release/ March 6, 2006).

Incidents such as these women recounted as new immigrant children entering the U.S. school system must not be tolerated and allowed to continue. Educators and researchers must examine the current standards for teaching English as a Second Language (ESL) courses to evaluate their effectiveness in educating immigrant Hispanic children. Interventions must be developed to help build immigrant Hispanic students' self-efficacy and self-esteem, undaunted by ethnic discrimination or teacher bias regarding their ability to learn or be taught. Programs for new immigrant Hispanics must

be developed to educate parents of the U.S. school system's customs and expectations. Community health nurses and advanced practices nurses serve as gatekeepers for immigrant Hispanic women and children's access to health care. Immigrant Hispanic women would benefit from, and are especially in need of, assistance in helping them help their children succeed in school. Primary care nurses could inquire about the children's progress in school and be prepared to assist with community resources as needed.

A recent report on the health of Hispanic children by The Latino Consortium of the American Academy of Pediatrics Center for Child Health Research (2002) identified Hispanic youth as having the highest school dropout rates in the nation (29% compared with 13% for blacks, and 7% for whites). Disparities in school performance begin as early as kindergarten, with a greater proportion of Hispanic children being held back in school, a major predictor of dropout in later years. It is uncertain how disparities in school performance and dropout rates affect health status and health outcomes in Hispanic youth; however, it is likely to keep them in low paying jobs with little or no health insurance for their families. This would create a vicious cycle among immigrant Hispanic families (Flores et al., 2002).

Goldenberg (1996) suggests that immigrant Hispanic children be taught in their native language in order to attain high academic achievement in English. Thus language-minority students build academic knowledge in their own language while learning to build proficiency in English. He states however, that this method as well as other theories is enmeshed in controversy in the ideological level as well as the political level.

Undocumented immigrant issues are presently in a major political upheaval in the U.S (Retrieved July 22, 2007, from www.chicagotribune.com/services/newspaper-

/premium/printedition/Sunday/chi-immig_bdjul22, 0, 1259223.story). This may be damaging to new and continuing efforts to develop interventions that would improve education experiences for new immigrant Hispanic children. Recently a county in the state of Virginia approved a resolution to limit illegal immigrants' access to county services (Retrieved July 11, 2007, from http://www.foxnews.com). Other states are considering passing similar resolutions. It is important for health care providers to keep abreast of these new resolutions and examine the potential harm they may inflict on immigrant Hispanic children's ability to attend public schools or access community health care services in their service areas. Undocumented parents' fear of being caught and deported may affect these children's ability to receive health care. It is important for community health personnel to be aware and to educate new immigrant Hispanic parents of the legal rights of all children in this country to receive an education and to receive appropriate medical care.

In summary, perceived discrimination played a key role in this study relative to how immigrant Hispanic women are able to negotiate within and between cultures. Perceived discrimination is not a new concept in studies with immigrant Hispanic populations; however, this study illuminated how these women situate themselves in order to function in their new environment and as recipients of varied discriminatory acts. They shared their viewpoint on how they were made to feel "different." Women voiced narratives describing how they personally responded to discrimination. Numerous quotes were shared in Chapter Four illustrating the stress, pain, and trauma that perceived discrimination caused in the lives of these women and their families.

The findings of this study regarding perceived discrimination should raise a warning flag that bias continues to exist for immigrant Hispanic children and women in many sections of our society. Discrimination based on ethnicity, physical appearance, or inability to speak English is detrimental to the lives of these individuals and for society as a whole.

Limitations and/or Alternate Explanations for Findings

A convenience sample recruited from two community health centers in one county in Utah was selected for this study. A multi-site approach would have provided a more representative sample and added significance to the findings of this study. Only two follow-up interviews were conducted. Second interviews were difficult to attain because of the transient nature of this population and/or because of the possibility that some of the study participants may have been undocumented. This study was conducted during a time when there was a tremendous amount of attention in the media about the future of illegal immigrants in this nation. Several marches were held on behalf of and against proposed government actions regarding this issue weeks before data were collected. A multi-site approach might have produced a greater number participants and a greater number of follow up interviews.

Another limitation of this study was the small sample size. The researcher is aware of the many subgroups within this ethnicity, and this study did not allow for a larger sampling of each sub-group. It was a goal of this researcher that small samples representing various regions of Central and South America would be recruited to examine any apparent differences in health beliefs or behaviors. There were no notable differences among the women in how they responded in general to the survey questions that might be

attributable to sub-group or country of origin. The recurrent themes presented in this study seem to be true across all sub-groups represented.

Several of the study participants were health care workers. This may have influenced their level of knowledge regarding health care practices utilized in the U.S. Health care education and experience may have influenced their own personal health care beliefs and behaviors. Lived experiences in the health care arena may also have influenced their answers regarding access to health care among new immigrant Hispanic populations. Additionally, all of the participants were recruited from a health center setting so were receiving health care to some degree. This may have limited the sample, since it did not include those immigrants who had not interfaced or negotiated the U.S. health care system.

All the interviews were conducted in a small conference room at one of the clinics. For some of the women that were employed at the clinic, this may have been convenient but distracting. The women may not have felt as free to relax and talk openly. Every effort was made to insure privacy and comfort. Fruit, muffins, and water were offered to all women, especially in cases where the women had been at the clinic for a long period of time.

Most of women in this study reported that they felt they were in good health. The majority of the women participants were less acculturated according to the SASH scale. The literature supports previous findings that less acculturated women experience greater health than highly acculturated Hispanic women (Lara, Gamboa, Kahramanian, Morales, & Hayes-Bautista, 2005). Most of the women in this study reported that they felt healthy and attempted to practice behaviors that would keep them feeling healthy. It is also

possible that the emphasis on abstinence of smoking and drinking encouraged by their religious community also influenced healthier lifestyles among this group of women.

No questions were asked regarding the participants' religious affiliations; however, four women volunteered that they were members of the LDS faith and three indicated that they were Catholic. Members of the LDS faith believe in the Word of Wisdom, which encourages members tp practice "a healthy lifestyle promotes a sense of well-being" (Retrieved July 26, 2007 from www.lds.org.). They also teach that exercise, eating, sleeping properly, and a cheerful attitude will all contribute to experiencing happiness. Along with emphasizing the benefits of proper eating, physical exercise, and spiritual health, members are also encouraged to avoid alcohol, tobacco, caffeine, non-herbal tea, and harmful, habit-forming drugs (Retrieved on July 26, 2007 from www.lds.org.). Almost 65% of the population in Utah is of the LDS faith; their religious beliefs and practices permeate the lifestyle of the society. Naturally, members and non-members alike are influenced to some degree by their strong belief and definition of "a healthy lifestyle."

The researcher's own Hispanic ancestry, immigration experiences, and extended work among immigrant Hispanic women had the potential of introducing bias. However, being bilingual and bicultural allowed the researcher increased understanding of the women's traditional cultural health beliefs and practices and permitted the women to voice their stories in whatever language they desired.

Recommendations for Future Research

Most of the women in this study requested more health education in a variety of health areas (i.e., women's health and chronic illnesses) as the greatest need in their

individual communities. Spanish language classes on how to negotiate access to health care were urgently needed. Women also volunteered suggestions for improving health education classes and written materials. Further research is needed at the community level to assess the adequacy of current programs and patient education materials.

As health care delivery continues to shift to community and home settings, health care professionals will be increasingly challenged to provide teaching materials that patients can later review at home and study for further clarification and/or reinforce concepts and instructions given at the health care setting. Community health nurses and primary care nurses are at the forefront of this health care need. The findings of this research suggest a need to evaluate the effectiveness and readability of our present patient education materials for immigrant Hispanic populations. Research is needed to assess the current effectiveness of the patient education materials provided to patients. Culturally appropriate health education materials can be an effective way to enhance immigrant Hispanic women's knowledge regarding women's health and chronic illness concerns. With the consistent and expected increase of new Hispanic immigrants in the U.S., further research is needed in the development of new immigrant socialization programs to help this population acclimate to their new society and to improve access to the U.S. health care system.

More research is needed on the effects of perceived discrimination from health care professionals on access and equity of health care. Many foreign-born immigrant Hispanic women seek out health care services only when the medical needs are more serious and of greater concern to their families. Findings from this study suggest that there is still much to do in the area of cultural competency and training of health care

professionals in evaluating and dealing with their own racial/ethnic biases. Programs such as the "Undoing Racism Community-Based Partnership Research in Cancer Care" are needed to bring community members and researchers together in a united effort to examine why institutional racism exist (Yonas et al., 2006). As the immigrant Hispanic population continues to grow in this nation, affordable and culturally sensitive programs that help to expand access to health care are critical. These programs are essential to insure that immigrant Hispanic women can receive equitable, high quality health care.

Future research must also address the disparities in education performance in immigrant Hispanic children. Evaluation studies must be performed to assess the effectiveness and cultural appropriateness of current ESL programs in school systems. More basic is the need to understand how immigrant Hispanic children learn best. More research is needed in examining cultural competence training among elementary school educators. There is a critical need to examine how disparities in health education performance affects health among immigrant Hispanic students and how immigrant Hispanic parents may be taught to assist their children succeed in the U.S. health system. Community-based participatory research is needed to examine the many aspects involved with addressing the education disparities experienced by new immigrant Hispanic children. The use of community health workers or *promotoras* in the classroom is an option that has worked successfully in other community settings.

Finally, new theory development in caring for the socio-cultural health needs of immigrant Hispanic women is needed. Some research has been done on specific areas of health perceptions and behaviors in recent years. These studies are beginning to shed light on the embodied experiences and values of these women; however, new research in

the development of theory, models, and conceptual frameworks is needed to guide research trajectories and improve our current nursing practice. Research with larger samples of immigrant Hispanic women is needed to better understand the way in which resources (family, social support, cultural heritage, etc.) and stressors (perceived discrimination, language barriers, health disparities, etc.) which are associated with the process of immigration and acculturation combine to affect the future health of immigrant Hispanic women.

Conclusion

This study sought to examine the traditional culture-related factors practiced by women in their native countries and to examine how these practices are influenced or changed with time and exposure to health care in the U.S. Women representing nine different countries in Mexico and Central and South America shared their stories of immigrating to the United States. A few of these women came as adults looking for new opportunities and a better quality of life. Most however, came as children, following their parents who were looking for refuge, safety, freedom, more education, and a better life for their children. Individuals and complete families left everything behind and ventured out to a land of opportunity.

This study allowed twenty women to share what happened when they arrived to this new land. Most of the women did not know exactly what they would find, but they all had hopes that it would be better than what they left behind. The narratives in this study illuminated the struggles, the joys, the tears, the strength of families, the sadness, the support of friends, the ugly face of discrimination, and the determination of a group of women to succeed in a land not called home but where they would choose to stay.

They would choose to stay and maintain their love for home and their cultural heritage, but they would learn from those in their new land. They would combine the new with the existing and find greater strength in both.

These women brought with them teachings from their mothers regarding how to keep themselves healthy. Balanced diets and daily exercise were part of their childhood lessons. Mothers taught their daughters about the use of home and herbal remedies to use during time of illness. They were taught to use these remedies initially, and if no improvement was seen or if illnesses worsened, then they were to seek medical care. Most of the women still follow these teachings. Some women admitted that they have let go of some of these traditional practices, but all women still practice the use of herbal teas. Their spirituality and prayers to their God remain a source of strength, peace, and comfort and are cultural practices many hold dear.

A significant finding in this study is that despite the number of years in the U.S. and level of acculturation, this group of women passionately desires to maintain their cultural heritage, cultural practices, and Spanish language within their families. They also desire health care services that are culturally relevant and respectful of their traditional beliefs. They requested more health education taught in their language and at times when they might have a chance to attend.

Several women described traumatic experiences in their attempts to access health care. This significant finding was revealed through painful tears and voices filled with confusion at what seemed to them unwarranted disdain. Perceived discrimination or being treated “different” or “weird” or racial” led to self questioning. “What had they

done?" The question hung in the air during many of the interviews. It was not what they had done; it was who they were that caused them to be ignored and despised.

Feelings of being set aside or ignored were not new for some of the women in this study. Those who came as children experienced these perceptions earlier, particularly in the classroom. The effects of this neglect on future academic efforts of these students is unknown; however, the achievements of immigrant Hispanic women were not supported and may have contributed to their present day financial struggles to make ends meet in lower-paying jobs, because they lack higher education.

The voices of these women have been presented through their narratives in this study. The findings are relevant to present day discussion of immigration where many are calling for reforms in policies, education, immigration laws, and health care. Nurses, health professionals, and educators alike are the gatekeepers. Through education, training, experience, and opportunities, these professionals are key to helping support the changes that must occur to improve the future health and life opportunities for immigrant Hispanic women who live throughout this nation.

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Appendix A

Screening Form for Inclusion Criteria

Thanks you for your interest in this study. I am exploring ways that women keep themselves healthy. I need to ask you several questions to see if you are eligible to be in the study.

1. Are you currently pregnant? (Yes/No)

2. Do you have any life threatening medical illnesses? (Yes/No)

3. Do you have any physical handicaps that require you to see a health care provider various times a year? (Yes/No)

4. Are you currently in treatment for drug or alcohol use? (Yes/No)

5. Do you currently have a psychiatric illness that interferes with your ability to think clearly? (Yes/No)

6. I do not need to know about your immigration status, but can you please tell me how long you have lived in the United States?

A yes answer to questions 1-5 (or less than 3 years in the U.S. to question 6) precludes the woman from taking part in the study. If this occurs the co-investigator will state the following:

I really appreciate your interest in this study. However, I need to talk with women who are not currently in treatment for the questions I just asked (or have been in the United States for less than three years). Thank you so much for taking the time to answer these questions.

If the woman is eligible for the study, arrangements will be made to schedule her interview.

Appendix B

Dear Clinic Manager:

This letter is to request permission to recruit research participants at Mountainlands Community Health Center (MCHC). The proposed study is being conducted as a dissertation research study for the Nursing Doctoral program at the University of California, San Francisco. The aim of this study is to describe the health care practices of reproductive- age immigrant Hispanic women.

I am hoping to recruit a convenience sample of 20 healthy, immigrant Hispanic women between the ages of 20 – 45 for this study. After giving consent participants will be asked to respond to a questionnaire containing demographic information such as: age, place of birth, education level, number of years in the United States, occupation, income level, etc. This questionnaire will take approximately ten minutes to complete. They will also be asked a list of questions regarding their definition of health, their health care practices, and disease prevention practices. They will also be asked questions on the influence of the American culture on their own cultural beliefs and health care practices. The interview may take approximately 1-2 hours. The interview will be audio taped. The interview will be conducted in a private place and at a time that is convenient for the participants. I do not want nor need any immigration information. Participants will be given the choice of answering the questions in English or Spanish. The women will be paid $20 for participating.

The women will be informed of the study by poster/ flyer advertisement. I would like your permission to post these posters/flyers at the clinic in a location that will be seen by your female Hispanic patients. I would also like permission to visit your facility and help distribute flyers and answer any questions that the patients may have regarding my study. If not too time consuming for your staff it would be helpful if they could mention the study to the women visiting the center on the days I am there and if they are interested, refer them to me to discuss the details of the study. It is my hope that Hispanic women will call the telephone number on the poster indicating an interest in the study. I will then schedule an appointment for the interview. I appreciate your offer of the use of the conference room on selected days to interview the participants.

The information gathered from this research study will be kept confidential. The audiotapes from the interviews will be destroyed at the completion of the project. No individual identities will be used in any reports or publications that may result from this study. Participants will be reassured that taking part in this study will not influence their current or future status at your facility.

Gratefully,

Ana C. Birkhead, RN, MSN, WHNP, PhD (c)
Doctoral Student
(801) 422-6891

Approval to conduct this study given by:

_____

Date _____

Appendix C

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Study Title: "Factors that Influence Health Promotion Practices Among Reproductive-Age Immigrant Hispanic Women"

This is a research study about the health care practices and health care decisions of reproductive -age immigrant Hispanic women. You are being asked to participate in this study because you are a healthy Hispanic woman. Ana Birkhead, a doctoral student from the School of Nursing will explain this study to you.

Research studies include only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions, you may ask the researchers.

You are being asked to take part in this study because you are a healthy foreign-born, immigrant Hispanic woman.

Why is this study being done?

The purpose of this study is to better understand how immigrant Hispanic women take care of their health. The results of this study will assist in the development of interventions that will better meet the cultural needs of immigrant Hispanic women.

How many people will take part in this study?

About twenty Hispanic women will take part in this study.

What will happen if I take part in this research study?

If you agree, the following procedures will occur:

- The researcher will interview you for about one to two hours in a private conference room at your clinic or in a location mutually agreed upon. If we are unable to complete the first interview or if further clarification is needed- a second (overflow) interview may be requested. It will be scheduled at the end of the first interview. The researcher will ask you to describe your experiences with how you keep yourself healthy here in the United States as well as how you kept yourself healthy in your country of origin.
- The researcher will make a sound recording of your conversation. After the interview, someone will type into a computer a transcription of what is on the tape and will

remove any mention of names. The sound recording will be destroyed at the end of the study.

How long will I be in the study?

Participation in the study will take about 1-2 hours.

Can I stop being in the study?

Yes. You can decide to stop at any time. Just tell the study researcher or staff person right away if you wish to stop being in the study.

Also, the study researcher may stop you from taking part in this study at any time if he or she believes it is in your best interest, if you do not follow the study rules, or if the study is stopped.

What side effects or risks can I expect from being in the study?

- Some of the interview questions may make you uncomfortable or upset, but you are free to decline to answer any questions you do not wish to answer or to leave the group at any time.
- For more information about risks and side effects, ask one of the researchers.

Are there benefits to taking part in the study?

There will be no direct benefit to you from participating in this study. However, the information that you provide may help health professionals better understand/learn more about how to develop more effective health programs to meet the cultural needs of Hispanic women.

What other choices do I have if I do not take part in this study?

You are free to choose not to participate in the study. If you decide not to take part in this study, there will be no penalty to you. You will not lose any of your regular benefits, and you can still get your care from our institution the way you usually do.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used. No information regarding immigration status will be collected

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include:

- UCSF's Committee on Human Research

What are the costs of taking part in this study?

You will not be charged for any of the study treatments or procedures.

Will I be paid for taking part in this study?

In return for your time, effort and travel expenses, you will be paid $20 for taking part in this study. You will be paid in cash immediately after the interview.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way. You will not lose any of your regular benefits, and you can still get your care from our institution the way you usually do.

Who can answer my questions about the study?

You can talk to the researcher(s) about any questions or concerns you have about this study. Contact the researcher **Ana Birkhead at (801) 422-6891**.

If you have any questions, comments, or concerns about taking part in this study, first talk to the researcher (above). If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the **Committee on Human Research**, UCSF's Institutional Review Board (a group of people who review the research to protect your rights).

You can reach the CHR office at **415-476-1814**, 8 am to 5 pm, Monday through Friday. Or you may write to: Committee on Human Research, Box 0962, University of California, San Francisco (UCSF), San Francisco, CA 94143.

****

CONSENT

You have been given a copy of this consent form to keep.

You will be asked to sign a separate form authorizing access, use, creation, or disclosure of health information about you.]

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in this study, you should sign below.

Date	Participant's Signature for Consent
Date	Researcher's Signature

Spanish Consent Form

UNIVERSIDAD DE CALIFORNIA, SAN FRANCISCO
DOCUMENTO DE AUTORIZACIÓN Y CONSENTIMIENTO

TITULO: "Factores Que Tienen Influencia en la Promocion y Practicas de Salud en Las Mujeres Hispana de Edad Reproductivas".

Por que se esta haciendo esta investigación?

El propósito de esta investigación es para entender las practicas culturales en manteniendo la salud que existen en las mujeres Hispana de la edad reproductivas. Queremos entender como las mujeres Hispanas se cuidan su salud en los paises de origen y como estas practicas cambian cuando la mujer viene a los Estado Unidos. Ana Birkhead, es una enfermera especializada en la salud de mujeres. Tambien es una estudiante en la universidad. Ella le esplicara esta investigacion.

Tome tiempo en su decision de participar en esta investigación. Puedes hablar con su familia o amistades, si deseas. Usted esta invitada de participar en esta investigación porque eres una mujer saludable.

Cuantas personas participaran en esta investigación?

Esperamos que participen veinte mujeres Hispanas en este estudio.

Procedimiento del estudio:

Si usted está de acuerdo en participar, entonces los siguientes ocurrirán:

1. Al recibir el consentimiento informado, usted recibirá instrucciones de responder para un cuestionario conciso conteniendo información demográfica, algo semejante como su edad, y el número de niños. Este cuestionario tomará aproximadamente hacia quince minutos para completar. También recibirá un cuestionario que se llama el Short Acculturation Scale for Hispanics. Este cuestionario también tomara aproximadamente quince minutos para completar.

2. Usted también se le pedirá una lista de preguntas con respeto a cómo se mantenía usted saludable en su país de origen y como los haces ahora en los Estados Unidos. Esta entrevista puede tomar aproximadamente 1 -2 horas. Si necesitamos aclarar informacion o no terminanos la primera encuesta es posible que tengamos una segunda entrevista. La segunda cita sera solo para terminar or aclarar informacion. La segunda cita se ara al terminar la primiara entrevista. La entrevista será audio grabado. La entrevista será dirigida en un lugar privado y a un tiempo que sea mutuamente conveniente para usted y la investigadora. Las entrevistas serán traducidas como sea necesario y transcritas textualmente y serán analizadas en términos de los temas relacionados. Para mantener confidencial no se usara su identificación.

Todas estas entrevistas serán realizadas con una investigadora enfermera hispana bilingüe. Se entrevistará a las participantes en inglés o en español, según indique la participante.

Cuanto tiempo estara en este estudio?

La entrevista tarda una o dos horas.

Puedo terminar el estudio?

Si, usted tiene el derecho de terminar esta investigación cuando desea. Su participación es completamente voluntaria. Solo tiene que communicar sus deseos con la investigadora. La investigadora puede terminar la entrevista si las rasones son mejor para usted o el estudio. Por ejemplo, si no sigues la reglas o si se termina la investigacion. Las pacientes pueden dejar de participar en el estudio en cualquier momento sin sanción alguna.

Cuales son los riesgos de participar en esta investigación?

No existen riesgos previsibles asociados con esta investigación. Tal vez las entrevistadas no se sientan cómodas con algunas de las preguntas. Cuando éste sea el caso, se les recordará que no es obligatorio contestar las preguntas. Las pacientes tendrán en todo momento el derecho de rehusar y/o dejar de participar en el estudio.

Hay beneficios por participar en este estudio?

No podemos prometer beneficios directos por haber participado en el estudio. La información que se recoja y se analice puede contribuir al desarrollo de programas de salud para mujeres hispanas y el mejoramiento en el estado del la mujer hispana en los estados unidos.

Hay procedimientos alternativos?

No existen procedimientos alternativos. Usted puede decidir no participar en esta investigación.

Se va a mantener mi informacion privada?

Vamos a hacer todo posible para mantener su informacion personal privada. Pero no podemos prometer que se va atener completamente privada. Se la ley lo requiere, tendremos que compartirla con ellos.

Se cuidaran todos los datos agregados de manera que se mantenga la confidencialidad al estudiarlos y publicarlos. No se le preguntara informacion de su esatado de immigracion.

Es posible que las siguentes organizaciónes vean a su información:

- UCSF Committee en Research Humano

Hay costos por participar en esta investigación?

No habrá costos para las participantes.

Recibirá un pago por participar en este estudio?

Usted recibirá $20 para su participación en este estudio. Usted recibirá su dinero en efectivo inmediatamente después de que usted complete la entrevista.

Quien puede contestar mis preguntas sobre esta investigacion?

Usted puede hablar con la investigadora, Ana Birkhead (925) 876-1583.

Si usted tiene cualquier comentario o preocupaciones acerca de la participación en este estudio, entonces usted primero debería hablar con los investigadores. Si por alguna razón usted no tiene el deseo de hacer esto, entonces usted puede contactar al **Comité en Research Humano**, lo cual está preocupado con la protección de voluntarios en proyectos de investigación. Usted puede alcanzar la oficina del comité entre 8:00 y 5:00, de lunes a viernes, llamando a (415) 476-1814, o escribiendo: El comité en Research Humano, Box 0962, Universidad de California, San Francisco San Francisco, CONTADOR PÚBLICO CERTIFICADO 94143.

El consentimiento

Usted recibirá una copia de este formulario de consentimiento para sus registros.

LA PARTICIPACIÓN EN LA INVESTIGACIÓN ES VOLUNTARIA. Usted está en libertad para rehusarse de este estudio, o retirarse de él en cualquier momento., sin dar razón alguna y sin que se vean afectados mis derechos legales y a la atención médica.

Si usted está de acuerdo en participar de este estudio, entonces por favor firme debajo.

_____ _____

Fecha
De Estudio

Firma De Participante

_____ _____

Fecha
Firma de Investigadora

Appendix D

Are you a Hispanic Woman? Would you be interested in participating in a research study?

We are conducting a research study to explore how Hispanic women keep themselves healthy.

You must be a healthy woman between the ages of 20 and 45. You must have been born outside of the United States and have lived in the U.S. more than 3 years. You must be willing to share information about how you keep yourself healthy.

$20.00 will be given to all participants who take part in the study.

If you would like to know more-

Please call Ana Birkhead, RN, MSN, WHNP, PhD (c) at (801) 422-6891

This study is being conducted by University of California, San Francisco

Appendix E

Demographic Data Collection

1. What is your age?

2. What is your race or ethnic background?

3. Where were you born?

4. How long have you lived in the United States?

5. Where were your parents born?

6. Are you
    a. Married
    b. Single
    c. Living with a partner
    d. Divorced
    e. Widowed

7. How many children do you have?

8. How many years of school did you complete?

9. Are you employed outside of the home?

10. What type of work do you do?

11. What is the approximate annual income of your household?
    a. Less than $5,000
    b. $5,000 - 9,999
    c. $10,000 – 19,000
    d. $20,000 – 39,000
    e. $40,000 - 59,000
    f. More than $60,0000

12. Do you have health insurance?

Appendix E (Spanish)
Demographic Data Collection
Spanish version

1. ¿Qué es su edad?

2. ¿Cual es su raza o grupo étnico?

3. ¿En cual país nació usted?

4. ¿Cuantos años tienes de vivir en los Estados Unidos?

5. ¿En cual país nacieron sus padres?

6. ¿Cual es su actual estado civil?

    a. Casada
    b. Soltera y nunca casada
    c. Vives con su compañero
    d. Divorciada
    e. Viuda

7. ¿Cuantos hijos/hijas tienes?

8. ¿Cual es el nivel de educación mas elevado que usted ha completado?

9. ¿Trabajas fuera de su hogar?

10. ¿Que tipo de trabajo haces?

11. ¿Aproximadamente, que es su ingreso anual antes de los taxes?

    a. Menos de $5,000
    b. $5,000 - 9,999
    c. $10,000 – 19,000
    d. $20,000 – 39,000
    e. $40,000 - 59,000
    f. Mas de $60,0000

12. ¿Tiene usted algún tipo de seguro de salud?

Appendix F

Hispanic Short Acculturation Scale

Background:

This 12-item acculturation scale has been widely used in research on Latinos. Acculturation, as measured by this scale, correlated highly with respondents' generation, length of residence in the U.S., age at arrival, ethnic self-identification, and with another acculturation index (Marin, Otero-Sabogal & Perez-Stable, 1987). Both English and Spanish versions are included in the reference cited below.

Developer:

Gerardo Marin, Fabio Sabogal, Barbara VanOss Marin, Regina Otero-Sabogal and Eliseo Perez-Stable

Reliability:

Coefficient alpha = 0.92 (Marin et al., 1987)

Assessment:

Scale items (English version):

1. In general, what language(s) do you read and speak?
2. What was the language(s) you used as a child?
3. What language(s) do you usually speak at home?
4. In which language(s) do you usually think?
5. What language(s) do you usually speak with your friends?
6. In what language(s) are the T.V. programs you usually watch?
7. In what language(s) are the radio programs you usually listen to?
8. In general, what language(s) are the movies, T.V. and radio programs you prefer to watch and listen to?
9. Your close friends are
10. You prefer going to social gatherings/parties at which people are
11. The persons you visit or who visit you are
12. If you could choose your children's friends you would want them to be

USE THE FOLLOWING RESPONSE CATEGORIES FOR QUESTIONS 1-8

1. Only Spanish
2. More Spanish than English
3. Both equally
4. More English than Spanish
5. Only English

USE THE FOLLOWING RESPONSE CATEGORIES FOR QUESTIONS 9-12

1. All Latinos/Hispanics
2. More Latinos than Americans
3. About half and half
4. More Americans than Latinos
5. All Americans

References:

 Marin, G., Sabogal, F., Marin, B.V., Otero-Sabogal, R., & Perez-Stable, E. (1987). Development of a short acculturation scale for Hispanics. .

Short Acculturation Scale for Hispanics
(Spanish version)

1. ¿Por lo general, que idioma(s) lee y habla usted?

1	2	3	4	5
Solo Español	Español mejor que Ingles	Ambos por igual	Ingles mejor que. Español	Solo ingles

2. ¿Cual fue el idioma(s) que hablo cuando era niño(a)?

1	2	3	4	5
Solo Español	Español mejor que Ingles	Ambos por igual	Ingles mejor que Español	Solo ingles

3. ¿Por lo general, en que idioma(s) habla en su casa?

1	2	3	4	5
Solo Español	Español mejor que Ingles	Ambos por igual	Ingles mejor que Español	Solo ingles

4. ¿Por lo general, en que idioma(s) piensa?

1	2	3	4	5
Solo Español	Español mejor que Ingles	Ambos por igual	Ingles mejor que Español	Solo ingles

5. ¿Por lo general, en que idioma(s) habla con sus amigos (as)

1	2	3	4	5
Solo Español	Español mejor que Ingles	Ambos por igual	Ingles mejor que Español	Solo ingles

6. ¿Por lo general, en que idioma(s) son los programas de televisión que usted ve?

1	2	3	4	5
Solo Español	Español mejor que Ingles	Ambos por igual	Ingles mejor que Español	Solo ingles

7. ¿Por lo general en que idioma(s) son los programas de radio que usted escucha?

1	2	3	4	5
Solo Español	Español mejor que Ingles	Ambos por igual	Ingles mejor que Español	Solo ingles

8. ¿Por lo general, en que idioma(s) prefiere oír y ver películas, y programas de radio y televisión?

1	2	3	4	5
Solo Español	Español mejor que Ingles	Ambos por igual	Ingles mejor que Español	Solo ingles

9. Sus amigos y amigas más cercanos son:

1	2	3	4	5
Solo Latinos	Mas Latinos que Americanos	Casa mitad y mitad	Mas Americanos que Latinos	Solo Americanos

10. Usted prefiere ir a reuniones sociales/fiestas en las cuales las personas son:

1	2	3	4	5
Solo Latinos	Mas Latinos que Americanos	Casa mitad y mitad	Mas Americanos que Latinos	Solo Americanos

11. Las personas que usted visita o que le visitan son:

1	2	3	4	5
Solo Latinos	Mas Latinos que Americanos	Casa mitad y mitad	Mas Americanos que Latinos	Solo Americanos

12. Si usted pudiera escoger los amigos(as) de su hijo(as), quisiera que ellos(as) fueran:

1	2	3	4	5
Solo Latinos	Mas Latinos que Americanos	Casa mitad y mitad	Mas Americanos que Latinos	Solo Americanos

Note: an asterisk indicates items making up the first factor (short scale).

Appendix G

Interview Guide

I am interested in the ways that Hispanic women keep themselves in good health. I would like to discover some of the special or everyday things women do to keep themselves from becoming ill and staying healthy and strong. The questions I will ask will have you reflect on how you do this for yourself and/or your family. *I do not want any information about your immigration status.

Examples:

1. Tell me about your experience of settling in the U.S. from your country of origin. (What was it like?)
    a. Tell me about how you have maintained the important things about your culture? (Has this been important to you?)
    b. Tell me about how you have adapted to the lifestyle of the U. S.? (Has this been important to you?)

2. What has been your experience of living as a (_ethnic group or country of origin) in the U.S?

3. Tell me what it meant to you to "be healthy" when you lived in (country of origin)
    a. What were you taught as a girl about health and being healthy?

(Probing questions will be geared toward eating habits, exercise, herbs, special care during pregnancy, etc.)

    b. Tell me a story of how you kept yourself healthy in your home country.

4. Tell me what it means to "be healthy" since you moved to the US?
    a. What kind of differences do you see in keeping yourself healthy here in the U.S. versus in your country of origin?
    b. Tell me about things you did to stay healthy in your country of origin that you still do in the U.S.?
    c. Tell me a story about how you keep yourself healthy now that you live in the U.S.

(Probing questions will be geared toward eating habits, exercise, herbs, special care during pregnancy, etc.)

5. Tell me what it was like for you when you got sick when you lived in (country of origin)?
    a. How did you care for yourself when you were sick?

(Probing questions will be geared toward identification and treatment of symptoms, seeking health care, etc.)

b. Tell me about what your experiences when you get sick since you moved to the US?

c. What kind of differences do you see in your experiences here in the U.S. versus those in your country of origin in seeking health care when you are sick?

6. Where do you feel most "at home" or comfortable in getting health care for yourself? For your family? Why?

7. Tell me about your experiences in getting women's health exams such as pap smears, breast exams, mammograms, etc.

a. Do you have annual screening exams?
b. Did you receive these exams in your country of origin? How often?
c. Do you have a regular health care provider? How often do you see your provider?
d. Tell me about your relationship with your health care provider

9. What resources would you like to have available in your community to help you stay in good health or improve your health?

10. Some people turn to spiritual resources, like God or religion, or other beliefs to help them with their health. What has been your experience with this?

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Ana C. Bilkhed 9/9/07