Childbirth and Culture
Providing Services to Latin American Families in the United States

By Emily Wehby

Childbirth, a universal biological event, occurs in all cultures and therefore may seem independent of any specific cultural influences. Culturally based beliefs and values, however, influence women's experiences of childbirth and determine the practices a society believes appropriate for providing care for pregnant and postpartum women. Since views and beliefs about the events surrounding childbirth—pregnancy, labor and delivery, and infant care—vary by culture, health care providers can increase their effectiveness by taking into account the home culture of the new parents. An increasing number of children born in the United States are born to parents from Mexico and other Latin American cultures. Although a wide variety of diverse cultures often fall under the umbrella term Latin American, researchers have identified characteristics shared by many Latin American cultures. Field research carried out in specific communities in Oaxaca, Yucatán, Texas, and Guatemala illustrate some of the beliefs and traditions surrounding childbirth within these populations. Knowledge of such beliefs can help health care workers in the United States communicate more effectively with their immigrant patients.

Childbirth as Culturally Based
The research compiled in the collection Childbirth and Authoritative Knowledge highlights the role of cultural influence on women's childbirth experiences. The editors Davis-Floyd and Sargent point out that “birth is almost never simply a biological act; on the contrary . . . birth is everywhere socially marked and shaped” (2). Cultural views about women, women's bodies, and reproduction lead to a wide variation in the kinds of care pregnant women receive. Polynesian culture, for example, values women's bodies and confers high status on pregnant women. Pregnant women are treated with great consideration and benefit from the attention of respected midwives. In contrast, in Bangladesh and rural north India “menstruation and birth are regarded as disgusting and intensely polluting” and women are reluctant to assist other women in childbirth, since if they do they will also be tainted by the pollution of birth (Davis-Floyd and Sargent 4).

The extent to which a culture embraces technology also affects the dominant views on childbirth. A culture that highly values technology, such as the United States, tends to view the process of childbirth as requiring a high level of medical intervention. As a culture experiences growth and change, views towards childbirth may change as well. In Japan, for example, the majority of births before the 1960's occurred at home, attended by a midwife. In recent years, most Japanese births have taken place in hospitals. Although traditional midwives may still be present, they defer to the authority of the obstetrician. (Fiedler 160).
Differing views about healthy delivery can cause friction when a woman of one culture is attended by a doctor or other health care provider from a different culture. Davis-Floyd and Sargent illustrate this in their discussion of birth culture among the Maya:

“From an American point of view, the Maya women encourage pushing much too early in labor, often resulting in a swollen cervix and a more painful and difficult labor than necessary...from a Maya point of view, the medical practitioners in the clinics would be seen to be acting inappropriately when they forbid women to be accompanied by other women for support - a primary criterion of indigenous Maya birth - as well as when they demand unnecessary genital exposure, which the Maya perceive as shameful” (3).

The Growing Hispanic Population in the United States

Various newspaper articles in recent years have pointed out the rapidly growing Hispanic population in the United States. A *San Francisco Chronicle* article of February 2003 reports that “beginning in July, 2001, more than half of all California babies were Latino” (Hendricks A17). The population increase is due partly to immigration and partly to births to Latinas already residing in the United States, who tend to have a higher fertility rate than women of other cultural groups. Although immigrants enter the United States from many countries in Central and South America, the greatest number come from Mexico, El Salvador, and Guatemala (Neria). In a study on the effects of U.S. migration experience on Mexican women's fertility, Lindstrom points out that “migration from Mexico to the U.S. constitutes one of the largest migration systems in the world” (1342). Marketing researchers also reference the growing Hispanic population. *Marketing News* reports that the “US Hispanic marketplace grows at a phenomenal pace...it is expected to make up 1/4 of the population by 2050” (James 17).

Diversity of Latin American Cultures

Immigrants to the United States from Latin America come from many different countries, speak different languages, and have different reasons for moving to the United States. In most Latin American countries, Spanish is the dominant or official language. A significant percentage of the population, however, consists of indigenous groups. Individuals who identify with these groups may speak Spanish in addition to their native language or may speak only an indigenous language. Even among Spanish-speaking groups, there is a great deal of cultural diversity.

Latin Americans living in the United States also differ as to degree of acculturation and economic status. Those who have resided in the United States longer are more likely to have gained a greater degree of proficiency in English and learned strategies that allow them to negotiate the host culture. Many Latin American women who give birth in the United States have recently immigrated to the country and may face multiple challenges, as “they are often living in the United States without extended family, speak little or no English...and typically work in minimum wage, low-skill level jobs that do not offer benefits such as health insurance or paid sick leave” (Denman-Vitale and Murillo 51).

This is not the case, however, for all Latina mothers who give birth in the United States. Many women who cross the border from Mexico solely for the purpose of giving birth in the United States are wealthy professionals who want to give their children the opportunities available to U.S. citizens. To do so, “Mexican women simply apply for
visitors’ visas that permit border residents to travel inside a 25-mile zone in the United States for up to three days,” give birth in a U.S. hospital, and then return home to Mexico with the newborn (Gorman B1). Most of these women are members of the upper class who can afford to prepay in cash for hospital services. Health care providers will probably encounter less cultural misunderstandings among this population, as they are more likely to be familiar with U.S. medical facilities and procedures.

**Some Characteristics and Beliefs Shared by Many Latin American Cultures**

Although Latin America comprises diverse cultures, health care researchers identify some cultural characteristics and beliefs surrounding childbirth that are common to most groups within Latin America. Latin American cultures tend to place a high value on personal relationships, trust, respect, and the extended family. While patients in U.S. culture may trust health care providers because of the authority of their title or the prestige of the institutions with which they are associated, Latin Americans value a personal connection to a particular health care worker and give confianza, or trust and confidence, slowly, as the personal relationship develops. Respect for a person's age, gender, or position of authority also plays an important role in Latin American culture. Denman-Vitale and Murillo point out that respect for the health care provider may prevent some Latin American patients from asking questions or voicing disagreement with the provider (53). The importance of family relationships leads to a high level of family participation in health care decisions, especially by the head of the household. Denman-Vitale and Murillo also observe that “mothers’ infant care practices were influenced by their grandmothers' beliefs” (54).

The American Public Health Association publishes an online pamphlet entitled “Understanding the Health Culture of Recent Immigrants to the United States: A Cross-Cultural Maternal Health Information Catalog.” The section on Latin America includes beliefs and practices about pregnancy and childbirth that are common to many Hispanic cultures. Pregnant women often attach a safety pin, or two pins in the form a cross, to the front of their underwear in order to protect the baby from developing a cleft lip or palate. This is especially important during an eclipse and comes from the Aztec belief that an eclipse occurred when a bite was taken out of the moon. This led to the fear that a bite would be taken out of the baby's mouth. Women also may avoid cutting their hair when pregnant in order to prevent cutting the baby's vision. In some Latin American cultures, a pregnant woman’s cravings are considered very important. If a mother's cravings are not satisfied, the baby might be born with unpleasant personality traits or physical characteristics associated with the food. For example, if the mother craves strawberries and does not eat them, the baby might have strawberry spots (Neria).

Some cultures, including many in Latin America, adhere to a “hot-cold” theory of illness. Illnesses, foods, and medications are assigned to either a “hot” or “cold” category. “Hot” foods and medications should be used to treat “cold” illnesses, and “cold” foods and medications should be used to treat “hot” illnesses. For instance, hot chicken soup and herbal teas might be used to treat an illness considered “cold” while in U.S. culture health care practitioners might recommend foods such as fruits and orange juice, considered “cold,” to treat the same “cold” illness. According to the American Public Health Association, however, “categorization of ‘hot’ and ‘cold’ for illnesses,
medications, and foods does not necessarily relate to the literal meaning of hot and cold” (Neria). Culture, tradition, and personal experiences lead to the classifications. Pregnancy is considered a “cold” condition, so pregnant women should consume only “hot” foods in order to remain healthy. This also leads to the belief that heat is lost after delivery, so postpartum women must consume “hot” foods in order to restore balance (Neria).

Most Latin American cultures place a high value on the bond between mother and infant. *La cuarentena* refers to the forty-day period after childbirth allowed for a new mother to rest and adjust to motherhood. Family members take care of household chores so that the new mother may dedicate herself to this time of special bonding with her newborn. During this time family members also prepare home remedies, called *purgantes*, for the mother in order to help her body “eliminate impurities from the birth that would otherwise lead to health problems,” including postpartum depression (Neria). Strong family ties also lead to inclusion of family members during medical visits and may mean that someone in the family other than the patient ultimately makes health-care decisions.

### Case Studies in Oaxaca, Yucatán, Texas, and Guatemala

Anthropologists and health care researchers have published several case studies that examine the childbirth process in specific communities. Examples from fieldwork can increase health care providers’ awareness of the beliefs surrounding childbirth in cultures other than their own. The field research conducted in Oaxaca, the Yucatán, and Texas appears in *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Information on Guatemala makes up a section of the American Public Health Association's Web site on the health culture of Latin American immigrants to the United States.

#### Oaxaca

In her article “‘Women come here on their own when they need to’: Prenatal Care, Authoritative Knowledge, and Maternal Health in Oaxaca,” Paola Sesia reports her observations of childbirth culture in four villages in southeastern Oaxaca, where most of the population belongs to the Huave indigenous group. In these communities midwives attend the majority of births, and the *sobada*, or prenatal massage, is the midwives' main technique for managing the pregnancy. Pregnancies are considered normal events that do not require a great deal of medical attention. Typically, a woman will wait two to three months after missing her period before she pays an initial visit to a midwife. The purpose of the initial visit is not to confirm the pregnancy, as women tend to have little doubt as to their own knowledge of the state of their bodies, but to have the midwife perform the first *sobada*. Midwives do not encourage their clients to visit regularly, but rather trust that the expectant mother will come to her when needed. Sesia highlights the importance of the *sobada* in the childbirth culture of the villages in Oaxaca:

> "The prenatal sobada is undoubtedly the most important diagnostic tool, as well as the most significant preventive and curative prenatal strategy, that midwives have. It has, in fact, several different functions: to estimate gestation time, identify fetal position, relocate the baby in the head-down position, relieve and soothe pain and ache in the
expectant mother, establish physical and emotional contact between the midwife and the woman, and detect when the time of labor and childbirth approaches” (406).

The midwives’ use of the sobada limits the contact with the patient to external exams only. Unlike in hospital births in U.S. culture, the expectant mothers in Oaxaca do not undergo internal examinations to determine the state of progress of the pregnancy.

Because pregnancy is considered a normal state, midwives do not search for abnormalities or consider the notion of “risk.” If midwives encounter a difficult situation, they will attempt to correct the problem through the use of the sobada. Midwives will never refuse to attend a birth and will rarely refer women to doctors or clinics, despite the existence of risk factors or adverse conditions. To refuse would be socially unacceptable for a midwife. Midwives, Sesia observes, are “valued for courage, strength, and expertise” (408). Refusal to attend a difficult birth would be interpreted as a lack of courage, and the midwife would lose both clients and prestige.

Yucatán

In another case study on Mexico, Carolyn Sargent and Grace Bascope conducted ethnographic research in the early 1990’s in the predominately Maya village of Yaxuna in the Yucatán. There they observed two births attended by two different midwives. The midwives, Dona Lila and Dona Flora, had different standings within the community. The community regarded Dona Lila as a courageous and gifted midwife whose practice set the standard for correct births. Her years of experience gave her authority as a midwife, but the respected place of her family within the community reinforced that authority. Dona Flora, on the other hand, was regarded was skepticism. She did not come from a well-respected family and was not widely regarded as a legitimate midwife. People chose her to attend births when Dona Lila was not available or because they were closely related to her and thus were obligated to have her attend the birth (Sargent and Bascope, 188).

The anthropologists observed two births, one to Dona Susi, who had had five children previously, and one to Dona Nina, a first-time mother. The mother’s previous experience affected the level of intervention by the midwife and others in attendance. Both women gave birth at home, attended by the well-respected midwife Dona Lila and close relatives, including husband, mother, mother-in-law, and father. For Dona Susi, the mother of five, labor started early in the morning, but she did not call for the midwife until late afternoon. Those attending the birth, including the midwife, husband, and mother-in-law gave no advice or instructions. Instead, they discussed the affairs of the household and the village while they waited for the birth. Everyone in attendance assumed that Dona Susi had enough knowledge from her previous childbirth experiences to manage the labor and delivery herself. Dona Nina, on the other hand, was experiencing the birth of her first child and so had no previous experience. In this case, those in attendance, including the midwife, mother, mother-in-law, and husband, gave instructions constantly and admonished Dona Nina for not working hard enough. Unlike Dona Susi, Dona Nina was not consulted about her preferences or asked to assess the progress of her own labor (Sargent and Bascope, 190).

These observations highlight the cultural values placed on family relationships and experience. The culture assumes that a woman, if she has experience, is better equipped than anyone else to decide what is best for her during labor. Inexperienced women, on the
other hand, need help and guidance from experienced women. The importance of family relationships leads to the presence, and often active participation, of family members at the delivery.

Texas

Sargent and Bascope also carried out fieldwork at a public hospital in Texas. In this portion of the research, they focused on the higher level of technological intervention typical in childbirth in U.S. culture, as opposed to cultures such as that in the Yucatán where family members and midwives attend births but do not usually intervene. The authors conducted interviews in Spanish with Hispanic women who had recently delivered by cesarean section, or surgical birth, in the Texas hospital. The sample included women who were born in the U.S., women who were born in Mexico, and women newly arrived from Central American countries. In these cases, “language limitations particularly constrained these women from participating in decision making during labor and delivery” (Sargent and Bascope 193). The women had little or no information about why they had had cesarean sections. In most cases they were uninformed about their own health and the health of the baby and were unable to question doctors or nurses. The hospital environment was overwhelming for some women, especially those who had previous births outside the United States and were not used to such limited interactions with their health care providers. In a few cases, mothers who expected to receive the baby immediately after birth and then to share their bed with it did not see their newborns until a few days after the birth. While this was often due to an infection, the mother received no explanation or information about the baby’s health. Additionally, many of the women had no idea how long the hospital stay would last. The hospital did hire interpreters, but they were not often available (Sargent and Bascope 195). The experiences of these women highlight the need for a greater degree of linguistic and cultural understanding between U.S. health care workers and immigrant patients.

Guatemala

The American Public Health Association presents a case study of Guatemala to illustrate Latin American health culture as it relates to pregnancy and childbirth (Neria). Guatemala contributes the third largest number of illegal immigrants to the United States from Latin America, after Mexico and El Salvador. While most Guatemalans speak Spanish, there is a large indigenous population, and 32% of the population speaks only a Mayan language. Similar to the communities studied in Mexico, Guatemalan culture views pregnancy as a natural condition that does not require medical care. The fertility rate in Guatemala is high, at an average of five children per woman. Most women believe, especially if they have experienced childbirth previously, that they can monitor their own pregnancies. They also tend to receive extended family support, and so see no need to seek medical prenatal care. Many Guatemalans do, however, believe that pregnant women are in a weakened state and therefore are more susceptible to illness and evil spirits. Women may remain at home throughout the pregnancy because they fear exposure to illness, evil spirits, or even the ill will of others.

During labor and delivery most Guatemalans value extended family support and privacy. Women take herbs during labor in order to gain strength and ease pain. Most
women give birth at home, sometimes in a kneeling or squatting position. Guatemalan women may prefer to have a nonmedical assistant present at the birth to provide support during labor. An assistant, or doula, who shares the mother's culture or language can provide support for the family and also function as an interpreter. Women in Guatemala may be hospitalized for twelve hours after a vaginal birth and usually will share their bed with the newborn, as part of la cuarantena, the forty-day period of adjustment and mother-infant bonding.

**Interaction with Health Care Providers in the United States**

Knowledge of cultural values and beliefs about childbirth can aid health care workers in providing effective, culturally sensitive care for their immigrant patients. Continued immigration to the U.S. from Latin America, as well as the high fertility level of Latin American women, will lead to increasing numbers of encounters between U.S. health care providers and Latin American mothers and infants. Most Latin Americans value personal relationships and will benefit from developing a personal relationship with the health care provider. The extended family is very important in Latin American culture, and patients will most likely involve family members in appointments and medical decisions. Women from many Latin American cultures believe that they should monitor their own pregnancies and will act based on past personal experience and the advice of extended family members. Latin American women, especially those who have given birth previously, may expect a greater degree of control over the process of childbirth and may expect to be able to deliver in positions other than the traditional gynecological position favored in most U.S. hospital settings. Finally, most Latin American women value the development of the bond between mother and infant and will expect to be given the baby immediately after birth. Awareness of these cultural values can enable U.S. health care providers to develop a trusting, effective relationship with patients from Latin American cultures.

**References**


