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(Not) Everything is Good and Easy: Language-related Healthcare Experiences of Two Groups of Low-income Latina Mothers

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(Not) Everything is Good and Easy:
Language-related Healthcare Experiences of Two Groups of Low-income Latina Mothers

by

Aria A. Walsh-Felz

A thesis submitted in partial fulfillment
of the requirements for the degree
Master of Arts
with a concentration in Applied Medical Anthropology
Department of Anthropology
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Figure 1. Non-English Languages Spoken in the Home in Hillsborough County Florida (18-64 Year-olds) ..................................................................................................................................................21
This cross-sectional, comparative, qualitative study explored language-related issues experienced by low-income Spanish-speaking mothers navigating pediatric care for their children in Hillsborough County, Florida. Hospitals, pediatric clinics, specialists, and dental care have differing degrees of linguistic accessibility and accommodations for limited English proficient families. Two groups of mothers were interviewed: bilingual (n=9) and Spanish-speaking limited-English proficient (SSLEP) mothers (n=21). These groups perceived the effect of language on navigating pediatric healthcare differently, creating tension in perceptions and experience between them. Such tensions included SSLEP mothers expressing satisfaction with pediatric care simultaneously with shortcomings in communication. SSLEP mothers said that everything was easy, at the same time stating that navigating healthcare, and other aspects of their family life would be far easier if they spoke English. SSLEP expressions of self-sufficiency were countered by bilingual mothers who provided language support to SSLEP family members, friends, and strangers. This research points toward the need for consistent language services in healthcare settings as well as facilitation of effective English language acquisition opportunities for families.
CHAPTER ONE:
INTRODUCTION

Study Overview

This study addresses health equity and seeks to promote accessible, affordable, timely, and language-appropriate care, which satisfies health and social needs among members of a low-income Latino population concentrated in West-Central Florida. My work is situated in applied medical anthropology as a form of anthropology in public health (Brown, Barrett, Padilla, & Finley, 2009). This project touches on issues pertaining to the alignment of policy and practice, highlighting areas for quality improvement in healthcare settings. Beyond healthcare, this research suggests that changes in immigration policy, housing segregation, and language acquisition programs are necessary distal factors contributing to social and health inequity.

Using a cross-sectional, comparative qualitative study design, I explore language-related healthcare experiences of low-income Spanish-speaking mothers and issues they face when seeking and navigating pediatric care for their children in Hillsborough County, Florida. The study was carried out in a migrant farmworker population. Study objectives included identifying issues that low-income Hispanic/Latina mothers of school-aged children encounter when accessing healthcare for their children and identifying how mothers navigate healthcare access for their children. This includes identification of successful strategies for navigation of healthcare, strengths and gaps in instrumental and informational support in the community, and examination of how healthcare navigation for children is impacted by English-language
proficiency of their parents. To explore these issues, two groups of low-income Hispanic/Latina mothers were recruited using convenience sampling to participate in one semi-structured interview. The interview questions address navigation of pediatric care for elementary school-aged children of study participants. The two groups interviewed were (a) Spanish speakers with limited English proficiency (SSLEP) and (b) mothers who speak both English and Spanish, hereafter referred to as bilingual mothers.

**Genesis and Framing of the Issue**

In the current political climate, where “immigrant” is a polarizing buzzword, I elected to approach the topic of language-related equity in healthcare through exploring how children may be affected by issues their parents’ experiences when interacting with the United States (U.S.) healthcare system. This interaction includes what parents do at home to care for ill children, how parents know where to take their children, and experiences ranging from the moment they pick up the telephone to schedule an appointment to following through with doctors’ recommendations.

Most people are willing to listen about how children are impacted by certain issues; news stories and rhetoric often focus on the suffering of children (Fassin, 2005; Sclater & Piper 2001; Ticktin, 2006). Moral economies of care ascribe innocence and lack of autonomy to children, and obligations to care for and protect them are conceptualized in ways unique from the ways adults are cared for (Sclater & Piper; 2001; Taylor 2008). Much immigration policy rhetoric utilizes on a hierarchy of deservingness, moralization, and casting children as victims. The victimization of children can also have the ill effect of criminalizing parents. By framing language-related healthcare experiences as an intergenerational issue affecting U.S. citizen
children, it is my hope to make the topic more amenable to a wider audience than it might be when directly framed as an “immigrant” issue.

Framing the issue around language is not a perfect approach; the sentiment that “this is America, we speak English here” (Crawford, 2000; Pac, 2012) may be a response to this study. I rebut that while English is the operating language in the U.S., it is also recognized that the entirety of the population does not speak fluent English. Furthermore, there are laws to protect the rights of individuals with limited English proficiency, regardless of language acquisition expectations, including workplace protections under the U.S. Equal Employment and Opportunity Commission (EEOC) and Title VI of the Civil Rights Act of 1964 and its regulations (Limited English Proficiency, 2015; National Council on Interpreting in Healthcare [NCIHC], 2016; U.S. Equal Employment and Opportunity Commission [EEOC], 2016).

While English language acquisition is an advantageous skill, it is far from a simplistic process. Furthermore, language literacy may not equate to health literacy, which may not equate to sociocultural literacy. These aspects of language acquisition and the various forms of literacy are beyond the scope of this research, but must be considered when understanding the larger sociopolitical contexts. I do not advocate here that English proficiency become a demand or prerequisite for respect. Rather, I advocate that opportunities for language acquisition be made more accessible and feasible for families facing multiple constraints and barriers, only one of which is language acquisition.

**Background: English Language Proficiency, Spanish, Health**

It is widely recognized that language and literacy play a role in access to resources (Balcazar, Grineski & Collins, 2015; Horton 2004). Language-related health disparities are well documented, showing that language preference and English proficiency are associated with use
of healthcare services (DuBard & Gizlice, 2008; Fiscella, Franks, & Doescher, 2002; Ku & Flores, 2005). English proficiency is also associated with different provision of healthcare services (DeRose, Bahney, Lurie, & Escarce, 2009; Jacobs et al., 2001).

Spanish is the non-English language in highest demand in healthcare settings across the U.S. (Arthur et al., 2015). Nationally and locally, Latino populations are growing, as are the number of Spanish-speaking households (Lopez & Gonzalez-Barrera, 2013). Therefore, it is important to address issues relating to equitable access to healthcare among all people. While equitable access to healthcare, symbolically proposed by Healthy People 2020 (HealthyPeople.gov, 2014), is unlikely to be achieved within the next three years, it remains an important goal worthy of investment in research and interventions designed by and tailored toward marginalized communities.

The objective of this research is to understand how English-language proficiency affects healthcare seeking and navigation practices of low-income Spanish-speaking mothers. The main research questions are: (1) What issues do SSLEP parents encounter when accessing healthcare for their children? and (2) How is pediatric healthcare navigation similar and how is it different between low-income SSLEP parents and bilingual parents? These questions are important to understand in order to address issues faced by non-English speaking parents accessing care for their children from a process and outcomes standpoint. Comparing the experiences of SSLEP and bilingual mothers serves to answer language specific issues related to healthcare access in comparison to more global issues that affect groups based on income or ethnicity.

Other questions of interest include: (a) how do parents navigate healthcare access issues relating to their children? (b) What language-based resources are offered during the clinical encounter? (c) In what ways do parents succeed and in what ways do barriers persist? (d) How is
healthcare seeking for children impacted by English language proficiency? (e) How is healthcare seeking impacted by immigration status (legal status, time in U.S., generation)? These questions of interest aid in answering specific aspects of the primary research questions.

In this study, English-language proficiency is linked to a family history of migration. It is known that immigrants, across a range of legal migration statuses, face magnified barriers to accessing equitable healthcare (Castañeda, 2010). Such barriers result from a number of factors including legal status, language barriers, income, employment, and racial/ethnic discrimination (Balcazar, Grineski, & Collins, 2015; Castañeda et al., 2015; Heyman, Nunez, & Talavera, 2009).

Access to and exclusion from healthcare is clearly exposed by examining issues salient to first-generation immigrants, specifically those who are undocumented, owing largely to the multifaceted vulnerabilities of undocumented legal status (Heyman et al., 2009; Martinez et al. 2015). However, immigration-related health effects affect migrants of varying legal statuses (Schenker, Castañeda, & Rodriguez-Lainz, 2014) and persist through multiple generations (Belcazar et al., 2015). Thus, health-seeking behaviors and health outcomes for citizen, resident, and non-resident immigrants and their families are a useful lens through which to examine and ultimately promote health equity.

Terminology. It is important to be transparent about specific terminology to ensure common understanding between author and audience. In many cases, there are academic definitions, governmental definitions (which may vary among departments), and local definitions. For the purposes of this paper, I use the term “immigrant” to refer to any foreign-born person who crossed at least one national border during their lifetime in order to reside in the U.S.; immigrant is not indicative of legal status, but of transnational social processes. For the purposes of this
an immigrant is also a child of at least one foreign-born parent (American Academy of Pediatrics, 2013). In much academic literature, Hispanic and Latino are used interchangeably (Caballero, 2005). For some, these identities are fiercely contested, owing to specific histories that vary by geographic region. The government officially uses “Hispanic” to collect ethnicity information (not race) (U.S. Census Bureau, 2012), though in many situations “Hispanic or Latino” is used as a catch-all. I use the term Latina in the title of this paper and throughout because the study pertains specifically to women, thus the feminine indication “a” is used as opposed to “o”, “@” or “x” which signify masculine referents, both, or neither, respectively. Interestingly, the local population I spoke with largely referred to the demographic group as Hispanic, using phrases like “como hispanos…” [as Hispanics] and “hay muchos hispanos aqui” [there are many Hispanics here].

For the purposes of this study, participants were categorized as low-income, owing to the nature of the recruitment setting - a charity clinic serving the uninsured. While an individual not otherwise considered low-income may be uninsured, the likelihood of such individuals accessing care at this clinic is low, as it is located in in a rural agricultural area of the county.

Equity is synonymous with equality, and is used in situations where avoidable inequalities, or inequities, are addressed (Carter-Pokras & Baquet, 2002; U.S. Department of Health & Human Services, 2011). In contrast, a disparity is a difference – in the context of health, health disparities indicate differences in health outcomes. Language-related health disparities are those differences in health that may be traced to language proficiency and language preference. Examining the human experience through the approach of anthropology in public health is one avenue through which to gain understanding and contribute to changes, improving processes, quality of interactions, and health outcomes.
Anthropology in Public Health

This research addresses equity in accessible, affordable, timely, language-appropriate healthcare, which satisfies health needs and social processes among members of a low-income Latino population concentrated in West-Central Florida. It is situated as anthropology in public health; using this approach emphasizes the active use of theory and methods to address social problems. As applied medical anthropology in a healthcare setting, this project touches on issues pertaining to the alignment of policy and practice, highlighting areas for quality improvement in healthcare. Finally, I respond to calls by medical anthropologists to employ long-term holistic approaches in the formation of health intervention initiatives. Framing the nebulous “immigrant access to care” issue as a language-based healthcare disparity issue allows me to argue for specific changes in local healthcare seeking and providing practice which may be more immediately malleable than changes in state or national policy.

This study contributes to the current landscape of work in anthropology and public health through its documentation of mothers’ experiences with the healthcare of their children – it touches on parental knowledge and social capital, especially related to language use and expectations of self-advocacy. The study took place in an area where the Latino population is rapidly growing, jumping from 18% county-wide in 2000 to nearly 25% in 2010. In the county of study, 26% of Spanish-speaking adults 18-64 years of age speak English not well, or not well at all (Hillsborough Community Atlas, 2017). This has important implications for the provision of area health services.

Chapter Overview

In Chapter Two, I continue with an in-depth literature review, which further situates my work as an anthropologist and public health educator. The literature review addresses issues of
immigrant health, breaking the conversation into subsections about immigration, Latinos in the U.S., language use in the U.S., healthcare seeking and navigation, and culture in the clinic.

Chapter Three provides a description of data collection and analysis methods employed for this study. I address ethical concerns related to working with marginalized populations.

In Chapter Four I provide the findings of my study, first introducing three case studies to provide a broad context for the audience and illustrate issues that emerged throughout the analysis. In the second part of the chapter, I take the reader through findings specifically related to and framed by the research questions posed regarding issues SSLEP mothers face navigating pediatric healthcare for their children. Furthermore, I compare and contrast experiences of SSLEP and bilingual parents.

In the final chapter, Chapter Five, I provide a discussion of study findings presented in Chapter Four, applied aspects, and contribution to scholarship. I propose future directions for this type of study and provide conclusions and recommendations which include both immediate adjustments that can be made in healthcare settings, as well as structural changes that can be made to facilitate greater social and health equity.
CHAPTER TWO:
LITERATURE REVIEW

There is abundant work in medical anthropology addressing immigrant access to healthcare and social services. Like the field of medical anthropology, this expanse or work is based in a diversity of theoretical approaches and utilizes a multitude of methods. In the following text I situate my work specifically as medical anthropology in public health and guide the foundation of my work, drawing on previous works to frame local particularities of West-Central Florida and language-related disparities in healthcare.

Disciplinary Position and Theoretical Orientation

Medical Anthropology. Medical anthropology is a multifaceted, interdisciplinary field akin to a rhizome (Young & Rees, 2011), which is composed of multiple loosely connected shoots of a tree and symbolizes a “structured progressive development and application of a dominant methodology and body of theory” (p. 594). This is because medical anthropology is a broad and sprawling field guided by multiple approaches and theories. Broadly, medical anthropology addresses health, illness, and disease-related questions pertaining to individuals and populations and tends to emphasize culture and patterns of thought or the interactions of humans and their environment (Brown et al., 2009). Medical anthropology includes an array of theoretical and methodological approaches to health-related questions. Methods of data collection frequently include participant observation, systematic observation, and a spectrum of interviewing
techniques (Gravlee, 2011). Research in medical anthropology generally falls into one of two areas: (1) basic research to expand knowledge and understanding, and (2) applied research, aimed at solving specific problems (Brown et al., 2009).

An applied approach in medical anthropology emphasizes the active use of theory and methods to address social problems and includes anthropology in and of clinical and public health settings (Brown et al., 2009). An applied approach furthers cultural appropriateness and communication in clinical settings, with an emphasis on understanding and working with different explanatory models for successful health outcomes (Brown et al., 2009). While an applied approach overlaps with numerous theories and approaches to medical anthropology, the emphasis on tangible action is a distinguishing element of applied anthropology. An applied approach may apply study findings to design, implement, and/or monitor health interventions or inform policy change (Boonmongkon, Nichter, & Pylypa, 2010; Brown et al., 2009).

**Applied Medical Anthropology in Public Health.** Hahn and Inhorn (2009) argue that there are four major obstacles to promoting health: (1) ongoing deliberate production of harm, (2) continued inequitable allocation of resources and inefficient allocation of resources, (3) lack of investment in needed resources directed toward marginalized communities, and (4) inadequate translation of knowledge into action. They also argue that anthropology, and specifically applied medical anthropology, is paramount to mitigating obstacles to achieving greater public health (Hahn & Inhorn, 2009).

Doing applied anthropology in public health means tying ideas and approaches together from both disciplines. The local understandings and cultural nuances anthropologists document are complementary to the goals of public health. The purpose of public health as a discipline is to protect and improve the health of communities and families through health promotion, disease
and injury prevention, and detection and control of infectious diseases where people live, work, and play (American Public Health Association [APHA], 2016; Centers for Disease Control and Prevention [CDC] Foundation, 2016). This means promoting health, defined by the World Health Organization (WHO) as “a state of complete physical, mental, and social well-being and not merely the absence of disease” (World Health Organization [WHO], 2003). This broad definition of health is similar how medical anthropologists understand health (Sobo, 2011).

While there are many ideas and elements that make anthropology and public health a complementary disciplinary duo, the underlying idea of promoting social justice and equity is a strong unifier. Furthermore, anthropological theories of social production and reproduction, cultural relativism, reflexivity, and a systems thinking approach cast a critical approach to the use of theories of behavior change dominant in the field of public health.

**Structural Violence**

The ways that health equity and, more broadly, social equity are conceived are deeply embedded in and resulting from operating systems of structural violence (Farmer, 2004; Galtung, 1969). Structural violence is an idea defined as “the indirect violence built into repressive social orders creating enormous differences between potential and actual human self-realization” (Quesada, Hart, & Bourgois, 2011, p. 340). As an alternative for the term “violence,” “structural vulnerability” is sometimes considered more neutral and inclusive term. Structural vulnerability is defined as “a positionality that imposes physical/emotional suffering on specific population groups and individuals in patterned ways” (Quesada et al., 2011, p. 340). Individuals are considered structurally vulnerable when affected by structural violence as defined above, and how this idea intertwines with personal attributes, cultural values, and institutional structures (Quesada et al., 2011).
Structural violence becomes evident through examination of how changes in policy affect care-seeking strategies, especially for unauthorized immigrants. For example, the introduction of Medicaid Managed Care (MMC) had the effect of rationing charity care and excluding previously covered patient populations from care. While the policy was aimed at uninsured individuals, availability of the hospital insurance program to legal residents transformed it to a policy that restricted access for undocumented immigrants (Horton, 2004). Furthermore, children living in mixed-status families (immigrant families in which individuals have different legal immigration statuses) may decide not to use formal health services accorded to them by their citizen status (Castañeda & Melo, 2014).

These examples of structural violence and social exclusion contribute to the continuation and solidification of a “medical underclass” (Castañeda & Melo, 2014) which emerges from policies of exclusion. The resulting embodiment of health is evidence of the interaction between social and biological determinants of health; this “…embodiment reveals racial disparities in health as not genetically determined but, rather, as the mutable and embodied expression of discrimination itself” (Horton & Barker, 2010, p. 201). It is clear that inequalities are rooted in structural violence, contemporary and historical differential treatment, and access to resources. While health and illness do not privilege national borders, economic statuses, or legal migration statuses, such factors play a role in promoting or hindering access to equitable healthcare. Furthermore, some groups experience heightened scrutiny based on public constructions of deservingness (Horton, 2004).

Health Disparities, Health Equity, and Migration

The U.S. is one of the industrialized nations with the highest investment and poorest outcomes in health (Bezruchka, 2012; Stiefel et al., 2010). Healthcare reform in the U.S.
continues to be a contentious political issue following the 2010 introduction of the Patient Protection and Affordable Care Act (PPACA), generally referred to as the ACA and sometimes called Obamacare. Former President Obama instituted this plan to overhaul healthcare in the U.S. The ACA created change in healthcare including but not limited to the initiation of a universal requirement for health insurance, elimination of insurance denial based on pre-existing health conditions, and systematization of preventive measures (Kohn, & Sevelius, 2010; Meltzer, 2011). The ACA was effective in reducing ethnic health disparities in health insurance coverage, however significant disparities remain (Buchmueller, Levinson, Levy, & Wolfe, 2016). The ACA is presently under fire by the newly instated Trump administration.

Nationwide efforts to improve the public’s health depend on balancing quality, access, and costs of healthcare. Unfortunately, although this balancing act is publically recognized, many segments of the population continue to face inequalities in health and healthcare particularly marginalized, vulnerable, and sub-populations explicitly excluded and pushed to the edge of moral economies of care (Horton & Barker, 2010).

Fundamental cause theory posits that social factors function as root causes of disease and illness (Link & Phelan, 1995). This theory is guided by evidence that factors such as socioeconomic status and social capital allow for differential access to resources (Link & Phelan, 1995; Phelan, Link, & Tehranifar, 2010). Distal factors are those which fundamentally drive disparate health outcomes and include elements such as acculturation, housing, employment, and language acquisition. Proximal factors include those more immediately controllable at an individual level (Link & Phelan, 1995). Social inequities experienced by marginalized populations exacerbate existing health disparities among such populations.
Health disparities are gaps in the quality of health among groups of people; often, differences in health status related to socioeconomic factors and other forms of systematic marginalization of sub-populations including racial-ethnic minorities, socioeconomically constrained groups, immigrants, non-English speakers (HealthyPeople.gov, 2014). Health and healthcare disparities are often exacerbated in populations which experience systemic and structural violence (U.S. Department of Health & Human Services, 2011). Equitable access to healthcare would mean that all individuals would have access to affordable, high quality, culturally and linguistically appropriate care in a timely manner (Latino Coalition for a Healthy California, 2015). Health equity is defined as

“…attainment of the highest levels of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities” (U.S. Department of Health & Human Services, 2011)

Access to health care in the U.S. is compromised for a number of marginalized groups based on a variety of social determinants of health (Horton & Barker, 2010). Social determinants of health are the conditions in which people live, learn, work, and play (CDC, 2016). Low-income families regardless or ethnicity, language, or legal status experience barriers to healthcare that include location, transportation, long wait times, and low-flexibility jobs (Heyman, Nuñez-Mchiri, & Talavara, 2009). Low-income status and immigration statuses intersect to magnify these problems (Heyman et al. 2009; Ku & Waidmann, 2003; Ziol-Guest & Kalil, 2012). The dynamic of social exclusion and the resulting second-class status is the result of “web of barriers” contributes to lasting physical and social consequences (Castañeda, 2010; Heyman et
al., 2009). For immigrants living in the U.S., issues accessing care are exacerbated by various legal statuses which put exclusionary pressure them and their families (Heyman et al., 2009).

Access to healthcare is further compromised through legislation, social interactions, and cultural expectations (Horton, 2004; Pintor & Blewett, 2011). Title VI of the Civil Rights Act obligates medical caregivers to provide interpretation and translation services to limited English proficient patients so that they can have access to healthcare services equal to that of English speakers. When patients face language barriers and barriers accessing adequate translating services, they are less likely to have a usual source of medical care, receive lower rates of preventative services, have increased risk for nonadherence to medication, and are less likely to return for follow-up appointments (Flores, 2006). Despite requirements for language services, Spanish-speaking patients nationwide experience varying quality of healthcare services (Ku & Flores, 2005).

Because immigrants face a “web of effects” (Castañeda, 2010) it can be difficult to untangle a single root problem families face when accessing and following through with healthcare. As stated earlier, because issues regarding access to care are exacerbated by the marginal sociocultural position of minorities in the U.S., learning about issues accessing care among non-English speaking immigrants is a rich angle through which to approach health disparities and promote social and health equity.

**Im/Migrant Health.** Immigration and immigration-related discussions can easily become contentious and highly politicized, especially in climates of struggling economies and conflict (Schenker et al., 2014). Heavy politicization and public anxiety about immigration ignite nativist sentiment and make it difficult to discuss unintended consequences of policies barring immigrants from services, yet policies blocking immigrants from government-funded services
and other services extend beyond the individual and affect those otherwise lawfully able to access such resources (Willen, Mulligan, & Castañeda, 2011; Castañeda & Melo 2014). When individuals and organizations use specific terms to talk about immigrant groups, their choice of language reflects their sociopolitical stance regarding these groups and ascribes intent and agency to immigrants (Castañeda, 2010; Willen et al., 2011). Language choice supports categories of “deserving” and “undeserving,” specifically regarding access to social services and other benefits including healthcare (Castañeda, 2010; Willen et al., 2011).

One might pose the question, how are ideas surrounding language proficiency uniquely related to ideas of deservingness where ideas of immigration are not? Access to healthcare based on immigration status is explicitly exclusionary both legally and politically – tied to ideas of deservingness (Fassin, 2005; Horton, 2004, Willen, 2013). A language frame is explicitly inclusive. For example, the language of National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare (CLAS Standards) state: “aim to improve healthcare quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.” And proposes four of fifteen standards specific to communication and language assistance (U.S. Department of Health & Human Services, 2016). Adoption and implementation of such standards is not bound to the same ideas as healthcare as a right versus healthcare as a privilege, though many individuals occupy immigrant and language proficiency roles simultaneously.

The exclusion of immigrants is not a new development in the provision of health and social services in the U.S. It is a familiar tactic of social and economic exclusion of already marginalized groups (Messias, McEwen, & Boyle, 2015). However, this marginalization is also harmful to the general population’s health and counter to a public health approach, which
encourages prevention as the best method to preserve and promote individual and population health.

It is important to recognize that while the focus of this thesis is on Spanish-speaking Latina immigrants, immigrants and Latinos are not mutually exclusive groups and consist of nationally, linguistically, and demographically heterogeneous and intersectional subgroups. In the current political climate in the U.S., immigrant is incorrectly perceived as synonymous to “illegal Mexican.” However, migrant, immigrant, im/migrant, illegal, undocumented, unauthorized, and refugee are all terms used to refer to “individuals and populations who have crossed national boundaries, along with those moving within such boundaries” (Castañeda, 2010). As stated in the introduction, the term immigrant is used in this thesis to refer to any foreign-born person who crossed at least one national border during their lifetime in order to reside in the U.S., as well as the child of at least one foreign-born parent. Often in a position of precarious legality, immigrant groups face magnified challenges when seeking and accessing healthcare (Castañeda 2010; Chavez, 2003; Willen et al., 2011). As stated by Chavez (2003), “Immigrants are disadvantageously embedded in a political economy of healthcare characterized by pervasive structural inequalities” (p. 197).

Much access to healthcare is compromised by policy, which is written to exclude certain groups based on legal immigration status (Balcazar, 2015; Castañeda, 2010; Pintor & Blewett, 2011). Federal policies impact immigrant access to health care in several ways including the criminalization of undocumented immigrants and limiting eligibility to services for all immigrants based on different requirements (Hilfinger et al., 2015; Ortega, Rodriguez, & Bustamante, 2014). These limitations reach beyond targeted individuals to affect entire families (Castañeda & Melo, 2014; Rhodes et al., 2015). Examples of exclusionary policy include the
1996 welfare reform, the 2009 Immigrant Children’s Health Improvement Act, and 2010 ACA which place restrictions on eligibility for Medicaid and the Children’s Health Insurance Program (CHIP) for legal residents and exclude “illegal” immigrants altogether (Pandey et al., 2014, Pintor & Blewett, 2011). As part of these policies, undocumented immigrants are explicitly excluded from accessing state-sponsored health care (Medicaid) and purchasing health care through the ACA Exchange. Legal immigrants remain subject to a five-year-ban from Medicaid, but may purchase subsidized insurance through the Exchange (Ortega, Rodriguez, & Bustamante, 2014; Rosenbaum, 2011).

Despite barriers to healthcare, immigrants access care in a variety of ways. Community health centers (CHCs) are often the only place that undocumented immigrants can go for health care (Liebert & Ameringer, 2013; Ortega et al., 2014). There are many immigrants who utilize private and federally qualified health centers (FQHCs) for care. In the case of an emergency, documented and undocumented immigrants alike may utilize emergency hospital care because of the availability of emergency Medicaid.

Beyond legal barriers, structural (or distal) issues influencing access to care include language skills, employment status, and legal status, keeping in mind that not all immigrants with documentation are able to access government-funded healthcare systems. One result of occupying a legally ambivalent or socially marginalized position is that while health knowledge and health behaviors can be strong for individuals, a systematic web of legal and social barriers may prevent or deter individual actions (Castañeda et al., 2015; Chavez, 2003).

Immigrants occupy a highly heterogeneous social body, yet still face universal challenges when accessing the formal healthcare system in the U.S. Issues of healthcare access and equity
shed light on the limited effects of individual health behaviors in the face of systematic challenges for individuals in liminal zones of belonging.

**Latino Immigrants in the U.S.** Not all immigrants are Latinos, not all Latinos are immigrants, and not all Latinos speak Spanish. Latinos in the U.S. vary in national origin and occupy a range of economic, social, educational, and legal statuses as well as contexts of migration and cultural history (Castañeda, 2010; Chavez, 2003). Furthermore, a “Latino pan-ethnic label” cannot capture the severe racialization of belonging and ideas of “deservingness” among groups (Horton, 2004). For example, Cuban patients are generally perceived and perform as proactive citizens, whereas Mexican patients are often stigmatized as people who do not contribute to the cost of their care, as drains on the system, and as irresponsible and noncompliant (Horton, 2004). Some of these perceptions are the result of enabling factors and barriers such as legal status, language acquisition, economic class, and the presence or lack of social support services afforded to political immigrants and not afforded economic immigrants (Horton, 2004).

According to the U.S. Census Bureau (Grieco et al., 2012) the most incoming immigrants arrive from Latin America and the Caribbean, with the largest group immigrating from Mexico. Like the fact that not all Latinos are immigrants, not all Mexicans are immigrants; four primary Mexican subgroups in the U.S. are generally identified: (1) U.S. citizens of foreign born parents from Mexico, (2) naturalized U.S. citizens who were born in Mexico, (3) legal-permanent residents born in Mexico, and (4) undocumented Mexicans living in the U.S. with no current legal residence (Gonzalez-Barrera & Lopez, 2013).

The population of Latinos in the U.S. has grown from 6% in 1980, to 17% in 2015 and continues to grow; this number accounts for native-born and foreign born Latinos (U.S. Census Bureau, 2015). The Latino population in Hillsborough County, Florida has grown over the past
forty years (Martin et al., 1995; U.S. Census Bureau, 2015). In the past two decades, the Latino population in Hillsborough grew from 18% of the total county population in 2000 to 27% in 2015 (U.S. Census Bureau, 2015). These percentages are slightly elevated compared to the state of Florida (24.5% Latino), and that national population (17.6% Latino) as of 2015 (U.S. Census Bureau, 2015).

Just as not all Latinos are immigrants, not all Latinos speak Spanish. While it is important not to conflate Latino heritage with limited English proficiency, considering Spanish-speaking populations nationwide, state-by-state, and within states, helps paint a general and comparative picture of areas where need for language services may be elevated. Ninety-one percent of the U.S. population is English proficient (Motel & Patten, 2012). Nearly 21% of people (over the age of 5) living in the U.S. speak a language other than English at home (U.S. Census Bureau, 2015), a growing trend since the 1980s (Flores, 2006). Spanish is the second most spoken language in the U.S. (Ryan, 2013) as may be expected owing to the sizable and growing Latino population. Many Latino families speak Spanish at home (78%), and more than half (58%) speak English very well (U.S. Census Bureau, 2015); the remaining 42% speak English well, not well, or not well at all (Ryan, 2013); this is the Spanish-speaking limited English proficient (SSLEP) population.

In Hillsborough County, 26.4% of the population speaks a language other than English at home, 5% above the national average (U.S. Census Bureau, 2015). Twenty percent of adults (18-64) speak Spanish, and of those who speak Spanish, 26% report speaking English not well or not at all (Hillsborough Community Atlas, 2017).
Figure 1. Non-English Languages Spoken in the Home in Hillsborough County, Florida (18-64 Year-olds). Figure was built with data from the Hillsborough Community Atlas (2017).

Language-Related Health and Healthcare Disparities

Individuals with limited English proficiency experience compromised access to healthcare, quality of healthcare, and increased risk of adverse health outcomes (Ku & Flores, 2005). Using national data, DuBard and Gizlice (2008) found significant differences in health status between English-speaking Latinos and Spanish-speaking Latinos, where Spanish-speaking Latinos reported worse health status, access to care, and receipt of preventive care. In contrast, the presence of trained medical interpreters has a positive impact on healthcare and health outcomes which include that limited English proficient patients ask more questions, receive more preventive services, make more outpatient visits and receive, fill more prescriptions, and have higher satisfaction with care (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Jacobs, Shepard, Suaya, & Stone, 2004; Ku & Flores, 2005).
Ku and Flores (2005) emphasize the fact that healthcare providers are obligated under Title IV of the Civil Rights Act to provide translation services for patients in recognition that limited English proficient individuals experience language-related disparities in health care (Ku & Flores, 2005, p. 435). However the resources and mechanisms to fund such services are inconsistent, leading to continued language barriers for limited English proficient patients (Flores, 2006; Ku & Flores, 2005). Inappropriate care and avoidable medical mishaps (and disability) occur due to misinterpretations in clinical settings (Flores, 2006). Many healthcare facilities do not provide language services, citing cost as a barrier (Flores, 2006; Jacobs et al., 2004). However interpreter services at clinics are not only economically feasible and cost-effective, they contribute to greater utilization of clinics by patients, and more preventative care by providers (Jacobs et al., 2004; Ku & Flores 2005).

Different forms of interpreting services exist and include in-person professional medical interpreters, “blue phones” (over-the-phone interpreters), and bilingual interpreters (who are not trained medical interpreters) who may include bilingual staff or family members (Arthur et al., 2015; Flores et al., 2012; Tapp et al., 2013). Patients in emergency departments indicate higher satisfaction with care when provided in person by professional medical interpreters (Bagchi et al., 2011). It is clear that English proficiency or lack thereof has important implications for clinical interactions and resulting health statuses and behaviors. Medical interpreting errors from untrained and professional medical interpreters alike include omission, addition, editorialization, and false fluency (Flores et al., 2012) which can lead to medical errors. This is not to say that interpretation services are not necessary, however increasing the number of language-concordant healthcare practitioners would be another way to address this issue. Language-concordant
healthcare practitioners may also contribute to an increased sense of cultural capital for SSLEP individuals; cultural capital plays a significant role in how care is administered and received.

**Culture in the Clinic.** According to Kleinman and Benson (2006), culture in the clinic matters; professional appropriateness and humility is necessary when caring for patients. Culture in anthropology is understood as “a set of shared symbols and meaning that people create in the process of social interaction which orient people in their ways of feeling, thinking, and being in the world” (Carpenter-Song et al., 2007). However, public understanding of “culture” is often much more static, often confused with physical characteristics of race or identity and heritage that make up ethnicity (Carpenter-Song et al., 2007; Kleinman & Benson, 2006). Ethnicity and language of the doctor-patient dyad affect the quality of their relationship, the quality of care, and health outcomes (Ferguson & Candib, 2002). However, culture must be considered in context instead of ascribing it as a factor enabling or barring “appropriate” health behaviors (Hirsch, 2003).

Cultural competency is an idea aiming to decenter ethnocentrism in healthcare. Cultural competency training of healthcare personnel is one approach to addressing cultural and language differences in clinical settings. Though well-intentioned, cultural competency is itself problematic in attempts to operationalize culture that can lead to checklists and assumptions about patients (Kleinman & Benson, 2006). Language concordant care is not equivalent to culturally competent care. Cultural competency in practice is most successful in situations when employed to understand what is important to patients regarding their illness and treatment (Kleinman & Benson, 2006).

Context is a way to delve into local complexities, to explore the ways individuals access cultural capital or negotiate cultural power. Cultural capital (Bourdieu, 1989) includes, but is not
limited to, consonance in language skills between patient and provider (Shim, 2010). Cultural health capital is a “specialized collection of cultural skills, attitudes, behaviors and interactional styles that are valued, leveraged, and exchanged by both patients and providers during clinical interactions” (Dubbin et al., 2013); it affects how patients and providers communicate verbally and nonverbally in the pursuit of patient health (Dubbin et al., 2013; Shim, 2010). Patients and providers personal common sense (habitus) about disease and illness greatly informed their interactions (Dubbin et al., 2013). Language plays a large role in how cultural health capital is deployed; having a common language in which to discuss health concerns is paramount to providing adequate health services.

Acculturation is another term often used when discussing immigrant health; it remains poorly defined, but is often linked to language and English literacy (Hunt et al., 2004). Language preference and English proficiency play important roles in accessing at utilizing healthcare services (Arthur et al., 2015; DuBard & Gizlice 2008; Ku & Flores, 2005).

Expectations for healthcare service shape clinical interactions from patient and provider perspectives. Horton (2004) juxtaposes generalizations about Cuban refugees and Mexican immigrants to show how differing expectations from providers, as well as from patients, drive clinical interactions. Providers and patients likely come from different socioeconomic backgrounds, yet middle-class common sense is expected of all; “patients are expected to internalize this middle-class ethic and assume responsibility for ‘managing’ their own behaviors and health” (Horton, 2004, p. 477). Horton (2004) shows that not only are patients expected to conform to a certain form of “common sense,” providers often have different expectations regarding patients of different nationalities, who are treated differently depending on their own
fulfillment of the expected social roles. These expectations and interactions are deeply embedded in cultural health capital as defined above.

A different approach to expectations and cultural capital is taken by Paternotte et al. (2014), who focus on intercultural communication for doctors; patient-centered communication encourages healthcare providers to acknowledge difference perceptions of disease and illness and increased awareness of misunderstandings owing to language differences. The idea of cultural health capital encompasses behaviors, attitudes, and skills exchanged between patients and providers. Cultural health capital is an important aspect of clinical interaction and when there is a large amount of dissonance between provider and patient, it can contribute to patient and provider expectations of one another in unproductive ways.

In conclusion, my approach, rooted in applied medical anthropology and public health, seeks to understand how healthcare access for SSLEP mothers functions to include or exclude mothers and their families from accessible, equitable, and culturally appropriate healthcare. Understanding the heterogeneity and interconnectedness of the Latino population, immigrant population, and the Spanish-speaking population in the U.S. helps situate this research. Finally, the roles of cultural capital and cultural health capital (including language preference) factor greatly into how individuals and populations experience healthcare.
CHAPTER THREE:

METHODS

Gaining Entry

I drove through the sun-speckled countryside, Spanish moss hanging off the giant oaks that stretched over the two-lane county highway. I passed a McDonalds. Signs for strawberry farms popped up along the side of the road. And there it was - a residential community of adobe-style apartments. I followed the signs for the clinica [clinic] and parked behind a converted trailer. The gravel crunched underfoot and semi-feral cats watched me warily and scattered as I walked up to the back door and turned the knob wrapped in duct tape. I had arrived early to meet the people running the charity clinic and receive a brief training before beginning monthly volunteer visits as a bilingual but untrained medical interpreter. I poked my head in, nervous that my Spanish might not be good enough, but excited to be making a connection that might make this research project possible. I was upfront with clinic staff that my intentions were to get to know the community and possibly recruit participants at the clinic. That first night as a volunteer was busy; I was there late into the evening, the clinic staff was there well into the night.

I volunteered as a medical interpreter in the charity clinic for roughly a year before beginning interviews for this research. My consistent volunteering allowed me to gain rapport and show myself as a reliable ally to their community. The clinic staff was incredibly generous in allowing me to recruit parents for interviews on site. While the study pertains to the effects of language on healthcare in pediatric settings, the time I interpreted and the time I spent in the
waiting room chatting with adult patients helped me understand some aspects of language-related issues present in healthcare settings such as timing, trust in interpretation, and having bilingual, but not medical interpreter-certified, translators.

Later, during my research, the time I spent in the waiting room chatting with people between interviews allowed me to gain rapport with patients and other volunteers. Many patients were curious about my fluency in Spanish, some complimented my fluency, while others admired that even though it was obvious I was not a native speaker I didn’t let it stop me from speaking Spanish. My upcoming wedding to a Mexicano [Mexican] was also of particular interest. Women of all ages, whether they participated in the study or not, liked to give me marriage advice; everyone told me to wait a few years before having children of my own. Families talked about politics, bragged to me about their children and grandchildren who were first-generation college students, and discussed how their families were doing in Mexico. In an attempt to separate my volunteer interpreter self from my University of South Florida graduate student researcher self, I always wore a USF t-shirt on site during data collection activities.

Nearly every Monday (barring torrential rain and holidays) from February through July 2016, I arrived at the clinic around 4pm. I checked in with the clinic staff and asked if they required volunteer medical interpreter services; they did not, as there were two other regular volunteers who were native Spanish speakers and young members of the community. After exchanging pleasantries, I would walk to a separate converted trailer where patients registered before going to the clinic waiting room. The sign-in room was one big room with a heavy door and a rattling air conditioning unit that would occasionally sputter to a halt, deafening the space with sudden silence. The room also housed small tables, chairs, and a few dividers giving the illusion of privacy. I would direct patients to sign in and then ask each woman if she would be
interested in hearing about and possibly participating in my project - it was difficult to estimate
the ages of women, so I simply asked every woman who came into the waiting room if she
would be interested in hearing about and participating in my study. Some said yes. Some said no.
Some didn’t qualify. Some said “later” and followed up with me, while some did not.

When a woman told me she was willing to hearing more about the study, I introduced
myself and explained the research project. If she agreed to participate and fit the sampling
requirements, we would walk to my “office” – a space between a white board and two dividers
with a few chairs. Occasionally a mother preferred to do the interview outside if it was nice and
her kids were playing in the yard. After a mother agreed to do the interview, I delivered a verbal
informed consent and provided a printed copy of the consent in her preferred language.

**Research Design**

This, qualitative study took an inductive approach, that is, an exploratory approach which
begins with specific observations that lead to the development of research questions and the
subsequent gathering data, identifying emerging themes, and making data-based conclusions
specific to the context of study. Inductive and deductive approaches are often juxtaposed. A
deductive approach begins with a hypothesis and seeks to systematically collect observations in
support of the hypothesis. I began with specific observations about how English proficiency
functioned as an element affecting healthcare for SSLEP adults. I developed a research question
based on these observations and framed the question in the context of family health. I gathered
data through semi-structured interviews with parents and supplemented this method with
participant observation. I then identified emerging themes and patterns in participant responses,
and made data-based conclusions specific to the context of this study.
Requirements for participation included being a Spanish-speaking mother of at least eighteen years of age utilizing pediatric services in Hillsborough County, Florida for a preschool-aged child (3-5 years old) or elementary-aged child (6-11 years old) (CDC, 2017). To participate mothers were bilingual in Spanish and English or Spanish-speaking with limited English proficiency (SSLEP). Recruiting in two groups – SSLEP and bilingual samples – allowed for identification of continuities and differences in pediatric care-seeking perceptions and experiences among the two groups of mothers.

For the purposes of this study, participants were categorized as low-income, owing to the nature of the recruitment setting - a charity clinic servicing the uninsured. While an individual not otherwise considered low-income may be uninsured, the likelihood of such individuals accessing care at this clinic is low, as it is located in in a rural agricultural area of the county.

All mothers were recruited using purposive convenience sampling; the sample population included Latina mothers accessing care for themselves or family members at a charity clinic for low-income uninsured individuals in West-Central Florida. This clinic serves low-income adults, largely Latino members of a local farmworker community. This study (#25306) was approved by the University of South Florida (USF) Institutional Review Board (IRB) (Appendix A).

**Semi-structured Interviews.** Interviews are useful for gathering personalized and nuanced information about the experiences of individuals; what they think and do (Weller, 2015). It is an important method for collecting descriptive information in the participants own words (DeWalt & DeWalt, 2002; Weller, 2015). This was also the most feasible method given time and resources.

I asked mothers to participate in one in-person interview; the interview consisted of a continuum of questions ranging from highly structured to open ended exploratory questions and
lasted 12-52 minutes. Interview questions were informed by current literature (DeCamp et al., 2012) and designed to address the principal research questions: (1) What issues do SSLEP parents encounter when accessing healthcare for their children? and (2) How is pediatric healthcare navigation similar and how is it different among low-income SSLEP parents and bilingual parents? I used prompts and contrast questions throughout the interview to elicit rich, detailed responses. The interview questions can be found in Appendix B. I conducted all interviews in person, audio-recorded them when granted permission, and furiously scribbled notes when mothers declined to be recorded. I took field notes during and after each interview session, and transcribed twenty-five transcripts verbatim. Five participants opted not to be audio-recorded. Transcripts were left in their original language for analysis. Illustrative quotes presented in the results were translated from Spanish to English for readability and checked for accuracy with a native Spanish speaker.

As stated above, once a mother expressed interest in participating in an interview, and prior to beginning, I would share a printed information sheet (Appendix C) and talk about the study - performing verbal consent prior to beginning each interview. After each interview, I provided the participant with a recruitment flyer in the language of her choice (English or Spanish) which included a brief description of the study and my contact information (Appendix D). While I provided this information in the hopes of gaining referrals, expanding my sampling reach beyond the clinic, and truly carrying out snowball sampling, all participants were recruited from the clinic.

I provided $5 Wal-Mart gift cards to each participant as a token of thanks for spending their time in the waiting room sitting behind two dividers and talking with me about the process of obtaining pediatric care for their children. After discussing with my adviser and the clinic
manager, $5 gift cards were deemed the most affordable and the most appropriate incentive. Though gift cards were purchased through personal funds, I copied receipts and gift cards after purchasing them in batches of five. Upon receiving the gift card after the interview, each mother initialed a tracking sheet to account for all gift cards and maintain reconciliation records.

Analysis

As Luker (2008) states, analysis begins after the first set of interviews and writing of field notes. Luker (2008) also emphasizes the importance of pattern recognition throughout data analysis as key. Reviewing interviews and writing field notes after each site visit assisted in the process of identifying recurring themes and surprising elements from each field session. Zero to four interviews were collected during each field session. Before leaving the site I would write down my observations, I elaborated upon these notes upon my arrival home. Additionally, after each field session I recorded a brief comment where I talked about the interview session. Upon arriving home I would review the recordings for quality. Transcription was ongoing as interviews were collected.

I coded by hand keeping an original electronic file of interview transcripts and printed out a hard copy on which to write notes. As I read through the transcripts, revisited fieldnotes, and listened to interviews I took notes. I noted common or repeated experiences, ideas, and expressions and experiences that stood out as unique. I was then able to look at contrasting ideas within, among, and between interviews. I took note of patterns common to the entire study sample as well as differences between the SSLEP and bilingual samples.

As I collected interviews I would note main concerns (both positive and negative) that emerged in that day’s interviews. This relatively short list helped guide coding of transcribed interviews. I listened to interviews and reviewed transcripts multiple times, which allowed me to
identify repetitive themes, consistencies, tensions, and opposing viewpoints among participants and between groups. By spending time with the data I was able to reflect on the accuracy of identified themes. In this way, I identified thematic clustering within and among language-group samples using a priori codes such as facilitators, barriers, language-related issues and emerging narrative themes including immigration, dental care, and language in school and at work. Thus I can say with confidence that valid themes are presented in the results section.

**Ethical Considerations**

The population I sampled from is largely low-income, uninsured, Hispanic immigrants. Imbalances of power are inherent when working with vulnerable populations (Schenker et al., 2014). Specifically with this population, legal immigration status is a major source of vulnerability for many families. To respond to this vulnerability I made it clear that I was an ally and to be trusted by sharing some details of my own experience and family who occupy different legal statuses themselves. Another imbalance was my status as a white woman in higher education, I embraced this identity and answered questions about seeking a college education for families who had questions and listened when parents told me proudly about their children who were in college. Some adults needed assistance signing into their appointments; direction and assistance with sign-in became part of my presences at the site.

One issue at the charity clinic is that it is an over-researched underserved population. In designing the general research project and interview guide, I consulted with three key gatekeepers to gauge their interest in allowing me to sample at their location. They mentioned multiple times their concern that students arrive at the clinic, conduct needs assessments, then leave without contributing resources (follow up to the needs assessments) to the clinic or the population it serves. The frustration is palpable - there are few resources to begin with and little
to no follow-up from students who are allowed “in.” This issue is somewhat complicated as students may not have the resources or networks disposable to follow up on the research and points to the need for more structure and commitment to follow-up from students and the University of South Florida as a partner institution.

As occurs with small communities, anonymity emerged as a concern. This community was participating in multiple research projects of varying scales. At one point during my research I heard a story about a patient who I later translated for. It was a personal, private, traumatic, and highly identifiable story; evidence that merely assigning a pseudonym is not sufficient to conceal and protect the identity of some individuals and care must be taken among researchers discussing their work. Furthermore, staff and volunteers repeated the story to “give a heads up” to one another regarding this patient which resulted in more people being privy to this patient’s trauma than may have been desired by the patient themselves or necessary.

Because I had been interpreting in the clinic previous to beginning my research, to differentiate my new role as researcher, I introduced myself as a University of South Florida Master’s student researcher, wore USF attire, and a lanyard with my student identification card. I was cognizant of allowing time for women to sign in, aware that they were at the clinic to see to their own healthcare needs. I made clear that no health services at the clinic were contingent upon participation in my study. I clarified that results would be shared with the community and healthcare providers, and that my individual work is unlikely to bring about large scale or rapid change, but has the potential to make a small contribution to local practices and has larger implications in the field of study of access to healthcare and equity.

This study was not considered greater than minimal risk to participants; the primary risks to research participants included individuals feeling uncomfortable answering questions or
divulging personal information and experiences to an unknown researcher. For this reason, I ensured that interview participants fully understood the study by first describing the study when asking if they would be interested in participating. Many parents were curious about the types of questions that would be asked and I would describe some of the questions and provide a paper copy of the interview for their review upon request. If interested in participating in an interview, we would go to a more private setting, either behind the dividers or outside per participant preference. Verbal informed consent was conducted during which I assured mothers that their participation in my study would remain voluntary and confidential – they could stop at any time or decline to answer any question. Mothers had another opportunity to ask questions about the study prior to beginning the interview and at the conclusion of the interview.

No identifiable information was collected – women shared only their first names with me, which I replaced with pseudonyms in electronic participant logs, transcription titles, and which I use in this text. Verbal consent was administered in recognition that the population served included those without legal immigration status. Though the mothers in this study are all considered immigrants, and the idea for the project emerged out of my larger interest in healthcare access for undocumented immigrants, no questions were asked about mothers’ legal status due to the sensitivity and repercussions of disclosing legal status. I did not ask specifically about income; the mother's presence at the charity clinic was considered to “qualify” them as low income.

While risks of participating in this study largely included emotional discomfort and fear linked to possible repercussions of disclosing legal immigrant status there were a number of benefits for participants. In sharing about their experiences navigating their children’s healthcare, and at times relating experience with their own healthcare, women felt they were heard by an
outsider about issues relevant to their daily lives and community. An executive report with the results will be shared with the community as well as with local Federally Qualified Health Centers that highlights both positive aspects of the client experience as well as areas which can be improved from a quality service and health equity perspective. The community has an opportunity to benefit through enhanced awareness about parent expectations and experience regarding their children’s healthcare.

One issue that comes up, and is particularly important to distinguish in the current xenophobic political climate, is how “immigrants” are presented and talked about in the media (public/popular media, social media, press etc.). Talking about immigrants, talking about Mexicans, and talking about Mexican immigrants are not one-in-the-same as they are often narrowly portrayed. In this research the population is a Mexican immigrant population consisting of individuals of varying statuses.

**Language and Positionality.** I am white, even what many would describe as “very white.” My parents and grandparents were born in the U.S., my dad’s family comes from Russia and Germany, my mom’s family comes from Hungary, Holland, Ireland, a grand mix of Eastern European countries. We’ve been in the U.S. for three or four generations. However, some friends and family have also noted that there is something “not so white” about me. While I think this an odd thing to say, and I think it owes largely to the fact that I speak nearly fluent Spanish. As Trevor Noah stated in a Morning Edition interview with National Public Radio, “maybe I didn’t look like you, but if I spoke like you I was you.” There’s evidence that the language(s) we speak influences how we think and act generally referred to as the “Whorf Hypothesis” though postmodern interpretations have also been set forth (Seuren, 2013).
Throughout my research, my bilingual status, near fluency in Spanish, and the fact that I’m married to a Mexican man from Chiapas elicited a lot of curiosity, some praise, and plenty of marital advice. On slow evenings, I would strike up conversation with adults in the waiting room. They would ask me: where are you from? Here, the north. But really, where are you from?

I would laugh to myself; social media often satirizes this question when directed at people of mixed or Asian descent. For me it did not carry the irritation of having to legitimize myself as “belonging,” instead the question hinted that despite my apparent whiteness, there was something that seemed out of place to people (an anthropologist’s dream, to occupy both the *emic* and *etic*). I would briefly explain my ancestral history. When the questions continued I would explain that my husband is Mexican and we speak mostly Spanish at home, but that is changing so he can improve his English. This elicited an “*ah ha, con razón*” [ah ha!] moment and advice to wait before we have children. One woman expressed her appreciation that I was “*aquí con los hispanos*” [here with the Hispanics].

**An Engaged Approach to Methods and Analysis**

This research was planned and carried out with applied aspects of using theory and methods to address the specific issue of language-related access to quality healthcare. This applied approach has policy implications in that it is one way to show where healthcare organizations are meeting the needs of local patient populations and areas for improvement to better serve these populations. Specifically in populations who may not voice concerns explicitly (Sabo et al., 2014), narratives are particularly important to capture to give depth to patient surveys or other less interactive ways of assessing quality and accessibility of healthcare.
CHAPTER FOUR: RESULTS

This study examined issues that low-income Spanish speaking Latina mothers face when accessing and navigating pediatric care for their children. As part of this research question, I also ask: how are the experiences of SSLEP mothers similar or different to those of bilingual mothers? In responding to these research questions, first I present three case studies meant to provide the reader with context and insight to the conversations I had with mothers and to enrich the more general results of this study. English translations of illustrative quotes are used in the body of the text for readability, the original text can be found in Appendix E.

Next, I address commonalities that these two groups expressed throughout interviews. Third, I highlight issues unique to SSLEP parents and the tensions in their responses. I present findings regarding issues unique to bilingual parents and contrast the perceptions of SSLEP and bilingual mothers regarding spoken language and healthcare. Finally, I briefly discuss positionality, language, and ethnic identity.

Sample Profile

A total of thirty women agreed to an interview: twenty-one SSLEP mothers and nine bilingual mothers (Table 1). Ninety percent of the women interviewed were Mexican or of Mexican descent. The remaining women were Guatemalan, Puerto Rican, and Brazilian. All participants were foreign-born immigrants to the U.S. or the children of immigrants, their time in the U.S. ranging from birth to a mere few months. Throughout the interviews, many mothers
voluntarily disclosed their legal immigration status; they occupied various legal statuses including citizen, legal permanent resident, and undocumented. Women also occupied a variety of professions including home-making, agriculture, fish-hatchery workers, and restaurant workers. The characteristics they shared were motherhood, low-income status, and speaking Spanish.

**Table 1. Sample Breakdown.** A breakdown of the total sample. The SSLEP sample is slightly younger than the bilingual sample. SSLEP individuals also had a higher percentage of individuals in a committed partnership than those in the bilingual sample. Most families had three children.

<table>
<thead>
<tr>
<th></th>
<th>Total Sample (n=30)</th>
<th>SSLEP (n=21)</th>
<th>Bilingual (English/Spanish) (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age</td>
<td>35.93</td>
<td>35.95</td>
<td>35.89</td>
</tr>
<tr>
<td>Age Range</td>
<td>24-51</td>
<td>30-51</td>
<td>24-44</td>
</tr>
<tr>
<td>Number of children (range)</td>
<td>1-6</td>
<td>1-6</td>
<td>2-4</td>
</tr>
<tr>
<td>Number of children (mode)</td>
<td>3</td>
<td>3</td>
<td>2, 3</td>
</tr>
<tr>
<td>Years in the U.S.</td>
<td>&lt;1 to &gt;33</td>
<td>&lt;1 to 23</td>
<td>13 to &gt;33</td>
</tr>
<tr>
<td>Married, incl. Common Law</td>
<td>20</td>
<td>16 (76%)</td>
<td>4 (44%)</td>
</tr>
<tr>
<td>Single</td>
<td>5</td>
<td>2 (10%)</td>
<td>3 (33%)</td>
</tr>
<tr>
<td>Separated</td>
<td>5</td>
<td>3 (14%)</td>
<td>2 (22%)</td>
</tr>
</tbody>
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**Case Studies**

Below I present three case studies drawn from thirty interviews with mothers. The first woman, Evelyn, speaks only Spanish (she is currently taking English class); early in her residence in the U.S. she experienced a heartbreaking miscarriage. In the second case study, Andrea, says that learning English and the ensuing ability to advocate for herself changed her
life. In the third case study, we hear from Bianca, who grew up bilingual and speaks about the privilege and burden of being bilingual in her family and community.

**Evelyn.** Soft-spoken but enthusiastic, Evelyn did not want to be audio-recorded. She spoke with me detailing her experience about bringing her only daughter to the doctor in an almost-whisper. Evelyn began the interview by telling me of an early encounter with healthcare in the U.S. Her cuñada [sister-in-law] and father-in-law were key in helping her navigate the healthcare system during that event. Her sister-in-law speaks English and would make recommendations, translate, drive, and share her phone with Evelyn.

Evelyn had a miscarriage during her first pregnancy; when she started to feel poorly, her husband took her to the hospital where she had a sonogram and ultrasound. She didn’t understand a single bit of English at the time, in her words “ni una gotita [de ingles]”[not a drop of English]. Her husband spoke little English. All she knew was that her cuñada, who was serving as her interpreter, was crying and crying. Evelyn is not sure if medical interpreters were unavailable or if she simply was not offered one because her cuñada spoke English. She felt impotente [impotent], not knowing what to do or say and said that the experience was desesperante [infuriating].

When Evelyn gave birth to her daughter, someone asked the family about applying for Medicaid, but at the time they were saving money to buy a house and this person told them that in that case they probably would not qualify, so they did not apply. Thinking back on that moment, Evelyn and her husband believe it was a mistake not to apply, as their daughter qualifies for Medicaid. Now that Evelyn’s daughter has Medicaid (owing to support from Evelyn’s cuñada who helped fill out the application), healthcare is much easier. They had been paying for her daughter’s healthcare out-of-pocket. Evelyn’s cuñada recommended a bilingual
pediatrician who operates out of a totally bilingual clinic; having a doctor who spoke Spanish was very important to Evelyn. She said it wasn’t too hard to find the doctor, again referring to her cuñada, who made the recommendation and knows and trusts the pediatrician.

Everything about going to the pediatrician has been generally pleasant and easy, though when asked about what one needs to do to take a child to the doctor she pursed her lips and said “oh, es difícil” [oh, it’s difficult]. The most difficult part of healthcare is “andar pidiendo favores” [going about asking for favors] because she doesn’t drive or own a phone. While her daughter’s current pediatrician is excellent and the experience at her current clinic is great, there is a long wait time; “Where I take her is super. They are good people. They take time with me. They don’t make us wait very much. Everything is good. I wouldn’t change anything.”

However, Evelyn has had experiences that make her reluctant to take her daughter to the doctor if she can help it. For example, when her daughter was a toddler and had an ear infection, she cried and cried and cried, abnormal for her daughter, described as being normally very strong. The receptionists at the clinic (not her current primary care) were rude, telling Evelyn that she had to wait her turn to see the doctor, but if her daughter did not stop crying, Evelyn would have to leave the waiting room; “They told me she was making a scandal.” Eventually a doctor came out into the waiting room, brought Evelyn and her daughter to an exam room, and gave the child some ear drops and Tylenol to help with the pain and.

Now that her daughter is no longer a toddler, she communicates verbally with her mother, telling her when she doesn’t feel well. Even without words, Evelyn can tell if her daughter is getting sick by observing her behavior; “when her throat hurts she doesn’t eat and I know she will get a throat infection,” or “when she is getting sick she doesn’t sleep, she talks all night; all night she talks, and during the day she looks worn out.”
Evelyn cannot always bring her daughter to the doctor right away, so when she sees signs her daughter is under the weather she waits three to four days to see if an illness progresses or if it can be taken care of at home with Tylenol, ibuprofen, and tea. If her daughter is coughing phlegm, she restricts milk intake. Evelyn notes that her daughter is generally healthy, although when she started daycare she became sick more frequently; now that she has been in daycare for a while, she has not been ill as often.

When Evelyn decides to take her daughter to the doctor because symptoms could not be resolved at home, she chooses from three potential sites of healthcare; her primary care pediatrician, a walk-in clinic, or urgent care. For her annual checkup, she takes her to her pediatrician. Evelyn generally schedules appointments by phone, borrowing one to make the call. If the receptionist answers in Spanish, she proceeds in Spanish, and if they answer in English she asks for someone who speaks Spanish. Evelyn has found that if she explains the situation and describes her daughter’s symptoms over the phone, sometimes there is an opening the same day, maybe even fifteen minutes from the time she makes the call. If she does not explain, she could wait up to fifteen days for an appointment. She is always ready to go in fifteen minutes, just in case (and calls on her cuñada for assistance with transportation). Her primary care clinic is only open Monday through Friday.

At the clinic, some patients speak English, while others speak Spanish. Evelyn does not feel that her lack of English proficiency has affected her daughter’s healthcare, though it has affected her own. If Evelyn is paired with a doctor who does not speak Spanish, she says her ability to ask questions is compromised. Evelyn is most worried about how her lack of English proficiency will affect her daughter’s schooling as she grows - she is worried that she won’t be
able to help with homework, and her daughter wants to be a doctor someday. As a result of these concerns, Evelyn is currently taking English classes.

**Andrea.** Andrea has not been bilingual all her life. She grew up in Mexico, speaking Spanish. Andrea refers to her five children as her own, explaining that the two youngest are technically her grandchildren, but she has adopted and is raising them. She gave birth to her second child in Mexico, while the others were born in the U.S. In the early 2000s when Andrea first arrived in the area, she had a lot of trouble navigating healthcare and other services. She did not know English. At first she accessed pantries for food and clothes with the help of a friend and some support from her husband's family.

A family member pointed her to a clinic, which is where she went with her children at the time - paying for her son’s care out of pocket. She is thankful that he did not become ill often. For the children born in the U.S., finding healthcare was easier - in the hospital where they were born, they were assigned a pediatrician through Medicaid.

Now Andrea speaks English and is able to fend for herself. She sees more people in the community helping each other out;

At first yes, sometimes it would happen to me, not anymore because now I speak English and I can get by - but there were times when there wasn't anyone who spoke Spanish to help my son, to say 'the boy fell" or anyone who could bring me [to the clinic], but not anymore. Now wherever you go there are bilingual [workers] or if not, at least other people who are there help you, among Hispanics we help one another out.

Over time things have changed. Andrea has learned English; she said it is more embarrassing than it is difficult. After learning English everything changed for Andrea, she could advocate for herself rather than “putting up” with being brushed off;
I would say that everything changed when I learned English, because then I could say ‘Hey, I'm talking to you, can you help me!?’ You know, it's when you can fend for yourself. Because if not, you just bear it. If there isn't anyone to help you, or there is no one who understands you, you remain with your arms crossed. But when you know how to fend for yourself and you know how to make them listen to you, it is different.

Andrea described how she knows when her children are sick – they get sad and lose their appetites - and what she does to make them better. If they have a fever, she takes their temperature and gives them over-the-counter medications like Tylenol or ibuprofen, makes them soups, and hot food. "Los chipileo," [I spoil them] she crooned, describing how treats them with extra tenderness when they are sick;

I try to give them hot things, whatever they want, a little soup, chicken, nutritious foods, orange juice - let's call them home remedies. When they have a temperature I give them cold things like ice-pops or cold juice with ice to the fever inside them goes down. On the outside, if they are coughing, I put vapor rub on their chest, on their feet, on their backs. Or I make tea, like chamomile...or honey with lemon for the throat.

She says sometimes they do not want these foods if they are sick; they're not hungry but want candy. If over-the-counter medicines and home remedies do not work to bring down a fever after three days, she takes them to see the doctor. She says that there are many viruses that have to run their course which is why she waits a few days before seeking healthcare. She has also taken her children to the doctor for falls, scrapes, bruises, and gastrointestinal issues. The pediatrician sees all her children and provides referrals for the dentist; even so, there is a waiting period for the dentist up to three months’ time.
When Andrea cannot make a doctor’s appointment ahead of time, she might wait up to three hours to be seen in a walk-in appointment at the pediatrician or at an urgent care; Andrea says the wait time is the same everywhere because there are so many patients; she thinks this might be because there are too few clinics, or maybe not enough pediatricians at each clinic.

At hospitals, Andrea observes that patients are treated in order of emergency, not necessarily the order in which they arrived; she thinks this is good, but recognizes that everyone still wants to obtain service relatively quickly. There is one hospital nearby that Andrea says she will not return to even if she was paid to do so; her husband had two negative experiences there. In one case, he hurt his leg and there were no language services available. In Andrea’s opinion the lack of language services led to poor patient care and mistakes that put her husband in undue pain. In another instance, he cut his hand and waited three hours to be helped; in the end, he got twelve stitches. At a different hospital in the area, she says, there is a very short waiting time and she is satisfied with the efficiency of care there as well as the respect she feels staff have for patients.

Andrea says that she thinks clinics have seen the needs of the local Spanish-speaking population and have adjusted to meet them. She used to want to cry out of desperation, not being able to ask for a medicine or prescription at the pharmacy or trying to navigate information. Instead of crying she would seek help from others. Andrea thinks that the issues she faced before learning English still exist for many people. She estimates that 30% of SSLEP individuals still have these kinds of issues on a regular basis. In contrast, when she arrived, she suspects that around 70% of SSLEP mothers were in her position. She used to ask for a translator, often a nurse working at the clinic, but now she doesn’t need one. She’s confident, and her confidence has made a huge difference in her ability to navigate resources for herself and her family.
**Bianca.** Bianca is bilingual but is more comfortable speaking in English than Spanish. When her children become ill, depending on their symptoms Bianca first tries a variety of home remedies or over-the-counter medications before seeing a doctor. She says, “It depends what’s wrong with them. I am Mexican, so we do a lot of home remedies...if that doesn't work I do call their pediatrician and try to get an appointment to get them seen and go from there…” Laughing and a little bashful, fully aware of the stereotype that Latinos use Vicks Vapor Rub as a cure-all she says;

My mom does that Vicks thing, and I’ve started doing it...Vicks cures everything...At first I thought that was weird, but I’ve caught myself actually doing stuff to my kids with the Vicks...around the nose, on the chest. My mom would put it on the bottom of their feet then put their socks on. Right here” she gestured to her armpits, “whenever they’ve had a really bad fever and it won't go down...I’m in my thirties...if I’m sick she will do it to me too…She’ll put Vicks on the bottom of our feet, put our socks on, and [put Vicks] on our joints, and make us wear a sweater...and she will put it right here, you know, where it folds, on our chest, and on our back, and pretty much she will wrap us up as well and she will make us sweat it out.

Bianca takes her children to the doctor for pinkeye, earaches, and coughs with bad congestion, fevers, rashes, achy legs, and severe reactions to mosquito bites. Bianca’s children have been going to the same pediatrician since their birth in the hospital, where her pediatrician first met her children. Bianca explained that she was a young mother and didn’t know what to expect or how her children’s healthcare would work - she learned, for instance, that she would need to take her children for annual checkups. She has stayed with the same pediatrician through
multiple changes in location, saying that the clinic always contacts her to let her know about changes.

   Bianca values the relationship she has with the healthcare workers at her children’s pediatrician’s office;

   I’ve known them forever because I’ve gone with them for twelve years...It’s just like talking to somebody you see every day and they are really nice there. I’ve gone with some of my friends to other doctors’ offices to be with them whenever they take their kids. I really don’t like it because their office people are really grumpy. Where I go they are always happy, or I’ve never seen them be in a bad mood...not rude, you know. Where I go they are really nice.

She elaborated on the workers’ assistance referring her son to specialists who are “good” and accept Medicaid.

   She emphasized that her children’s health is very important to her; she does everything possible to ensure their health and well-being. This includes taking better care of herself; she was recently diagnosed with diabetes. While Medicaid makes the cost of healthcare easy for taking care of her kids, cost remains a barrier for her to take care of herself.

   Bianca says her ability to speak English makes it easier to navigate her son’s healthcare. He has an attention deficit disorder for which she has navigated numerous referrals, appointments with specialists, and follow-up appointments. She has observed that not speaking English in such settings is a huge barrier; Bianca related that sometimes she sees people struggling with paperwork, and no one helps them. This is frustrating for Bianca, in part because she used to work connecting Spanish-speakers with local services but had to quit her job due to lack of transportation when her office was relocated;
Even to this day, I will go to the store...and a lot of people I used to help see me and they are like ‘where have you been!?’. What I used to do [at my job] is I would help fill out the applications for food stamps, Medicaid, all that. I would help them fill out paperwork for school, a lot of parents can’t fill out their own paperwork for schools and stuff...or if they got a letter from school, read it to them and explain it to them…

Sometimes Bianca still offers assistance to SSLEP individuals she sees struggling, but has had some negative reactions from people who act offended when she offers to help; this makes her hesitant to continue to offer assistance to strangers. Her family is another matter - she says that she assists them with everything. Before she had kids she would assist her aunts and uncles, before her grandparents passed away she helped them, she helps her parents and her brother;

I have to do everything for them. I do everything for my mom. I do everything for my dad…even my brother, he’s already married...At times it does get overwhelming just because I do have my own family now...and I just started working...before I wasn’t working, so anytime the needed help or needed to go somewhere [I would be there]...now it’s a little hard, but before I loved it because I knew I was helping them and they were going to get things done right.

**Cases in Context.** Evelyn, Andrea, and Bianca are three women who share threads of experience navigating healthcare for their children with common issues such as transportation, getting time off work, and waiting at the clinic. They also share in valuing rapport with their child’s assigned pediatrician and being generally satisfied with the healthcare their children receive. At the same time, there are distinct differences. Evelyn says that if there were not bilingual personnel available, she would face greater challenges asking questions about her daughter’s healthcare. For Andrea, learning English and self-advocacy was life-changing. For
Bianca, her role in assisting family and friends gives her unique perspective into issues that SSLEP and bilingual parents face.

In the following sections, I respond to the research questions of this study. First, I present findings regarding similarities between SSLEP and bilingual groups. Second, I explore issues unique to SSLEP parents followed by an exploration of issues unique to bilingual parents. This includes discussions regarding tensions in participant responses within and between groups and language as a facet of ethnic identity. Finally, while the focus of this study relates to language in healthcare settings, parents brought up language in school, work, and other settings, indicating that the issue cannot be compartmentalized into one field of inquiry but permeates interactions across institutions.

**Similarities Between SSLEP and Bilingual Groups**

Overall, participants shared many elements interacting with healthcare settings. Participants shared general satisfaction with their primary care provider; these Medicaid assigned pediatricians tended to be bilingual or have bilingual staff on-hand. A common appraisal of these doctors is that they got along with the children, would speak with them to make them feel comfortable, and addressed the mother's concerns conversationally rather than demanding mothers adopt certain behaviors.

Elyse, who worked in the healthcare field, explained that having a physician familiar with Hispanic culture was helpful because they wouldn’t make demands that were culturally counter-normative; she specifically cited putting children to bed early. She found counter-normative suggestions more common among doctors unfamiliar with Hispanic culture(s). Other similarities among the healthcare experiences of SSLEP and bilingual mothers included; procedural aspects of seeking and accessing healthcare such as parental knowledge and home-care practices, issues
common for low-income families like time constraints, shared values regarding clinical rapport, and experiences shared owing to identity as Spanish speaking Hispanics regardless of English language proficiency. Finally, immigration status of parents and children came up in interviews with SSLEP and bilingual parents as an issue that affected the entire family in areas of healthcare, work, and school. Following I present major emergent themes.

A Mother Knows Her Child: Pride in Parenting and Taking Care of Ill Children. Mothers who participated in this study shared how they identify, monitor, and react to their children’s illnesses. SSLEP and bilingual respondents shared strategies and nurturing practices. While many public health interventions focus on improving parental knowledge, through interviews mothers demonstrated basic knowledge about taking care of common colds and minor ailments. While one new mother specifically cited not being aware of annual physicals until informed by her child’s pediatrician, mothers demonstrated knowledge and habits that conform with the American Academy of Pediatrics recommendation for annual checkups. Mothers also expressed responsiveness to doctor recommendations to reduce or control childhood health and behavior issues.

Mothers described their children similar to the way Evelyn did, as strong, calm, and observant, chatting away the night when ill. They cited their children’s love of LEGOS, playing outside, and watching movies, in contrast to their apathy and lack of appetite when ill. Mothers talked about learning the signs of illness for each of their children, emphasizing that each child is different. The fact that I was married, but not yet a mother, encouraged conversation, as mothers explained to me how their child’s behavior changed when they became ill. Yasmin commented; “One learns step by step. Because sometimes one will get so frightened that they run to the
doctor and sometimes that is not necessary. One can do it at home, knowing what's to be done [for each situation].”

Mothers described using home remedies and over-the-counter medications to treat illness, usually over the course of three days. If symptoms didn’t get better or they got worse, mothers would take their children to their pediatrician, a local clinic or urgent care, or to the hospital depending on hours and availability of the mothers themselves as well as the site of healthcare. Other common strategies to make children feel better included *trapitos frios* [cold washcloths], soups, teas, and cuddling.

All mothers reported taking their children to their pediatrician for annual physicals and when they become ill. For many mothers, taking children for their annual checkup is the easiest healthcare service because it can be scheduled far in advance. Many mothers receive reminders prior to the appointment, and it is an expected event. Some mothers reported keeping a calendar reminder for their children’s physicals. Others said they knew because physicals were the same time every year. Others mentioned that the clinic would give them a call to remind them of scheduled appointments. As Belén describes;

The physical is easier because it's every year and you know the routine they have. They do the labs, the doctor just checks to see what comes out bad from the analysis. She lets you know, you know what came out bad...

Most of the mothers described their children as *fuertes* [strong], meaning that they were not sickly. They talked about common colds, viruses, and bacterial infections. Additionally, a number of health conditions came up such as asthma, overweight, high cholesterol, attention deficit hyperactivity disorders. Seven mothers spoke about being referred to a specialist, such as ear nose and throat specialists, eye doctors, or behavioral specialists. Yasmin’s doctor said that
her child had high levels of cholesterol and glucose; she has had to adjust the sugars and fats in his diet, a challenge because he loves cookies and is used to the tastes of many foods she has reduced or removed from his diet. Three parents have had to adjust the diets in their household to control their children’s weight. As illustrated by these examples mothers’ expressed their knowledge and responsiveness to physician recommendations.

**Low-Income Barriers to Healthcare.** Barriers to healthcare such as cost of medication, transportation, location, and wait times, time off work, and balancing work and childcare, are issues for low-income families. Issues resulting from low-income status foreground language-related issues; however, language-related issues exacerbate certain barriers to care. For this sample, most children had Medicaid and parents did not cite cost as a difficulty in navigating pediatric care for their children. For Valeria, when cost of medication becomes an issue she calls Medicaid and they help her find a way to reduce the prices. This example of self-advocacy regarding the price of medications was unique to Valeria. Analise struggled with cost after her son’s Medicaid was cancelled - she had to cancel his dental appointment because she knew it would be too expensive without insurance. In cases where children were uninsured, parents paid out of pocket or sought care in Mexico and were thankful their children were generally healthy.

**Transportation.** Transportation was identified by over half of participants as an issue accessing healthcare. While many mothers drove their own vehicle, many others drove without insurance or a license, making driving risky, others depended on neighbors or family members to take them and their children to the clinic. A few mothers mentioned walking to the doctor’s office. Lack of transportation or inconsistent transportation makes the logistics of getting to and from a doctor's office tricky and can lead to reschedules or missed appointments and delayed care as well as limiting access to necessary medications.
While Valeria wanted to express ease accessing and navigating healthcare for her child, transportation stood out as a difficulty; “Thank God everything has been easy.” she sighed and continued, “...sometimes the ride doesn’t arrive, you have an appointment, and it is difficult.” Difficulty obtaining a ride to the doctor’s office was more salient for single mothers; these mothers often had less reliable avenues of transportation, largely depending on friends or neighbors for a ride. Bianca noted that lack of transportation affected her employment status (she had to quit her job when her office relocated); later, when she owned a car, she assisted others with transportation, as did Maribel. In many cases married women depended on their husbands for transportation if they didn’t drive themselves. Some families owned one vehicle, for which the primary use was getting to and from work. If the vehicle wasn’t available, mothers would seek assistance from friends or family, sometimes paying for a ride.

**Time off work and wait time.** Time off work and wait time are intricately related and impact people's ability to get to a doctor when necessary for unexpected illnesses and regularly scheduled doctor’s visits. For workers with inflexible work hours or limited time-off, taking time to attend to children’s healthcare needs can become tricky. Furthermore, for low-wage hourly workers every hour of work becomes meaningful, more so if this work is also seasonal. All of these elements play into how parents plan or manage healthcare for their children. While parents had different time-management strategies, it was a common factor for parents.

Some mothers expressed that their work schedule was flexible and that they could leave and return to their workplace with little hassle. Others said that they scheduled their children’s doctors’ visits specifically at the beginning of their work day to maximize available time. Belén mentioned how it can be difficult to get time off work for multiple doctors’ visits or follow up appointments;
Because of time off work, more than anything else, because at work, sometimes one cannot ask for appointments so often. For this reason, when I take my kids to a physical I try to get all four in, all four or first two and later the other two and that same day I go early so they [the doctors] can do everything that same day and be done.” Similarly, Graciela, a single mother, says “When you work, sometimes you can't get time off, or [the clinic] doesn’t have an appointment for the day you need, the one you are free. In this way it can be difficult.

She said that oftentimes she must be committed to work during the work day and taking care of her daughter once she gets home; this is very difficult.

While some parents found it challenging to balance work and healthcare for their children, other parents like Nora were able to build in some flexibility;

Medicaid gives you a list that recommends pediatricians for each location. It is a place that is close to our home, it's more comfortable because of work. We can leave work and we don’t lose a whole day to take them [to the doctor]. Rather the doctor can see us, sometimes just as we are leaving work and I truly, I like how he treats my child.

While living close to the clinic made end-of-the-workday clinic visits easier on Nora, for other families this timing was burdensome.

Wait time for an appointment affects the amount of time a parent might take off work. Melinda said; “What happens is that it is just too many hours waiting...sometimes I would have to be absent from my work because, well, she is first...because when you get out [of work] [the clinic] is already closed.” Andrea mentioned that timing of the end of the work day could make it difficult to coordinate a pediatric visit, making the end of the day rushed, not leaving time to eat, or leading to the need to visit urgent care or the hospital owing to the pediatric hours of
operation. Ingrid echoed this sentiment; “If it is in the afternoon I bring him to the hospital and if it is in the morning I bring him to the clinic.” For her the time of day dictates where she will take her child for healthcare.

While wait time was expressed as a difficulty, it was simultaneously stated that wait time is expected. Mothers said that when your child is ill wait time does not matter - you are receiving a service and someone else may be more sick and being tended to. This sentiment was more common regarding wait time in urgent care and hospital settings. Carolina pointed out that what is important is that healthcare workers do their work well, not necessarily quickly.

For mothers like Evelyn, taking one child to the doctor meant finding childcare for other children or bringing the entire family to the clinic. When parents and their children are waiting for long periods of time in the waiting room, children get restless, and this represents an added hurdle for mothers. These barriers to care were consistent across SSLEP and bilingual groups, illustrative of the pervasiveness of barriers to care for low-income families across language profiles.

Clinical Rapport and Familiarity. What makes a negative healthcare experience for mothers? What makes a positive healthcare experience for mothers? Women talked about “buen trato” [good treatment] and “mal trato” [bad treatment]. According to Mayra, the former is synonymous with patient, courteous treatment and smiling customer service, the latter indicative general mal gusto [bat attitude] including curt treatment and grumpiness. Women in SSLEP and bilingual groups expressed their value for relationship building with their child’s healthcare provider. While parents did not indicate that they avoided accessing healthcare owing to relationships or lack thereof, trusting and respectful relationships with healthcare providers were highly valued.
Andrea says that the process and treatment at the pediatrician and the hospital are
different because the pediatrician is familiar, they know you and your child's name, you hardly
have to bring identification because they have you on file; she says it's hardly a struggle. Going
to the hospital is a bit different, Andrea says; “Me, every time I go to the hospital I bring
[everything including] the birth certificate [of my child] because who knows…” She carries her
identification, her proof of address, and pay stubs with her. Bianca is also wary of taking her
children to the hospital;

I’ve taken them to the hospital because they’ve had like, a broken arm…they take
forever...I really don’t like going to the Hospital. They are always very rude. I really don't
like it, and that's in every hospital I have gone to. It's not just one hospital. I always think,
why are they so grouchy? It’s their job.

Bianca’s sentiment holds two sentiments. First she expresses a repetition of distaste for hospital
visits. Second, the sentiment that staff should simply “do their job,” and avoid rudeness and
grouchiness in the clinical encounter – was not uncommon among mothers. Discomfort and
distrust in a hospital setting owing to rudeness of staff could be detrimental to seeking necessary
care in a timely manner.

Though hospital settings did not yield particularly gratifying interactions, mothers valued
the rapport and familiarity they had with their children’s sites of pediatric care. Nora expressed
trust in her child’s primary care physician, describing the rapport she has with them. Similarly,
Belén appreciates how her pediatrician suggests how to make changes in her children's diets,
they are overweight; “She says it to you in a way that is pleasing. She tells you how it is, but in a
way that makes you feel good.” Belén feels the pediatrician does a good job because she also
seeks to have a positive relationship with her children, not just check them; “At the moment to
check the children, she looks for a way to connect with them...the doctor starts to chat with him, she talks to him, and plays...and for those reasons it goes well for me.” With four children Belén has her hands full. Though doctor visits go well for her she remembers the first time she took her children to their primary care doctor - she struggled with the paperwork;

The first time that one takes the children to the doctor, it is a little - it becomes very difficult because sometimes they give you sheets of paper and sometimes things that you don’t understand and you are filling out all of these forms, all the information and no - it is a little more complicated when it is the first time and you have to fill out everything. Let's say, what complications [your child has], diseases, everything. Who suffers from what, so on and so forth. It becomes very difficult...I take the time to fill it all out correctly because sometimes these are things, questions that...let's say, who in the family suffers heart problems, who in the family suffers diabetes, on the side of the mother or the side of the father, and well, these are questions that one has to answer, because, like they say, sometimes these are diseases that show up in the grandchildren or the children, that is why they ask. And this is where it becomes - ugh! With four children! I have to fill the forms our four times!

While Belén and many other mothers have built positive relationships at the sites of primary care for their children they rely on a number of locations and providers depending on the type of healthcare visit including unexpected, routine, specialist, emergency, and dental. Having negative experiences in certain settings is not ideal. When parents have an ongoing relationship with their provider they expressed more trust in the healthcare provided. Furthermore, when mothers felt they were treated rudely they expressed hesitation to return to those sites of care.
Different Settings, Different Issues. It may not be surprising that in different healthcare settings, parents encounter different issues; different sites are organized around different purposes. In hospitals, specialists, dental clinics, and urgent care, satisfaction with the provider and process of interactions diminished in comparison to primary care providers. Familiar issues of wait time, scheduling, and language services were heightened for SSLEP individuals in these settings where language-services were perceived as less accessible, though issues of rapport and satisfaction were common between SSLEP and bilingual parents.

Parents used very specific terms for “the doctor” pediatra [pediatrician], clínica [clinic], urgencia [urgent], doctor [doctor], emergencia [emergency]. While the terms didn’t always mean the same thing to each parent; probing clarified answers when the doctor was fabulous but the clínica elicited complaints about wait time and secretarial staff. According to Andrea, the pediatra is the child’s specific doctor (the office is often closed at hours healthcare is needed), urgencia has slightly extended hours (i.e., urgent care), and emergencia is synonymous with the hospital or emergency room; parents take their children to the hospital when no other location is open or the child’s illness cannot wait to be evaluated and treated. Melinda clarified; “Urgent care is like a clinic, but for emergencies, it is for people who didn’t have time to make an appointment or who don’t have an appointment but it is already something urgent.” This differentiation is important to note when thinking about overburdening of certain health services - how are healthcare services designed to serve the needs of the local population? Are parents taking children to their primary care, urgent care, or the hospital for non-emergency health issues? Why?

Maribel notes differences between accessibility at her daughter’s pediatrician and the hospital;
I like the pediatrician because there they speak my language, we understand one another. In the hospital, sometimes, well...I don’t speak English and they don’t speak Spanish, so we don’t understand one another. Sometimes, it's like they push you aside for not knowing [English]. Like they say some things to you. But she is bright” gesturing to her daughter, “she knows a lot of English and now she interprets for me...I don’t speak, but I try to help myself to understand some things.

Timely and appropriate language services in the hospital were consistently cited as problematic by SSLEP parents and will be revisited below in a section describing issues unique for SSLEP parents.

**Dental care.** Dental care is an arena of healthcare that is sometimes disconnected from the idea of “a doctor's visit” however, seven parents independently brought up the issue of access to dental care for their children. Long wait times between scheduling and the appointment date and availability of language services were issues specific to dental care. Yasmin wonders; “It is very difficult. I don’t know if there aren’t enough dentists or maybe it is a very special kind of job.” Yasmin’s child has no dental insurance, and she talked about how different access care is in the U.S., compared to Mexico. She elaborated on differences in accessing dental care;

…for him, they took out two molars and we were on a waitlist of one year. The dentist said that unless we come in with an emergency, then we could do it the same day...in Mexico it is different because going to the dentist, one pays, but they do it the same day.

While mothers expressed concerns about scheduling and communication referrals from the pediatrician helped establish a first appointment in a landscape where it is challenging for Medicaid patients to access dental care as new patients.
Formal Health Care Here and There: Other Countries, States, and Counties. SSLEP and bilingual parents had a range of migration backgrounds; all SSLEP parents were foreign-born but bilingual parents were both foreign-born and native to the U.S. Participants had experience navigating healthcare in their countries of origin, as well as other states in the U.S. and counties in Florida. This array of living histories provided a broader perspective on access to care.

Valeria’s youngest child was born in the U.S., but her older children were born in Mexico, therefore she has experience taking her children to the doctor in both countries. She says there is a difference in the processes and expectations of both systems. Yasmin compared healthcare for her children in the U.S. with that in Mexico; she feels that in Mexico doctors treat illnesses more quickly;

The difference is in Mexico, there they give something quickly - I imagine it is because of the different nutrition and care, if they don’t give something, because of the diet they are a little more malnourished, they fall [more ill] more quickly. But here, you can control it with liquids, *suero*, and things like that.

She went on to elaborate some of the differences she experienced between accessing healthcare in Mexico and the U.S., for example, she observed that in the U.S. a complete physical was emphasized in comparison to checking only the “problem” in Mexico. She also noted that there appeared to be more flexibility with appointments in the U.S. where she would receive a reminder phone call or be allowed to complete a visit even if a little late; in Mexico if she was a few minutes late or forgot about the appointment she would have to reschedule.

With so many Latinos in the local area, making appointments and communicating with doctors was generally viewed as an easy interaction (though some SSLEP participants did find it difficult). SSLEP mothers commented on difficulties in others states, like South Carolina and
Oregon, states with established migrant farmworking populations and along migrant farmworker routes. Two of the SSLEP mothers commented that it is very difficult if one doesn’t speak English; so difficult that language-related issues contributed to their decision to stay in Hillsborough County, Florida. Carolina related; “[in Oregon] if I asked for a hamburger, they would give me a cup of water. I said, what am I going to do? I can’t...here you find a little bit of everything...so I stayed.”

Graciela, who moved from Alachua County, Florida made a similar comment; however, she attributed the larger Latino population to the availability of agricultural work. She had moved from an area where she accessed few language-services and attributed it to the “more professional” workforce;

There, there are more universities, more people - American people than here and there aren’t Hispanics. Here there are more Hispanics than Americans...There the majority has to do with universities, construction, and things like that, hospitals, all that, here there is more agriculture.

Whatever the reason for more or fewer language services, she says everything is easier in Mexico.

**Adult Issues.** One contributing factor to the “everything is easy” response may be that in comparison to their own care, mothers face fewer barriers taking care of their children than seeking medical care for themselves. Indeed, the clinic from which I sampled participants services the uninsured, including adults who may face many more barriers to accessing and utilizing healthcare for themselves than for their children. They expressed that their children’s healthcare is better than their own. Remember the examples Andrea gave about her husband’s care? Additionally, health issues for children and adults tend to be different, with more adults
presenting with chronic diseases like diabetes and high blood pressure, or injuries that may affect their participation in the labor force. One woman is staying in the U.S. to make sure her cancer is “all clear” before heading back “home” to Mexico, where her children and grandchildren are.

Andrea commented that the local Latino community is in need of people doing more projects about their health and well-being. She commented that “the agricultural laborers are here, with or without papers,” and as key players in the local labor force it is imperative to treat them and their needs with dignity. Maribel spoke about the time she was discharged rudely after a surgery, with a simple dismissal and no follow-up with the doctor regarding restrictions and carrying out heavy-duty labor in the workplace. Women spoke about having seen discriminatory treatments, but only some having experienced language-based discrimination themselves.

**Discrimination.** Bianca tells how her friend is treated differently because people think he is White, even though he does not speak English;

> When you go to certain places and they see that you are Hispanic, they do treat you different. Now, if they see that you speak clear English and stuff like that, yeah, it changes sometimes. Sometimes it really doesn’t matter...I have a friend...he looks white, but he’s Mexican. He doesn’t speak English, he has colored eyes, and yeah - they treat him different because - oh, well, they think he’s white.

This shows how assumptions about language and ethnicity permeate the experiences of Latinos.

Melinda is bilingual but prefers speaking in Spanish, she says that sometimes she encounters situations where people are not inclined to help her out if they think she only speaks Spanish;
...sometimes you think the person speaks Spanish and they don’t speak Spanish. A lot of the time they think that since you speak Spanish you will just go. They say “I don’t speak Spanish” but they don’t tell you “wait”... I speak English too, so talk to me.

Giselle has observed similar reactions to people who speak Spanish, and she suspects it might be because workers are overwhelmed and just want to get to patients back out the door. Analise believes that quality of healthcare interactions depends on the individuals serving patients; “The person who is attending, how they treat the person, they should try to understand. Sometimes they don’t like speaking Spanish so they don’t help people.” In contrast, Valentina has not noticed language discrimination in healthcare settings, however, she used to work at a department store, where it was very obvious that people were treated differently based on their language, ethnicity, and skin color.

Caring Undocumented. Immigration status and language proficiency are not mutually exclusive, and the topic of immigration status came up in numerous interviews as well as in my role as volunteer translator. For individuals without a form of legal residency, immigration status was a source of vulnerability and stress that affected their everyday lives. Over the course of my time volunteering at the clinic, I was privy to the ebb and flow of patients with the flows of agricultural work - when there was more work, there were often more patients.

On days like the local strawberry festival, no one came to the clinic because they were all working - loading and unloading pallets of fruit under their farm’s vinyl tents, and selling late into the night. The other time no one came to the clinic was when Immigration and Customs Enforcement was running local raids. Carolina shared that she stopped going to work and her children took a short break from school;
“Well...Immigration was all around, yikes, and I even had to stop working because - I didn’t want to drop my kids off way over there for the fear...my kids, the other [older ones], I didn’t bring them to school. As one doesn’t have a social [security number], one doesn’t want to go out. The other ones (the young ones) they do have socials, from a law made by the government, DACA, but my son, he hasn’t done it yet. So we are waiting. ”

Mayra was approached by Immigration when she was at the Walmart picking up prescription medications. A man in uniform asked her for her papers but she didn’t have any. When she gave the officer her name they checked their system and saw she had no record. They told her that because she did not have a criminal record they were not going to bother her or deport her today. She said she remained calm and composed during the interaction, but it shook her up. However, this is a clear example of intimidation and gossip in the community served to warn people away from specific pharmacies at certain times - this is disruptive to people's lives in many ways.

One evening as I was readying to leave the clinic, the women in the waiting room summoned be back; the quickly conversation turned from inquiries about my personal life into a discussion of the pending 2016 presidential election, and issues of immigration. One woman said she would rather cruise on the highway than drive around her own town for fear of being stopped, detained, and deported. The women all exclaimed and nodded in agreement that they do not dare leave the house when there are immigration raids in the area. They are dismayed that families are targeted for detention and deportation; the government knows where undocumented people are employed and knows how vital this population is to the agricultural industry. These examples illustrate how a parent’s undocumented immigration status, and antagonistic practices affect the functions of family life for those who have undocumented family members.
Five mothers explicitly expressed concern about what would happen to their children if they were deported. Nora said;

We worry about it [immigration] because we came through as [undocumented] immigrants. One thing that worries us, for example, is they say that the kids that are born here, we can’t take them from here, that normally just the parents are deported and this is a bit worrisome. But the same need [to take care of our children] is what makes us go out into the street...I don’t have information. We are guided by the news. Whatever they talk about in the news, but really, there is not clear information for one to navigate the situations.

These reflections and worries about the repercussions of not having a social security number, residing in the US as undocumented immigrants, and at times being targeted by Immigration are scary for parents. They are concerned that if they are detained and deported they will be permanently separated from their children.

Another way in which legal im/migration status affects children is if they were born in another country. Carolina brings all of her children to the same FQHC. However, she must pay out of pocket for her children who were born in Mexico, in contrast to those born in the US and who have Medicaid. Yasmin also struggles to find care for her child born in Mexico; “he didn’t have a social, now he has health insurance through Obamacare, but noting for dental insurance, so we have to wait until we go to Mexico so that it is a little cheaper…”

**Gendered Opportunities.** In a small number of cases, women explicitly spoke about gendered differences in household roles and responsibilities such as driving, working outside of the home, cooking, and taking care of children’s health needs. In other cases, it was apparent that gendered labor roles (working outside the home and versus home-making) contributed to differences in
language acquisition and external socialization and access to resources. Marisol wants to work outside the home, but she has a toddler and two teenagers. Her husband doesn't want her to work or to drive; he wants her at home. Nora said that she and her husband take their children to the doctor together because they both like to be informed, but it would be easier if she drove too, because then he wouldn't have to miss work. Even when they both go to the doctor, she primarily interacts with the doctor.

Bianca, who is bilingual, expressed her gendered expectations when she exclaimed that she “even” cares for her brother who is married (implying he shouldn’t be her responsibility).

I have to do everything for them. I do everything for my mom. I do everything for my dad…my grandmother…my grandfather…even my brother, he’s already married…At times it does get overwhelming just because I do have my own family now and I just started working.

These gendered expectations placed extra responsibility on women to care for members of their families while at times limiting language acquisition and access to external resources.

**Issues Unique to SSLEP Parents**

I asked contrasting questions throughout the interview to elicit positive and negative elements of clinical interactions. An interesting pattern with SSLEP mothers was that they began by first saying how satisfied they are with the pediatric care for their children and announcing that nothing about the clinical encounter is difficult or uncomfortable. After this initial positive framing, mothers would proceed to say “except when…” and provide different examples of difficulties the faced throughout the process of accessing care. This presents an interesting contradiction - could it be that the quality of healthcare delivered to the child remains intact even when the delivery process is flawed? This response pattern may be further documentation of
respondents hesitant to critique a beneficial service or “authority” in a passive resistance style. It could also be that throughout the process of the interview participants became more comfortable sharing an opinion. Or it could be a reflection of how parents frame their experience - they can access the care, but the quality of what transpires over the entirety of the interaction is variable depending on the touch point.

**Interpreters & Translators.** It is federally mandated through the Equal Rights Amendment and CLAS Standards that language services be provided in healthcare settings in recognition that language affects the quality of healthcare. However, the availability of language services and the quality of those services is highly variable, often depending on local factors, community need, and the efforts of community advocates. Issues arose regarding the availability of interpreters (formal or informal), of trust in the accuracy of interpretation, issues communicating over the phone, and at the pharmacy. Bilingual providers were particularly appreciated.

Women mentioned that having official medical interpreters was rare; almost ubiquitously a bilingual healthcare worker attended them. In the absence of trained medical interpreters or bilingual workers, an adult family member, friend, or their children translated. Ingrid relies on her eighteen-year old daughter to interpret; she’s not sure, however, who she will rely on when her daughter moves out. In the experience of participants, the availability and quality of translators varied. Mothers expressed some uncertainty about the precision of translating, but also spoke about their strategies to assess translation such as paying attention to the context of questions and answers - if something was out of context it is likely something was not precisely translated. As Graciela put it;
…what is difficult for me] is to understand what they are saying. What they are explaining to me [in English], I don't understand it at all. What if the other person [the interpreter] is not saying the same thing to me?

Over-the-phone interpretation, sometimes called the “blue phone,” was a familiar idea to some women, mostly regarding their own health care. While some women had used a telephone interpreter, others in similar situations had never heard of such a thing. Yasmin said that when she went to a hospital the doctor didn’t speak any Spanish and she didn’t have anyone with her to translate. In this case, they used a telephone translation service - she called it an app – which allowed her to speak Spanish and the doctor to listen in English, and the doctor to speak in English and her to listen in Spanish - she said it worked perfectly. Ingrid had a similar experience. In contrast, Andrea had never seen or heard of any telephone-based language services. Valeria uses her cell phone to communicate and translate forms and information into Spanish. Carolina has been asked to bring her own interpreter to the hospital and has also called friends in California to interpret over the phone. Carolina has also had positive experiences, like when a healthcare worker saw that she was struggling to fill out papers and helped her out.

Belén spoke about the rapport she had with her pediatrician, a doctor who spoke Spanish. However, her daughter sees an ear specialist where there are not language services; there they tell her to bring an interpreter to appointments, if she cannot they might have someone who speaks very little Spanish act as interpreter;

...I have my daughter too who is always suffering ear problems. She sees an ear specialist. There, they only speak English. They will tell you, try to bring an interpreter. Sometimes they tell you, if you want we can give you this person who speaks little Spanish...I struggle because it is all [in] English.
Nora’s husband speaks some English, and they take their children to the doctor together because Nora does not drive. Nora always asks for an interpreter from the clinic because there are some words that her husband does not understand. She also says that sometimes the depth of her questions cannot be addressed;

Sometimes there are things that one would wish to ask with greater detail, but because you don’t know [the language] you can’t...and that is one of the things that most affects healthcare. Because sometimes, maybe you sign a form, and you don’t know what you are signing.

There are two ideas of importance here, first, while Nora did not say she had particular complaints, she wishes she could ask more detailed questions of her child’s pediatrician. Second, she has been asked to sign forms without knowledge of their content.

Erin does not speak English but her doctor is totally bilingual and she appreciates the ability to communicate directly with her in Spanish. Erin always seeks out doctors and services where there are bilingual workers “para no batallar” [so as not to struggle]. Erin’s doctor helped her out with an issue, in which her daughter was experiencing stomach aches and nervousness about school and didn’t want to go. Her daughter reported being moved around a lot in the classroom, the school suggested that her daughter was hyperactive and should get medication. Erin went to her doctor to discuss the issue and the doctor suggested she wait on medication because not all children mature at the same rate. Erin ended up changing schools for her daughter when the teacher was not supportive. In her new school, she is doing great and the doctor makes sure to always check in about how school is going. Erin appreciated the time the doctor took to work with her on this issue - it made her feel respected and she felt it was possible because she could personally communicate the situation.
For six out of eight women, scheduling an appointment over the phone was easy, they said that they’d ask for someone in Spanish and more often than not it was easy. Carolina shared that making an appointment over the phone can be difficult;

It is better for me to go in person...sometimes I call and I say ‘is there anyone who speaks Spanish?’ and I don’t know what they say to me, I wait and wait and in the end I hear ‘click!’ and they hang up on me. I will call again and they answer, ‘is there anyone who speaks Spanish?’ and then they say who knows what and hang up on me again… She is not the only woman to make appointments in person rather than wait on hold over the phone. The need to physically go to the doctor's office to make an appointment places undue burden on mothers.

Prescriptions can be problematic for parents who either cannot read English or are not sure what to say if a pharmacist asks them something about the medication. This is so when pharmacy workers do not have interpreters or bilingual workers. It is imperative that parents be told in a language they understand about how to administer medication to their children, are provided textual instructions in the language of their choice, and if possible images which they understand. These are important elements of health literacy that vary among and within populations and overlaps issues of concordant language services and literacy.

When SSLEP individuals and families do not have access to interpreters, healthcare experiences can become confusing and distressing. Situations like Evelyn's miscarriage become more traumatic owing to lack of communication and complete understanding of the situation. Even in mundane circumstances, communication is less than ideal. Incomplete communication or misinformation are both potential results of language issues in the clinic that affect access to and quality of healthcare as well as health outcomes. Nora suspects that not speaking English
deters many people from going to the doctor because they feel insecure in communication skills and want to avoid embarrassment. Yet Nora, so adamant that speaking English would make a huge difference in the process of accessing healthcare, has also always found her visits satisfactory. We are back at the curious contradiction of satisfaction with the outcome of healthcare despite issues throughout the process.

**Tensions in Responses: (Not) Everything is Easy.** While “everything is good” was a general sentiment, SSLEP mothers would go on to explain how everything would be easier if they spoke English, especially when broaching more complicated topics or pursuing more detailed conversations. Nora emphasized that she is not able to ask deeper questions and is sometimes asked to sign papers without knowing what she is really signing! Andrea mentioned that if she asks instructions for medication are provided in Spanish - why does she need to ask? Do parents know they need to ask?

Remember Evleyn’s case study? She said that everything about going to the pediatrician was generally pleasant and easy - however, when she thought about explaining the steps to take her child to the doctor she exclaimed “oh, it is difficult!” Evelyn was not the only woman to express these opposing viewpoints about the ease of accessing and obtaining healthcare for their children. This was particularly apparent when I asked women how their experience would be different if they spoke English instead of Spanish. SSLEP mothers let out a sigh or an exclamation like “hombre!” [oh man!]. As Nora said, “If I spoke English, everything would be easier.”

SSLEP mothers talked about how asking more detailed questions would be easier, about being able to read forms they needed to sign, about being secure in the knowledge that what they said and what the healthcare provider responded was not altered by an interpreter. According to
SSLEP mothers, everything would be easier if they spoke English: the doctor’s office, their child’s school, their workplace, and even ordering fast food.

The tendency for marginalized and underserved populations to express satisfaction with services rendered to them is well documented (Horton 2004) and asking questions about the clinical encounter in multiple ways explores responses in ways that a patient satisfaction survey may not capture. While it is gratifying to know that in most cases children are receiving pediatric care that is satisfactory for parents, this study did not capture vaccination rates, prevention services rendered in-clinic, or health outcomes for complicated or chronic children’s health issues; all areas where language-based healthcare disparities are documented (DuBard and Gizlice 2008). These are reasons why not everything is good and easy for SSLEP mothers.

**Issues Unique to Bilingual Mothers**

Bilingual parents had a different perspective than SSLEP parents regarding the ease of communication in healthcare settings. They agreed that speaking English was key in navigating healthcare and at times in demanding respect. The role of “helper” or “facilitator,” as explained by Bianca in her case study was nearly uniform among bilingual mothers. They talked about providing language support, transportation, and in some cases, literacy support.

The four mothers who grew up in the U.S. have been in assisting roles assisting since they were children, aiding their own parents, assisting SSLEP family members and friends, and seeing SSLEP parents struggle to fill out forms or receive rapid assistance in healthcare settings. Five of the bilingual mothers learned English after moving to the U.S. Iris said that the easiest aspect of taking her children to the doctor, now that she speaks English, is that she can communicate directly and tell healthcare workers what she needs; she doesn’t have to wait for or
depend on anyone else. Iris and Andrea had similar experiences where learning English gave them the language tools to advocate for themselves.

Issues unique to bilingual mothers largely hinged on their roles as advocates and helpers for members of the SSLEP community who were often their own family members or friends, but also included people they encountered struggling in healthcare settings. Giselle talked about her role helping another family while she and her partner were at the hospital with their baby:

We were in the hospital, and the other lady, she was heartbroken...because her kid had bronchitis, but when you have bronchitis, especially babies, they can really have a hard time breathing. I just saw her struggling, trying to tell him [the doctor]...I was like, Imma go help them...they probably want to tell the doctor ‘this is going on’ or ‘you need to check her’ or something, so I went ahead and helped her and I felt really proud of myself. When I was like that, when I was little, there was no one to translate...so it was very hard.” Similarly, Analise said; “Much of the time, we are there as patients, we see someone else who is suffering and we try to help, because we know it is difficult....not only in medical settings, but other places too. It is difficult for people who cannot speak the [English] language.

Analise commented on both language proficiency and literacy which she perceives are both issues for the local population. These issues don’t only affect people in areas of healthcare, they also affect how families interact in work and at school.

**Language in Other Settings: Work and School**

Belén talks about how changing her work setting inspired her to try learning and speaking more English. She gets along with her co-workers, even though they speak different languages. Her children also motivate her. Sometimes they ask for help with homework, and sometimes
they express their surprise and disappointment that after so many years in the U.S. she doesn’t speak English;

Well, the whole truth is that I understand one or two things [in English], but I don’t speak at all. But, you know that speaking English is indispensable...We have to be realistic, [English] is their language [that of the doctors], and they might try to understand us, but keep in mind, I feel that we are in a country where the language is theirs...we who speak Spanish have to put an effort to speak English. But at the same time we must have some time that is our own to learn. I am going to learn English...therefore I am going to put in my effort.

Similarly, while Marisol’s largest barrier to accessing healthcare for her child was lack of reliable transportation, she emphasized that her real language struggle is in the school;

Where I have struggled is in the school. Because in the school sometimes there is no one...in elementary school no, but in middle school, you have to bring your interpreter because there aren't many. I tell my husband, you should go, I don’t know [English]...Whatever message they tell you in English, if you understood it, good, but if not, it’s your problem.”

Marisol’s experience of language support for families throughout elementary school but not into middle school indicates a need for longitudinal language services throughout the school system.

As is documented here, the women I interviewed shared many experiential elements taking their children to the doctor, such as limits on time and resources, which are common among low-income families. SSLEP and bilingual parents shared more elements navigating healthcare than not. Challenges unique to SSLEP parents revolved around language and a greater degree of difficulty accessing resources, like cell phones and vehicles to get from place to place.
Bilingual parents had two distinct backgrounds: foreign-born individuals who learned English, and U.S. citizens in bilingual households. For those that learned English, becoming proficient in the language changed how they navigated, experienced, and advocated for themselves in different settings. For those who grew up in Spanish speaking households and learned English in school, their role as helper in their family is both a privilege and a burden.

**Intergenerational Language.** Giselle had a very interesting intergenerational perspective regarding language and identity. As a Mexican-American woman, she grew up in a Spanish-speaking household but prefers to speak English and her young son also speaks mostly English. Her parents tell her, “You need to talk Spanish, you’re Mexican-American,” to which she retorts, “Yes, I know, I understand that, but I live in Florida and we talk English.” Sometimes she feels embarrassed that she doesn’t speak more Spanish. As her son becomes more verbal, she realizes how beneficial it will be for him to learn Spanish and communicate with her entire family. Now, instead of helping her parents understand what is being said in English, she translates bidirectionally so that her son and her parents can understand one another. Luckily, her son’s pediatrician is bilingual - she didn’t find a bilingual doctor on purpose, but she’s glad about it because her mother, who does not speak English can take her son to the doctor if needed.
CHAPTER FIVE:
DISCUSSION AND CONCLUSIONS

Results of this study document and confirm barriers accessing healthcare for low-income families (Heyman et al., 2009; Phelan et al., 2010). SSLEP and bilingual parents cited transportation and time off work as difficult aspects of accessing healthcare for their children. SSLEP mothers in particular expressed satisfaction with the care their children received, but shared uncomfortable or difficult elements of the process of seeking and receiving care, especially accessibility of language assistance from the moment they made the appointment to picking up medications at the pharmacy and administering them in the home.

In this final chapter, I will discuss the results as they relate to literature on immigrant and Latino health, public health, and anthropological theory. I begin by reflecting on the methods used in this study and how my position as a researcher affected the fleeting relationships I built with participants including how language, ethnicity, and identity intersected. I position the results as they fit within the literature, outline applied dimensions and how findings will be brought back to the community in useful ways and provide an honest critique of the limitations and future directions of projects similar to this one. Finally, I provide a brief summary and concluding statement.

Methods and Positionality

The results of this research are based on thirty in-depth conversations over a six-month time frame with women regarding language-related healthcare experiences. I began conducting
the interviews after I had spent about a year volunteering as a bilingual interpreter. Over time, I had built rapport with clinic workers and patients. A common critique of qualitative research is that it is subjective; however, it is important to be aware that there are subjective aspects to all methods. However, through interpersonal interaction, we gain a unique perspective and forge an intimate relationship with participants (Manderson, Bennett, & Andajani-Sutjahjo, 2006).

My Spanish-speaking abilities, white ethnicity, and childless status positioned me as an outsider and a researcher, a curiosity and a novice in the realm of caring for children in the participants’ eyes. When I mentioned that my partner was an English language-learner, Mexican national, and had crossed the desert himself, this drew even more curiosity and an inferred understanding that if I was not an insider, I was at least not a complete outsider.

**Representation in a Local Sample.** By the time I conducted the thirtieth interview, participants were sharing similar elements about their experiences; my data collection had reached saturation. While all participants were recruited from one site, the charity clinic, they did not all live in the same neighborhood or town, they were not all employed in the same workforce, and they had different immigration histories. Mothers also had different comfort levels speaking English and Spanish; those who self-identified as bilingual were categorized as such for the purposes of this research (rather than using an English proficiency assessment tool).

Among bilingual parents, some were more comfortable speaking English and some more comfortable speaking Spanish. The varying comfort levels speaking, reading, and writing English and/or Spanish captures elements of heterogeneity among the U.S. Latinos population in general. It emphasizes the importance of not treating “the Latino population” as homogeneous (Gonzalez-Barrera and Lopez, 2013; Horton 2004) even when working with a group sharing a single nationality.
The time I spent at the site prior to formally beginning the study helped me understand aspects of language-related issues present in healthcare settings such as timing, trust in interpretation, and having bilingual, but not certified, and in some cases not qualified, translators (NCIHC, 2016). My role as a bilingual but untrained medical interpreter was difficult to reconcile, were patients saying they were swollen, bloated, or inflated, that they had burning, stinging, or tingling? Best interpretation practice is to have a trained medical interpreter. Errors such as omission, addition, editorialization, and false fluency, occur with both trained and untrained interpreters (Flores et al., 2012; NCIHC, 2016), but are more likely and more frequent with untrained interpreters. One may debate the roles of translators, interpreters, and the level of patient advocacy they should engage in, if any at all (Hsieh, 2008).

Sometimes, in the clinic, there was more than one volunteer interpreter and I observed that my skills were not lacking in comparison to other volunteers. I justified my volunteering in part by recognizing that a charity clinic setting does not have equivalent access to resources and personnel as an FQHC or other differently-funded medical facility; I considered improved but imperfect communication better than limited communication between an English-speaking doctor and SSLEP patient. However, past research shows that a bilingual interpreter is still not “good enough.” There is much evidence that the presence of a trained medical interpreter has a positive impact on healthcare and health outcomes with SSLEP patients and results in asking more questions, receiving more preventive services, fewer inpatient visits, more prescription utilization, and higher satisfaction with care (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Jacobs, Shepard, Suaya, & Stone, 2004; Ku & Flores, 2005). I was glad (and a bit relieved) when two native Spanish-speakers from the community began volunteering regularly. While having community members provide medical translation in a small community
may has its own imperfections (such as diminishing anonymity or privacy), these volunteers brought both language skills and a greater degree of cultural concordance to interpretation at the study site.

**Language and Ethnic Identity.** This brings me to reflect on language identity and ethnic identity. An interesting thing about using the terms “SSLEP” and “bilingual” are the layers beyond the terms. When people think of the Latinos, many assume that all speak Spanish; however, they do not. Some of the language-ethnicity conglomerate is cultural; in the broadest sense, people of Hispanic descent share a national history of Spanish conquest, which includes the Spanish language. Locally, people generally refer to the Spanish-speaking population as Hispanic (though Hispanic and Latino are used interchangeably and Latino is used for the purposes of this paper). However, there are many Latinos who speak only English, or only Spanish, or who speak but don’t read Spanish. Different fluency and literacy in English and Spanish among individuals and within families is not uncommon. Furthermore, bilingualism in this study means a person speaks *at least* English AND Spanish; one “bilingual” participant was fluent in Portuguese, Spanish, and English. Another SSELP parent spoke Q’anjob’al and Spanish, technically making her bilingual, though not classifying her as such for the purposes of this study. More than one woman thanked me for showing interest and “helping out the Hispanic community,” showing that there is a lack of crossover and ethnic admixture from outside of the community.

**SSLEP and Bilingual Experiences**

While much literature about health and language measures health outcomes and patient satisfaction (Lee, Batal, Maselli, & Kutner, 2002; Zandieh, Gershel, Briggs, Mancuso, & Kuder, 2009), I did not use scaled measures for this study but instead documented the experiences as
they were shared in conversational interviews. Measures of satisfaction are valuable, however a scale is not always necessary to assess satisfaction; satisfaction can be assessed qualitatively (DeCamp et al. 2013). Therefore, a discussion about what transpires in a clinical interaction may reveal aspects of patient satisfaction and experience that a scaled measure does not capture. Responses of ease may also be influenced by normalization of issues SSLEP parents face (Sabo et al., 2014).

DuBard and Gizlince (2008) found significant differences in health status between English-speaking and Spanish-speaking Latinos, where health status, access to care, and receipt of preventive care were worse for the latter group. The current study did not examine health status, but rather transactional and communication elements for mothers taking their children to the pediatrician at FQHCs. In Evelyn’s experience, not speaking English was frustrating in relation to own healthcare, but not the healthcare of her young daughter. Evelyn was more concerned about how her language abilities might impact her daughter’s education as she gets older. In Andrea’s experience, learning to speak English and culturally expected and accepted self-advocacy changed her satisfaction with pediatric care. Bianca attributed ease of navigating her children’s healthcare to her ability to speak English, and pointed out how many SSLEP family members and friends she assists.

SSLEP mothers who wanted to discuss health issues in greater detail with clinicians found it challenging to do so. Mothers who saw specialists with their children for vision, ear, nose-and throat issues, attention and hyperactivity disorders, and the dentist took greater issue with limited English proficiency and the lack of language-concordant providers or trained interpreters. When Belén spoke of her daughter’s ear problems she was told to bring her own translator or offered a translator who spoke little Spanish. She followed up by sharing that
though she has a sixteen-year old daughter who speaks English, she seeks an adult to translate at these appointments, she feels that an adult can more thoroughly understand and explain the content of conversations with the specialist. The mothers interviewed did not report managing chronic or complicated health conditions of children, which may have contributed to their demurely expressed concern regarding access to and quality of healthcare. The mothers who told of their own issues giving birth or dealing with one-time emergencies had more specific critiques of the availability, timeliness, and quality of language assistance in those moments of crisis.

**Determinants of Health.** Language proficiency is not the only factor that affects quality of and satisfaction with healthcare. Many factors intersect to affect how an individual acts and interacts with systems (Castañeda 2010; Castañeda and Melo 2014; Willen et al. 2011). The participants in this study occupied intersectional positionalities, such as having low-income, being immigrants, and being women of color.

Transportation and time off work are complicated for some participants because of their legal immigration status. Having any combination of no transportation, limited transportation, or lacking a valid driver's license all complicated the physical act of traveling from location to location, whether it be work, home, the pediatrician, or the pharmacy. Limited or uncertain transportation can lead to rescheduled and missed appointments and delayed care, and missed or delayed retrieval and use of medication (Syed, Gerber, & Sharp, 2013).

Time off work affects income, and can be tricky for individuals who work hourly jobs or harvest produce and may have less flexibility of difficulty getting permission to leave work. These issues that families with limited economic and social resources encounter when accessing healthcare often superseded language-related issues. To strategize, mothers described scheduling appointments for specific times, or trying to get up to four children to the pediatrician
for an appointment on the same morning. Because of children’s Medicaid coverage, cost was not a concern. However, this does not hold true for all family members, as adult members were often uninsured, increasing the overall cost of medical care for the household as a whole.

A veiled layer of mistrust in the content of written and verbal translation was evident in interviews - how did mothers know that the information they were getting was accurate? Some used their own common sense rules: did the answers match the questions? Others used smartphone translation apps. It is important to note that even though there was a level of mistrust in the accuracy of communication, mothers seemed to measure their own satisfaction by how they and their children were treated at their site of care, whether it was a pediatrician, urgent care, the hospital, a specialist, or a dentist. When healthcare providers were friendly and no follow up visits were necessary mothers were content. When healthcare providers were rude or numerous follow up visits were required, mothers were less content.

Interestingly, parents were more concerned about their own English language proficiency in relation to their children’s education than the realm of health care. The concerns about education specifically related to not understanding telephone and written communications from schools - especially in the middle and high schools – as well as concerns about parental ability to assist children with homework.

Finally, the role of mother, when combined with the role of wife, highlighted the gendered opportunities for generating income and gaining professional skills including learning English. This puts low-income women at a specific disadvantage, especially if they have undocumented status that further limits their access to resources. While Latinos, specifically migrant laborers, are particularly vulnerable to structural violence due to low economic status,
low positionality in the labor market, xenophobia, ethnic discrimination, and scapegoating, gendered roles further this structural violence (Quesada et al., 2011).

**Regional Differences.** Women who had children in their countries of origin or who had lived in different regions of the U.S. compared those experiences accessing healthcare with those in the study county. The large and growing local Spanish-speaking population (US Census Bureau, 2015) made accessing certain services easier in this county than in some other counties and states. However, even if the sizable population made language access easier than in other places, it was not expressed as easy in all daily activities and language concordance does not erase multi-national or multi-generational tensions among community members regarding ideas of deservingness and distribution of social services.

**Contributions to Scholarship**

Study results indicate that changes in the process of providing and receiving care could have profound impacts on patient satisfaction as well as the quality of care provided. DeCamp et al. (2013) provide a series of recommendations based on feedback from SSLEP mothers of children 3 years old or younger. These suggestions include encouraging providers to invest more in relationships with patients, provide same-day care, expanding clinic hours, improving access to language services, and improving the coordination of care services (DeCamp et al., 2013). The findings of this study corroborate these recommendations to improve quality of healthcare for SSLEP families.

This research contributes to broader discussions on immigrant access to care in anthropology and public health and drew on anthropological and public health literature as well as that of pediatrics and nursing (Castañeda et al., 2015; DeCamp et al., 2012; DeRose et al., 2009; Flores, 2006; Pandey et al. 2014; Questada et al., 2011). Findings contribute specifically to
language-related parent-provider interactions in formal healthcare settings. Discussion around parental expectations and testimonies from parents with particularly positive or negative experience shed light on quality improvement in healthcare for the study population. One major area is ensuring communication in the preferred language of the parent (Ferguson & Candib, 2002; Lee et al., 2002). Another evident recommendation is that providers address language and health literacy in healthcare interactions (Lion et al., 2013; Taveras & Flores, 2004). Findings also demonstrate the importance of interactions among systems and institutions; while the study is focused on language-related healthcare experiences, language affects families to different degrees in their day-to-day lives. This research shifts the focus from an emphasis on providing parents with educational information to addressing distal factors affecting language and interaction in healthcare settings (Phelan et al., 2010).

The idea that “(d)enial of care and treatment to some threatens the general health and well-being of all” (Quesada et al., 2011) is an important message to share with policymakers and to support with empirical evidence. Social perceptions and constructions of deservingness translate into very real public health policies of exclusion as seen by the effects of the MMC, ACA, and dental Medicaid. These policies allow for the creation and maintenance of second-class citizenship, which is often visible through the embodiment of poor health care. Their vulnerability is not random; it is systemically produced and reproduced through explicit political exclusion.

**Applied Dimensions**

This research fits largely within a basic applied research, as it serves to expand local understanding of language-related issues related to pediatric care for low-income Latina mothers. It aims to contribute to solving specific social problems. The results of this project point toward a
need for profound structural change; indeed, it is a reiteration of calls for change that have been going on for decades. Greater equity in housing and the workplace contributes to overall equity; these are elements of fundamental cause theory, under the umbrella of socioeconomic status and social capital (Link & Phelan, 1995). Furthermore, working to target social determinants of health requires collaboration among different social sectors, including housing and employment, to contribute to “creating the conditions that enable all people and communities to attain and sustain good health” (American Public Health Association [APHA], 2015: IV).

Shorter-term recommendations that emerged from this project include sharing information relevant to parental concerns and comments. In their interviews, parents expressed concerns about immigration, cultural expectations of self-advocacy, and English language acquisition.

Regarding immigration, specific concerns relate to parental rights and expectations in the case of detention and or deportation. Though immigration and child welfare policy are intended to keep families together, in practice immigration enforcement can have the opposite effect (Wessler, 2011). Unfortunately, Child Protective Services must become involved in cases where parents are detained, unless the family has an advocate that can work to reunify the family. Parents can work to create safety networks among community members and have a plan of action for children and close family or friends to follow. The Florida Immigrant Coalition and American Civil Liberties Union provide “Know Your Rights” resources such as information sheets on how to react if stopped by police or immigration (Appendix F). These tools will be shared with the community.

Regarding cultural expectations of self-advocacy, some parents shared their own best practices, such as bringing a written list with questions to the clinic and learning to be assertive.
This information will be shared with the community verbally and as wallet inserts in English and Spanish (Appendix G).

Regarding English-language acquisition, the clinic offers English classes, and there are numerous locations around the county that offer English learning opportunities. English for Speakers of other Languages (ESOL) classes are offered in different formats for different prices; a guide can be found in Appendix H and will be shared with the community verbally and as an information sheet in Spanish.

**Public Health Significance**

This research has a number of implications for public health, principally relating to language services in healthcare and consistent implementation of CLAS standards to further health equity. The four standards specifically addressing communication and language assistance promote actively informing individuals of language services, offering language assistance for limited English proficient patients for all healthcare services and settings, recognizing and limiting the use of untrained interpreters or minors as interpreters, and providing easy-to-understand print (and other) materials in languages common to the local patient population (U.S. Department of Health & Human Services, 2016). This work provides ample evidence that in this area services have grown to meet community needs, but are in need of continual assessment, improvement, and guidance regarding the provision of language services.

As supported by the work of DuBard and Gizlice (2008), differences in health status exist between English-speaking Latinos and Spanish-speaking Latinos, where SSLEP individuals exhibit disparities in health status, access to care and receipt of preventive care. In these situations having trained medical interpreters has a positive impact on healthcare and health outcomes (Anderson et al, 2003, Jacobs et al., 2004).
Limitations & Future Directions

A principal method that would have strengthened this study would be participant observation during pediatric visits or immediately post-visit. I did not carry out this aspect of participant observation owing to issues of privacy and confidentiality and prohibitive logistics at the type of study design. Another way to enhance this study would be to add a second phase consisting of a survey component based on response elements from the interviews. The survey could include Likert scales for items such as the ease of scheduling an appointment, the ease of communicating with the child’s doctor in English and in Spanish, and the ease of paying for an appointment as well as soliciting solutions to difficulties by participants themselves as well as listing health issues or outcomes for children. This would provide quantified standardized responses for a larger sample size.

Another suggestion would be to design a second arm addressing healthcare workers and staff at FQHCs. Eliciting the experience of providing services to SSLEP and bilingual populations would provide important insight into both provider and patient experience and expectations. By hearing the perceptions from client and provider sides of healthcare actionable areas of improvement could be identified for quality improvement in the process of accessing healthcare among this low-income SSLEP population. While this was originally proposed, contacts at FQHCs were not agreeable to collaborating at this (Master’s) level of study.

Lastly, greater community involvement in designing the research questions may more closely assess and address community needs and interests. For future health equity improvement initiatives, a locally specific perspective is critical for enacting changes that coincide with the values and experiences of the community for purposes of feasibility and sustainability. Though a locally specific example is not generalizable for all low-income Latina mothers across time or
geographic location, it is clear that this population shares common elements related to healthcare access with low-income and immigrant groups included in other studies.

**Personal Reflection**

I collected the final interview on a hot July day, I reached up and turned the air conditioning unit off, finally escaping its sputtering hum. I switched the lights off, checked to make sure the door would lock behind me, took a deep breath and walked back to the clinic. I celebrated internally. I walked over to the clinic and slid the glass door open stepping into the cool space, nodding at the patients. It was a little busy so I waited for a moment when the gatekeepers were available to say good-bye for the evening and thank them. They were happy for me, and bid me adieu with a simple good bye, take care, call us when you have the results of your research. It felt anticlimactic. Then again, the clinic workers are interested in providing healthcare for their community, not in my academic pursuit of knowledge, or my limited ability to know about systems without the resources to change them. They were clear about this going into the study. During the analysis process I shared information I felt would be useful to the clinic regarding their own patients’ comments and satisfaction with care and services there. These communications were appreciated by the clinic workers.

Since the completion of data collection the community has undergone various immigration raids and increased anxiety under the new presidential emphasis on implementing immigration law, removing guidance to protect family unity. As a result expanding the scope and priority of deportation efforts has expanded in ways that threaten families who live, work, attend school, and play in West-Central Florida.
Conclusions

The aim of this study was to examine the experiences accessing pediatric care for low-income Spanish-speaking women. The study revealed tensions in how a marginalized community with limited access to healthcare for themselves talks about healthcare access for their children. On the surface, everything appears to be great, however, deficiencies emerged in accessing language-related services at specialist clinics, at the dentist, and at urgent and emergency healthcare locations. Doctors who make children comfortable by talking directly to them and who take the time to listen to mothers’ concerns and address them in a culturally sensitive manner provide the most satisfying healthcare for this group of mothers. This study captures some of the nuances and issues involved in language acquisition and language services in the area of healthcare as well as other areas of everyday life such as educational settings, workplace settings, and consumer settings. This research is situated as applied medical anthropology in public health; as such, findings indicate that equity in access to healthcare and linguistically appropriate services are a distal factor affecting SSLEP individuals, families, and communities. This study indicates a need for consistent and readily apparent language services in healthcare settings as well as facilitation of effective English language acquisition opportunities for families and community input in the best way to service community needs.

These are locally-specific suggestions and it is important to consider further reaching messages of this research. A xenophobic social and political environment negatively affects the promotion, passing, and implementation of policy change. Healthcare policy and immigration policy are intersecting and polarizing issues. By reflecting on the negative effects on population health that occur in an environment antagonistic to the SSLEP population and their families, it is clear that there is a pressing need for change in both policy and the social environment. It is the
responsibility of the state to ensure the health of those residing within its borders; therefore, initiatives must address decriminalization of undocumented immigrants as well as provide concrete ways for those with limited economic means to access health care. Other changes in health care that may affect access to care for Spanish-speakers include greater utilization of community health care workers, increased bilingual medical interpretation training and certification opportunities for public health and healthcare professionals, continued efforts to increase the number of Spanish-speaking and Latino healthcare providers, and emphasis on cultural humility in the clinical encounter. In these ways, SSLEP individuals will have more opportunities for a positive clinical encounter, improved health care, and improved health outcomes.
REFERENCES


racism and mistreatment at the US-Mexico border. *Social Science & Medicine, 109, 66-74.*


APPENDIX A:

UNIVERSITY OF SOUTH FLORIDA INSTITUTIONAL REVIEW BOARD - STUDY APPROVAL LETTER

February 29, 2016

Aria Walsh-Felz
Anthropology
Tampa, FL 33613

RE: Expedited Approval for Initial Review
IRB# Pro00025306
Title: Navigating Health Care: Experiences of Low-Income Spanish-Speaking Immigrant Mothers Seeking Pediatric Care in Hillsborough County Florida

Study Approval Period: 2/29/2016 to 2/28/2017

Dean Ms. Walsh-Felz:

On 2/29/2016, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
2-22-16_IRBProtocolGuidelines_AWF_V2_2-22-16.docx

Consent/Assent Document(s)*:
2-24-16_InformedConsent_VerbalConsent_Parents_English_V1.docx **granted a waiver
2-24-16_InformedConsent_VerbalConsent_Parents_Spanish_V1.docx **granted a waiver

* Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s). **Waivers are not stamped.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review
category.

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5038.

Sincerely,

[Signature]

John Schinka, Ph.D., Chairperson
USF Institutional Review Board
APPENDIX B:

INTERVIEW GUIDE (ENGLISH)

1. When your child is feeling sick, what do you do to make them feel better?
2. When do you take your child to the doctor? (preventive/annual physical)
3. Tell me about the last time you took your child to the doctor. *(Probe: Where did you go? How did you decide to go there? When did you decide it was the right time to take your child? How did you get there?)*
4. Tell me about scheduling your child’s doctor’s appointment. *(Probe: over the phone, in person)*
5. If there is anything difficult about taking your child to the doctor, what is it? *(How do you manage that?)*
6. What is the easiest aspect about visiting the doctor with your child?
7. Describe how you communicate with your child’s doctor or nurse. *(Probe: family member, bilingual staff, medical interpreter, blue phone, body language)*
8. *(FOR SSLEP PARENTS) You consider that you don’t speak English well, how does that affect your experience at the doctor’s office?*
   a. Do you think the doctor or nurse understands what you ask?
      1) Always
      2) Sometimes
      3) Never
   b. Are your questions answered in ways you understand?
      1) Always
      2) Sometimes
      3) Never
   c. Does the doctor or nurse give you enough time to talk about your worries?
      1) Always
      2) Sometimes
      3) Never
   d. Is the doctor or nurse able to calm your child and make your child feel comfortable and safe?
      1) Always
      2) Sometimes
      3) Never
9. Describe your ideal visit to the doctor with your child. *(Probe: What must happen to meet this ideal?)*

10. Tell me about a time when:
   a. You did feel like the doctor/nurse understood you
   b. You felt the doctor/nurse did not understand you
   c. You had a bad experience at the doctor’s office
   d. You had a particularly good experience at the doctor’s office

11. Is there anything else about this topic I should be asking?
APPENDIX C:
INFORMATION SHEET (ENGLISH)

Script for Obtaining Verbal Informed Consent - Parents

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. I am asking you to take part in a research study called: Navigating Health Care: Experiences of Low-Income Spanish-Speaking Immigrant Mothers Seeking Pediatric Care in Hillsborough County Florida (USF IRB #25306).

My name is Aria Walsh-Felz, I am the researcher in charge of this research study. I am asking you to participate in this study because you are a mother and you are Hispanic/Latina. The purpose of this study is to learn about how language affects the experience of navigating health care for your child/children. And to learn about what makes it easy or difficult to get formal health care for your child.

If you take part in this study, you will be asked to participate in an interview which will be audio-recorded with your permission. You may choose for the interview not to be recorded, you may also choose not to participate in this research study.

You should only take part in this study if you want to volunteer and should not feel that there is any pressure to take part in the study. You are free to participate in this research or stop at any time. There are no consequences if you do not wish to participate, or do not wish to complete the interview.

I am unsure you will receive any direct benefits from participating in this study. This research is considered to be minimal risk. If you take part in this study, you will be asked to participate in an interview lasting between 20 and 60 minutes. The questions are about your experience tending to your child’s health and the process of taking them to see a doctor.

I will provide you with a $5 Walmart gift card in thanks for the time you took to speak with me as part of this study.

I must keep your study records as confidential as possible. I may publish what I learn from this study. If I do, I will not let anyone know your name. I will not publish anything that would let people know who you are. However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

• The research team, including the Principal Investigator, the Advising Professor.
• Certain government and university people who need to know more about the study. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.) These include:

  • The University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
  • The Department of Health and Human Services (DHHS).

If you have any questions about this study, you can contact the principal investigator, myself, Aria Walsh-Felz at (813) 446-5800. If you have question about your rights as a research participant please contact the USF IRB at (813) 974-5638.
APPENDIX D:

RECRUITMENT SHEET (ENGLISH)

I would like to speak with you about your experience navigating healthcare for your children.

¿Are you a mother 18-65 years old?
¿Do you self-identify as Hispanic/Latina?
¿Do you have at least one child 3-11 years old?

I am a master's student at the University of South Florida. I study anthropology and public health. I am doing a study about language-related health disparities (USF IRB #253806). I would like to do a short interview with you (20-60 minutes) to talk about your experience navigating healthcare for your children.

You will receive a $5 Wal-Mart gift card for participating in this interview.

If you are interested in participating in this study, please call or text me at:

Aria Walsh-Felz
813-446-5800
walshfelza@mail.usf.edu
## APPENDIX E:

### ILLUSTRATIVE QUOTE TRANSLATIONS

<table>
<thead>
<tr>
<th>Spanish (original)</th>
<th>English</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>andar pidiendo favores</td>
<td>going about asking for favors</td>
<td>Evelyn</td>
</tr>
<tr>
<td><strong>Donde la llevo es super bien. Son buena gente. Toman tiempo conmigo. No nos hace esperar mucho. Todo está bien. No cambiaría nada.</strong></td>
<td>Where I take her is super. They are good people. They take time with me. They don’t make us wait very much. Everything is good. I wouldn’t change anything.</td>
<td>Evelyn</td>
</tr>
<tr>
<td>Me dijeron que estaba haciendo mucho escándalo</td>
<td>They told me she was making a scandal.</td>
<td>Evelyn</td>
</tr>
<tr>
<td>Si le duele la garganta, no come, y yo sé que le va a dar infección de garganta.</td>
<td>When her throat hurts she doesn’t eat and I know she will get a throat infection.</td>
<td>Evelyn</td>
</tr>
<tr>
<td>Cuando se enferma, no duerme, platica toda la noche, toda la noche platica y en el día se ve muy caída.</td>
<td>When she is getting sick she doesn’t sleep, she talks all night, all night she talks, and during the day she looks worn out.</td>
<td>Evelyn</td>
</tr>
<tr>
<td><strong>De primero sí, a veces me toco que -ahorita ya no porque ya hablo inglés y me defiendo - pero había veces en que no había nadie que hablaba español, para ayudar a mi hijo, para decir ‘se cayó el niño’ o que me trajera [al doctor], pero ahorita ya no. Ahorita ya donde quiera vas hay bilingües o si no pues hasta las mismas personas que están te ayudan, entre las mismas personas Hispanics nos ayudamos.</strong></td>
<td>At first yes, sometimes it would happen to me, not anymore because now I speak English and I can get by - but there were times when there wasn’t anyone who spoke Spanish to help my son, to say ‘the boy fell’ or anyone who could bring me [to the clinic], but not anymore. Now wherever you go there are bilingual [workers] or if not, at least other people who are there help you, among Hispanics we help one another out.</td>
<td>Andrea</td>
</tr>
</tbody>
</table>
Yo diría que todo cambió cuando aprendí inglés, porque entonces podría decir "Hey! I’m talking to you, can you help me!?" Tu sabes – es cuando ya te puedes defender. Porque al contrario te aguantas. Si no hay nadie que te ayude, o no hay nadie que te entienda y te quedas brazos cruzados. Pero cuando sabes cómo defender y sabes hacer que te escuchen es diferente”

I would say that everything changed when I learned English, because then I could say "Hey, I'm talking to you, can you help me!? You know, it’s when you can fend for yourself. Because if not, you just bear it. If there isn't anyone to help you, or there is no one who understands you, you remain, you’re your arms crossed. But when you know how to fend for yourself and you know how to make them listen to you, it is different.

Andrea

Trato de darles cosas calientitas, lo que ellos quieran, un caldito, pollo, comidas nutritivas, jugo de naranja, por decimos remedios caseros. Cuando tienen temperatura darles cosas frías, como ice-pops o jugo frío con hielo para que les vaya bajando la temperatura por dentro. O por fuera si están tosiendo ponerle vaporol en el pecho, en los pies en la espalda. O los hago te, como te de manzanilla...o miel con limón para la garganta.

I try to give them hot things, whatever they want, a little soup, chicken, nutritious foods, orange juice - let's call them home remedies. When they have a temperature I give them cold things like ice-pops or cold juice with ice to the fever inside them goes down. O on the outside, if they are coughing, I put vapor rub on their chest, on their feet, on their backs. O I make tea, like chamomile...or honey with lemon for the throat.

Andrea

Uno va aprendiendo paso a paso. Porque a veces uno se asusta tanto que corre al doctor y a veces no es necesario. Uno lo puede hacer en la casa y sabiendo lo que hay que hacer.

One learns step by step. Because sometimes one will get so frightened that they run to the doctor and sometimes that is not necessary. One can do it at home, knowing what's to be done [for each situation.

Yasmin

Es más fácil el físico porque eso es cada año ya sabes la rutina que ellos llevan. Se hacen el laboratorio, nada más mira la doctora que algo sale mal de los análisis. Ella te deja saber, sabes que salio mal...

The physical is easier because its every year and you know the routine they have. They do the labs, the doctor just checks to see what comes out bad from the analysis. She lets you know, you know what came out bad...

Belén
<table>
<thead>
<tr>
<th>Name</th>
<th>Spanish Text</th>
<th>English Text</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valeria</td>
<td>**Gracias a dios, todo me ha salido fácil...<strong>a veces el ride no llega y tienes cita y es difícil.</strong></td>
<td>Thank God everything has been easy....sometimes the ride doesn’t arrive, you have an appointment, and it is difficult.</td>
<td></td>
</tr>
<tr>
<td>Belén</td>
<td><strong>Por el tiempo de trabajo más que nada, porque a veces en el trabajo no puedes pedir citas tan seguidas. Por eso cuando voy al físico, intento sacar a los cuatro juntos, a los cuatro juntos o primero dos y después otros dos y ese mismo día irme temprano para que todo lo hagan ese día y ya.</strong></td>
<td>Because of time off work, more than anything else, because at work, sometimes one cannot ask for appointments so often. For this reason when I take my kids to a physical I try to get all four in, all four or first two and later the other two and that same day I go early so they [the doctors] can do everything that same day and be done.</td>
<td></td>
</tr>
<tr>
<td>Graciela</td>
<td><strong>Uno trabaja, a veces no le dan permiso, o [la clínica] no tiene la cita para el día que uno necesita, que está desocupada. Así puede ser difícil</strong></td>
<td>When you work, sometimes you can't get time off, or [the clinic] doesn’t have an appointment for the day you need, the one you are free. In this way it can be difficult.</td>
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<td>Nora</td>
<td><strong>Medicaid da una lista que recomienda en tal lugar donde están los pediatras y eso. Y es un lugar donde nosotros quedamos cerca, más cómodo porque lo del trabajo. Podemos salir del trabajo y no perdemos un día por llevarlo, sino que él lo pueda atender a veces ya al salir del trabajo y me gusta realmente como trata al niño.</strong></td>
<td>Medicaid gives you a list that recommends pediatricians for each location. It is a place that is close to our home, its more comfortable because of work. We can leave work and we don’t lose a whole day to take them [to the doctor]. Rather the doctor can see us, sometimes just as we are leaving work and I truly, I like how he treats my child.</td>
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<td>Melinda</td>
<td><strong>Lo que pasa es que son demasiadas horas esperando...a veces tenía que faltar a mi trabajo porque pues está primero ella...y ya cuando tu sales [del trabajo] ya [la clínica] está cerrado.</strong></td>
<td>What happens is that it is just too many hours waiting...sometimes I would have to be absent from my work because, well, she is first...because when you get out [of work the clinic] is already closed.</td>
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<td>Ingrid</td>
<td>If it is in the afternoon I bring him to the hospital and if it is in the morning I bring him to the clinic.</td>
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<tr>
<td>Andrea</td>
<td>Me, every time I go to the hospital I bring [everything including] the birth certificate [of my child] because who knows...</td>
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<td>Belén</td>
<td>She says it to you in a way that is pleasing. She tells you how it is, but in a way that makes you feel good. At the moment to check the children, she looks for a way to connect with them...the doctor starts to chat with him, she talks to him, and plays...and for those reasons it goes well for me.</td>
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<tr>
<td>Belén</td>
<td>The first time that one takes the children to the doctor, it is a little - it becomes very difficult because sometimes they give you sheets of paper and sometimes things that you don’t understand and you are filling out all of these forms, all the information and no - it is a little more complicated when it is the first time and you have to fill out everything. Let's say, what complications [your child has], diseases, everything. Who suffers from what, if you so on and so forth. It becomes very difficult...I take the time to fill it all out correctly because sometimes these are things, questions that...let's say, who in the family suffers heart problems, who in the family suffers diabetes, on the side of the mother or the side of the father, and well, these are questions that one has to answer, because, like they say, sometimes these are diseases that show up in the grandchildren or the children,</td>
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<td>Melinda</td>
<td>Urgent care es como una clínica pero es como de emergencia, [es] para la gente que no tuvo tiempo de hacer una cita o que no tiene cita o que ya es algo urgente.</td>
<td>Urgent care is like a clinic, but for emergencies, it is for people who didn’t have time to make an appointment or who don’t have an appointment but it is already something urgent.</td>
<td>109</td>
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<td>Maribel</td>
<td>A mí me gusta más la pediatra, porque ahí hablan mi idioma, me entiendo con ellos.</td>
<td>I like the pediatrician because there they speak my language, we understand one another.</td>
<td>109</td>
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<td>En el hospital, a veces pues...no hablo inglés y ellos no hablan español, entonces no nos entendemos.</td>
<td>In the hospital, sometimes, well...I don’t speak English and they don’t speak Spanish, so we don’t understand one another. Sometimes, it's like they push you aside for not knowing [English].</td>
<td>109</td>
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<td>A veces, como que te tiran al no saber [ingles]. Como te dicen allí unas cuantas cosas. Pero ella es bien lista” gesturing to her daughter, “ella sabe mucho inglés, ahora me interpreta...no hablo, pero trato de ayudarme entender un poco.</td>
<td>Like they say some things to you. But she is bright” gesturing to her daughter, “she knows a lot of English and now she interprets for me...I don’t speak, but I try to help myself to understand some things.</td>
<td>109</td>
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<td>Yasmin</td>
<td>Es muy difícil. No se si faltan dentistas o sería muy especial el trabajo.</td>
<td>It is very difficult. I don’t know if there aren’t enough dentists or maybe it is a very special kind of job.</td>
<td>109</td>
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<td>Para él, le sacaron dos muelas y tardamos en una lista de espera de un año. El dentista dijo al menos que el venga de emergencia, entonces se lo podemos hacer ese día...En México es diferente porque yendo al dentista, uno paga, pero ese mismo día se lo hace.</td>
<td>For him, they took out two molars and we were on a waitlist of one year. The dentist said that unless we come in with an emergency, then we could do it the same day...in Mexico it is different because going to the dentist, one pays, but they do it the same day.</td>
<td>109</td>
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<td>A diferencia a México, allá rápido le dan algo por - yo me imagino por la diferencia de alimentación y de cuidados, de que si no le dan algo,</td>
<td>The difference is in Mexico, there they give something quickly - I imagine it is because of the different nutrition and care, if they don’t give something,</td>
<td>109</td>
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<td><strong>por la alimentación que están un poco más desnutridos, se caen más rápido. Que aquí le puede controlar uno con líquidos y suero y cosas así.</strong></td>
<td>because of the diet they are a little more malnourished, they fall [more ill] more quickly. But here, you can control it with liquids, suero, and things like that.</td>
<td><strong>Carolina</strong></td>
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<td><strong>[En Oregon] si yo pedí una hamburguesa me daban un vaso de agua. Yo decía, qué voy hacer? No puedo...Aquí se encuentra un poco de todo...me quede.</strong></td>
<td>[In Oregon] if I asked for a hamburger, they would give me a cup of water. I said, what am I going to do? I can’t...here you find a little bit of everything...so I stayed.</td>
<td><strong>Graciela</strong></td>
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<td><strong>Allá son más universidades, son más de gente - Americana de aquí y no hay hispanos. Aquí hay más gente hispana que americana...Allá casi la mayoría es puro universidades, construcción y cosas así, escuelas, hospitales y todo eso, y aquí es más agricultura.</strong></td>
<td>There, there are more universities, more people - American people than here and there aren’t Hispanics. Here there are more Hispanics than Americans...There the majority has to do with universities, construction, and things like that, hospitals, all that, here is more agriculture.</td>
<td><strong>Analise</strong></td>
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<td><strong>A veces piensas que la persona habla español y no habla español, muchas veces creen que como hablas español te vas a ir. Te dicen ‘I don’t speak Spanish’ pero no te dicen ‘espera’...I speak English too, so, talk to me.”</strong></td>
<td>Sometimes you think the person speaks Spanish and they don’t speak Spanish. A lot of the time they think that since you speak Spanish you will just go. They say “I don’t speak Spanish” but they don’t tell you “wait”...I speak English too, so talk to me.</td>
<td><strong>Melinda</strong></td>
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<td><strong>La persona que está atendiendo, el trato que les está dando a la persona, que los traten de entender. Que también hay veces que no les gustan hablar el español entonces no los ayudan.</strong></td>
<td>The person who is attending, how they treat the person, they should try to understand. Sometimes they don’t like speaking Spanish so they don’t help people.</td>
<td><strong>Carolina</strong></td>
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<td><strong>Bueno...andaba mucho migración, ay, yo tuve que dejar hasta trabajar porque no quería ir a dejar a mi niño hasta allá por el temor...mis hijos, los otros [mayores] no los lleve a la...</strong></td>
<td>Well...immigration was all around, yikes, and I even had to stop working because - I didn’t want to drop my kids off way over there for the fear...my kids, the other [older ones], I didn’t bring...</td>
<td><strong>Carolina</strong></td>
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<td>Escuela. Como uno no tiene seguro, no quiere salir. Los otros [jóvenes] sí tienen, una ley que les dio el gobierno, DACA...pero mi hijo, todavía no lo ha hecho. Entonces estamos esperando.</td>
<td>Them to school. As one doesn’t have a social [security number], one doesn’t want to go out. The other ones (the young ones) they do have socials, from a law made by the government, DACA, but my son, he hasn’t done it yet. So we are waiting.”</td>
<td>Nora</td>
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<td>Nos preocupamos por eso [migración] porque nosotros pasamos de inmigrantes. Y una cosa que nos preocupe es que, por ejemplo, dicen los hijos que nacen acá, no podemos sacarlos de acá, que normalmente deportan a los padres y eso es un poco preocupantes. Pero la misma necesidad lo hace salir a la calle...no tengo información realmente. Nosotros nos guiamos por las noticias. Lo que hablan en las noticias, pero realmente no hay información clara que uno maneja las cosas.</td>
<td>We worry about it [immigration] because we came through as [undocumented] immigrants. One thing that worries us, for example, is they say that the kids that are born here, we can’t take them from here, that normally just the parents are deported and this is a bit worrisome. But the same need is what makes us go out into the street...I don’t have information. We are guided by the news. Whatever they talk about in the news, but really, there is not clear information for one to navigate the situations.</td>
<td>Nora</td>
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<td>Él no tenía un seguro, ahora tiene un seguro de salud de Obamacare, pero para dental no tiene, entonces hay que esperar hasta ir para México para que salga un poco más barato...</td>
<td>He didn’t have a social, now he has health insurance through Obamacare, but noting for dental insurance, so we have to wait until we go to Mexico so that it is a little cheaper…</td>
<td>Yasmin</td>
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<td>[Se me hace difícil] entender lo que me están diciendo. Lo que me están explicando [en ingles], yo no los entiendo nada. Qué tal si lo que la otra persona [el intérprete] me está diciendo no es lo que están diciendo? ”</td>
<td>[What is difficult for me] is to understand what they are saying. What they are explaining to me [in English], I don’t understand it at all. What if the other person [the interpreter] is not saying the same thing to me?</td>
<td>Graciela</td>
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<td>Batallo porque es puro inglés.</td>
<td>I struggle because it is all [in] English.</td>
<td>Belén</td>
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<td>A veces hay cosas que uno quisiera preguntarle más hondo, pero por no saber [el idioma] no puedes...y es una de las cosas que más afecta en el aspecto médico. Porque a veces, tal vez uno firma un papel, y uno no sabe lo que está firmando</td>
<td>Sometimes there are things that one would wish to ask with greater detail, but because you don’t know [the language] you can’t...and that is one of the things that most affects healthcare. Because sometimes, maybe you sign a form, and you don’t know what you are signing.</td>
<td>Nora</td>
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<td>Mejor voy en persona...a veces yo llamo y digo ‘hay alguien que habla español?’ y yo no sé qué me dicen, espero y espero y al final, cuando oigo ‘paz!’ y me cuelgan. Otra vez vuelvo a llamar y me contestan hay alguien que habla español?’ y luego me dicen quién sabe qué y otra vez me vuelven a colgar...</td>
<td>It is better for me to go in person...sometimes I call and I say ‘is there anyone who speaks Spanish?’ and I don’t know what they say to me, I wait and wait and in the end I hear ‘click!’ and they hang up on me. I will call again and they answer, ‘is there anyone who speaks Spanish?’ and then they say who knows what and hang up on me again…</td>
<td>Carolina</td>
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<td>Si hablará inglés, todo fuera más claro.</td>
<td>If I spoke English, everything would be easier.</td>
<td>Nora</td>
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<td>Muchas veces, luego nosotros como estamos de paciente y ver que alguien está sufriendo, entonces tratamos de ayudar, porque sabemos que es difícil...no solo en el médico, sino en diferentes lugares. Es difícil para los que no pueden hablar el idioma [ingles].</td>
<td>Much of the time, we are there as patients see someone else who is suffering and we try to help, because we know it is difficult....not only in medical settings, but other places too. It is difficult for people who cannot speak the [English] language.</td>
<td>Analise</td>
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<td>Bueno, la mera verdad es que entiendo una que otra cosas, pero no hablo nada. Pero fíjate que eso se es indispensable hablar inglés...Hay que ser realistas, [ingles] es el idioma de ellos [los doctores], y ellos tratan de entender a uno, pero haz te cuenta que, yo siento que</td>
<td>Well, the whole truth is that I understand one or two things, but I don’t speak [English] at all. But, you know that speaking English is indispensable...We have to be realistic, [English] is their language [that of the doctors], and they might try to understand us, but keep in mind, I feel that we are in a country</td>
<td>Belén</td>
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<td>Spanish</td>
<td>English</td>
<td>Marisol</td>
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<td>estamos en un país que el lenguaje es de ellos...Nosotros que hablamos ese idioma [español] tenemos que poner un poco de esfuerzo de hablar el idioma es [ingles]. Pero a la vez, uno dice que tenemos que agarrar un poco de tiempo de nosotros para aprender. Ya voy aprender inglés...Entonces tengo que poner la mitad.</td>
<td>where the language is theirs...we who speak Spanish have to put an effort to speak English. But at the same time we must have some time that is our own to learn. I am going to learn English...therefore I am going to put in my effort.</td>
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<td>Dónde yo he batallado es en la escuela. Porque en la escuela si a veces no hay quien...en elementary no, pero en middle school, tienes que llevar tu interprete porque no hay mucho. Yo si digo a mi marido, vez tú porque yo no sé....Cualquier recado te hablan en inglés y si lo entendiste bien, y si no, tu problema.</td>
<td>Where I have struggled is in the school. Because in the school sometimes there is no one...in elementary school no, but in middle school, you have to bring your interpreter because there aren't many. I tell my husband, you should go, I don’t know [English]...Whatever message they tell you in English, if you understood it, good, but if not, it’s your problem.</td>
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APPENDIX F:

KNOW YOUR RIGHTS RESOURCES

Know Your Rights information sheet from the American Civil Liberties Union (in English and Spanish) Retrieved from https://www.aclu.org/feature/know-your-rights-immigration
CONOZCA SUS DERECHOS
Parado/a por la policía, agentes de inmigración o el FBI

Si la policía lo para
- Usted tiene el derecho de permanecer en silencio. Si desea permanecer en silencio, diga lo a la policía. (Algunos estados pueden requerir que se identifique a la policía si se lo considera sospechoso de un crimen.)
- Mantenga la calma. No huya. No discuta, no resista ni abandone a la policía. Mantenga siempre las manos donde la policía las pueda ver.
- Pregunte si usted es libre para irse. Si la policía dice que sí, síntese con tranquilidad en silencio.
- Usted no tiene que acceder a ningún registro de su persona o pertenencias.

Si lo paran en su vehículo
- Pare el vehículo en un lugar seguro lo más pronto posible. Apague el vehículo, estacione la luz intermitente, abre la ventanilla un poco y coloque las manos sobre el volante.
- Si se lo piden, muestre a la policía su licencia de conducir, registro y prueba de seguro.
- Si un policía o agente de inmigración le pide registrar su vehículo, usted puede negar su permiso. Sin embargo, si la policía cree que su vehículo contiene evidencia de un crimen, puede registrarlo sin su permiso.
- Ambos los conductores y los pasajeros tienen el derecho de permanecer en silencio. Si usted es pasajero, también puede preguntar si está libre de irse. Si la policía dice que sí, síntese tranquilamente.

Si le preguntan acerca de su estatus migratorio
- Usted tiene derecho a permanecer en silencio. No tiene que responder a preguntas acerca de su identidad, si es ciudadano de los EE.UU. Sólo ingresa al país, si aplican reglas distintas en los cruces fronterizos internacionales y aeropuertos, y a individuos con ciertas visas de inmigración, incluyendo los turistas y las personas en viajes de negocios.
- Si no es ciudadano de los EE.UU. y tiene documentos de inmigración válidos, debe mostrárselos al agente de inmigración que se los pida.
- No minta acerca de su estatus de ciudadanía ni entregue documentos falsos.

Si la policía o agentes de inmigración llegan a su casa
- Usted no tiene derecho a permanecer en silencio. No tiene que dejarse entrar a menos que tenga una orden judicial firmada por un juez.
- Pida que le muestre la orden judicial. Los oficiales sólo pueden registrar las áreas y los artículos que se mencionen en la orden. Una orden de arresto le permite a la policía ingresar a la casa de la persona indicada en la orden si cree que la persona se encuentra en el interior. Una orden de remoción/depuración ("I-E warrant") no les permite a los oficiales ingresar a una casa sin permiso.
- Aun si tienen una orden judicial, usted puede permanecer en silencio. Si usted elige hablar, salga y cierra la puerta.

Si lo arrestan
- No oparta resistencia.
- Diga que tiene derecho a permanecer en silencio y pida a un abogado. Si no puede contratar a un abogado, el gobierno debe proporcionarle uno.
- No diga nada hasta que ni siquiera lo arresten.
- Usted tiene derecho a hacer una llamada local. La policía no puede escuchar si llama a un abogado.
- No discuta su estatus migratorio con nadie excepto un abogado.
- Puede que un agente de inmigración le visite en la cárcel. No responda a preguntas si no tiene nada que en elante.
- Las completarán todos los documentos. Si no entiende o no puede leerlos, diga que necesita un intérprete.

Si lo ponen en custodia de inmigración (o "ICE")
- Usted tiene derecho a un abogado, pero el gobierno no le dará uno. Si no tiene abogado, pida que le dé una lista de proveedores de servicios de asesoría legal gratuitos o de bajo costo.
- Tiene derecho a comunicarse con un consulado o a que un oficial notifique al consulado de su arresto.
- Diga al agente de inmigración que desea permanecer en silencio. No habla de su estatus migratorio con nadie más que su abogado.
- No firme nada, como una solicitud donde acepte su salida voluntaria del país o una orden expedida de remoción, sin hablar con un abogado primero. Si firma, es posible que esté renunciando a la oportunidad de tratar de permanecer en los EE.UU.
- Recuerde su número de inmigración (número "A") y dónde vive su familia. Ayudará a que su familia lo localice.

Si cree que sus derechos han sido violados
- Anote todo lo que sucede, incluyendo el número de placa de los oficiales y sus vehículos de patrulla, a qué agencia pertenecen y cualquier otro detalle. Obtenga los datos de los testigos. Si usted resulta lesionado, busque atención médica inmediatamente y tome fotografías de sus lesiones.
- Presente una denuncia por escrito ante la división de investigación interna o un juicio civil contra la ciudadanía de quejas. En la mayoría de las casos usted puede presentar una denuncia de manera anónima si desea.

Para más información, llame al ACLU local www.ACLU.org/affiliates

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**KNOW YOUR RIGHTS NOTICE**

To Whom It May Concern: Please be informed that I am choosing to exercise my right to remain silent and the right to refuse to answer your questions. If I am detained, I request to contact an attorney immediately. I am also exercising my right to refuse to sign anything until I consult with my attorney. Thank you.

*I do not wish to speak with you, answer your questions, or sign or hand you any documents based on my 5th Amendment rights under the United States Constitution.*

*I do not give you permission to enter my home based on my 4th Amendment rights under the United States Constitution unless you have a warrant to enter, signed by a judge or magistrate with my name on it that you slide under the door. I do not give you permission to search any of my belongings based on my 4th Amendment Rights.*

*I choose to exercise my constitutional rights.*
APPENDIX G:

BEING PREPARED FOR YOUR DOCTORS APPOINTMENT WALLET INSERT

Write Down Questions
- If you have observations or specific concerns – note them:
  - What is it? Describe it.
  - How long has your child had it?
  - How often does it occur?
- Is my child growing as expected?
- What should I expect about my child’s growth and development?
- Are my child’s immunizations up to date?

- There is no such thing as a silly question. If you have any doubts, ask.

Escribe sus preguntas
- Si tiene observaciones o preocupaciones específicas – notarlas:
  - ¿Qué es? Describalo.
  - ¿Por cuánto tiempo lo ha padecido?
  - ¿Con qué frecuencia ocurre?
- ¿Está creciendo mi niñ@ como se espera?
- ¿Qué debo esperar sobre el crecimiento y desarrollo de mi niñ@?
- ¿Están sus inmunizaciones al corriente?

- No existe una pregunta demasiado simple, si tiene cualquier duda, pregunta.
APPENDIX H:

ENGLISH FOR SPEAKERS OF OTHER LANGUAGES (ESOL) IN HILLSBOROUGH COUNTY, FLORIDA

Hillsborough County Public Schools

English for Speakers of Other Languages program description: “This course is for adult students whose first language is not English. English Speakers of Other Languages (ESOL) classes are designed to teach students to listen, speak, read and write in English, and life skills. The goal is to prepare students to use English in their everyday lives. In addition, this course supports and directs adult students toward career pathways that can lead to technical careers, colleges, and universities. Childcare may be available at specific sites. Prerequisite: CASAS placement test

This site lists locations and contact information for ESOL programs run through Hillsborough county public school.

http://www2.sdhc.k12.fl.us/lynx/MoreInfo.asp?Return=&ReturnText=&Keyword=&PS_LocationID=&Language_Spanish=&PS_ClassMeetsID=&PS_ProgramListID=&CourseID=17&ThisLocat=16

Florida Literacy Coalition

“Established in 1985, The Florida Literacy Coalition (FLC) promotes, supports and advocates for the effective delivery of quality adult and family literacy services in the state of Florida.

As a statewide umbrella literacy organization and the host of Florida’s State Literacy Resource Center, FLC provides a range of services to support more than 300 adult education, literacy and family literacy providers throughout Florida. Special emphasis is placed on assisting community based literacy organizations with their training and program development needs”

The Florida Literacy Coalition Website lists Tampa Bay Area (including Tampa, Wimauma, Dover, Brandon, Gibsonton, New Port Richey) locations, details services offered at each location, and contact information.

http://floridaliteracy.org/search/search.php?type=services&county=Hillsborough
ABOUT THE AUTHOR

Aria A. Walsh-Felz received a B.S. in Anthropology and Ecology, Evolution & Behavioral Biology at Beloit College in 2011. In 2011 she received the John W. Bennett prize for her work advancing the use of anthropology to address community and world issues and the Gertrude E. Sweet award for her commitment to serving others and demonstrating leadership in confronting societal issues related to the life sciences.

Aria received a dual M.A./M.P.H. at the University of South Florida (USF) in applied medical anthropology and public health education in 2017. During her time at USF Aria was worked on various projects related to immigration and health domestically and internationally. She has further experience working on food security for which her research team received a small grant. Aria has lived and worked in Ecuador and Mexico through the international service learning program Amigos de las Américas.