ISSUE BRIEF

Listening to Asian and Pacific Islander Mothers in California

Listening to Mothers in California is the first state-level *Listening to Mothers* survey. It explores the views and experiences of childbearing women[1] with an in-depth focus on maternity care. This issue brief highlights results from Asian and Pacific Islander (API) women[2] survey respondents. It underscores many social and economic issues affecting pregnant and parenting API women, including their mental health, experiences with discrimination, postpartum experience and issues related to paid work.[3]

API women's voices and lived experiences are essential for understanding, and then addressing, the challenges the U.S. health care system faces, particularly poor maternal health outcomes. *Listening to Mothers in California* is based on a sample of more than 2,500 women.[4] It consisted of multiple choice questions with open-ended responses at the end.[5] It was adapted for mobile devices, enabling women to participate on any device or with a trained interviewer. (See Methodology appendix for more details.) The findings presented here illuminate some of the preferences, concerns and experiences of the API women surveyed. This survey and issue brief build on the work, advocacy and recommendations that community-based groups, many led by women of color, have done for decades to address health disparities.

Asian and Pacific Islander women reported:

- **Experiencing discrimination during childbirth;**
- **Feeling pressure to have a cesarean birth; and**
- **Lacking practical and emotional support after childbirth.**

California is home to more than 3.5 million API women and girls, nearly 1.5 million of whom are of reproductive age.[6] In addition to guiding state-level policymaking and practice, the *Listening to Mothers in California* survey results have implications for better serving pregnant and parenting API women across the country.

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API women's self-reported experiences during pregnancy and childbirth have received limited attention. API women have a higher birth rate nationwide than white women and on average, have a higher cesarean rate than white women.[7] Although API women's birth outcomes are generally similar to those of white women, research findings are varied. Some studies suggest certain subgroups of API women, such as Japanese, Filipinos and other Pacific Islanders, have worse maternal health and birth outcomes than white women.[8]

"(The worst thing that happened was) definitely the triage nurse. When it came time to check how dilated I was she was so rough."

"I only had one very rude nurse come in and physically hurt me. Normally, health care professionals come in and inform you of their actions involving you. I used to be an LVN (licensed vocational nurse) and never have I ever come up to a patient and inflicted pain on them, let alone (without) first telling them what I'm about to do."

Across all respondents, the survey identified shortcomings of the health care system and of the social supports provided to pregnant and parenting women in California. In some cases, these shortcomings were worse for API than white women, but that was not consistent across all the topics explored in the survey.[i] Even on survey questions where API women reported similar or better experiences than white women, alarming gaps between the women's experiences and what they would optimally experience and opportunities for improvement for all women were identified.

API women survey respondents reported that they experienced discrimination (unfair treatment) during childbirth, faced communication barriers with their providers, experienced depression and anxiety and started or returned to paid work earlier than they wanted after giving birth.

Asian and Pacific Islander women reported discrimination from maternity care providers.

Discrimination in the health care field is well documented. API women are often subject to unfair treatment and frequently report a lower quality of care,[9] which can contribute to disparities in maternal and infant health.[10] Everyday discrimination negatively affects pregnancy by increasing cortisol levels, which can adversely affect maternal and infant health.[11] Unfair treatment based on race can have negative consequences on the birth process and on labor and birth outcomes.[12]

The survey found that API women encountered discrimination based on race and ethnicity from their maternity care providers more frequently than white women.

- Eight percent of API mothers reported that they were treated unfairly during their hospital stay because of their race or ethnicity, compared to less than one percent of white mothers.*
- Thirteen percent of API women who speak an Asian language at home reported unfair treatment because of language, compared to two percent of English speakers.*
- On average, 10 percent of API mothers said they were handled roughly or experienced rude and threatening language from their health care provider, whereas eight percent of white women experienced the same.

[i] In this document, we have used an asterisk (*) to indicate comparisons that are significantly different at .01 or .05.

- Seven percent of API mothers reported that they were treated unfairly due to the type of insurance they had (such as Medi-Cal or private insurance) or their lack of insurance, a rate similar to that of white women.

Asian and Pacific Islander women reported that they faced barriers to open and supportive communication with their maternity care providers.

Continuous support, listening to women and providing culturally sensitive care during the birth process are associated with better maternal and infant health outcomes.[13] For many of the API women survey respondents, however, communication during the labor process was a problem. API women reported communication problems at almost the same rate as white mothers.

- One in five API mothers reported that they did not feel the delivery room staff encouraged them to make decisions about their birth progression.
- Five percent of API mothers said they did not feel well supported by staff during labor.
- Eight percent of API mothers reported that they felt medical staff did not communicate well with them.

Many API women reported feeling pressure to have medical interventions during labor and delivery.

- Sixty-seven percent of API women said they believed that childbirth should not be interfered with unless medically necessary; a similar percentage of white women respondents said the same. API women felt similar pressure as white women to induce labor and to use an epidural for pain relief.

"One nurse during my labor seemed to really push for epidurals, which I did not want at first. I did not like how she kept asking."

- Thirteen percent of API women reported they felt pressured to induce, whereas almost 20 percent of white women felt pressured to induce.
- Eleven percent of API women said they felt pressured to use an epidural for pain relief, a rate similar to that of white women.
- Fourteen percent of API women reported that they felt pressured to have a cesarean birth, whereas only 9.5 percent of white women reported the same.
- API women gave birth by cesarean section at the same rate as white women.

In California and nationally, there is growing recognition of the overuse of cesarean birth. Because unnecessary cesarean births are associated with excess risk and cost, pressure on women to have a cesarean birth is concerning.

Asian and Pacific Islander women reported symptoms of depression and anxiety during and after pregnancy.

Prenatal and postpartum depression and anxiety are common nationwide among all women. Untreated prenatal and postpartum depression has serious consequences, including premature birth, low birth weight and complications after birth. Moreover, suicide is a common cause of maternal mortality, exceeding hemorrhage and hypertensive disorders.[14]

API women reported some of the lowest rates – although still unacceptably high – of symptoms of anxiety and depression during pregnancy and postpartum.

- Eighteen percent of API women screened positive for anxiety, and eight percent screened positive for depression during pregnancy. Twenty percent of white women screened positive for anxiety, and 10 percent screened positive for depression during pregnancy.
- In the postpartum period, seven percent of API women screened positive for anxiety, and seven percent positive for depression. Twelve percent of white women screened positive for anxiety, and six percent screened positive for depression during the postpartum period.

The lower rates of symptoms of depression and anxiety after childbirth, compared to rates during pregnancy, are surprising and warrant exploration.[15] Additionally, social and cultural factors (including stigma) affect whether a woman is diagnosed with and seeks care for anxiety and depression.

Asian and Pacific Islander women reported a lack of sources of practical and emotional support after childbirth.

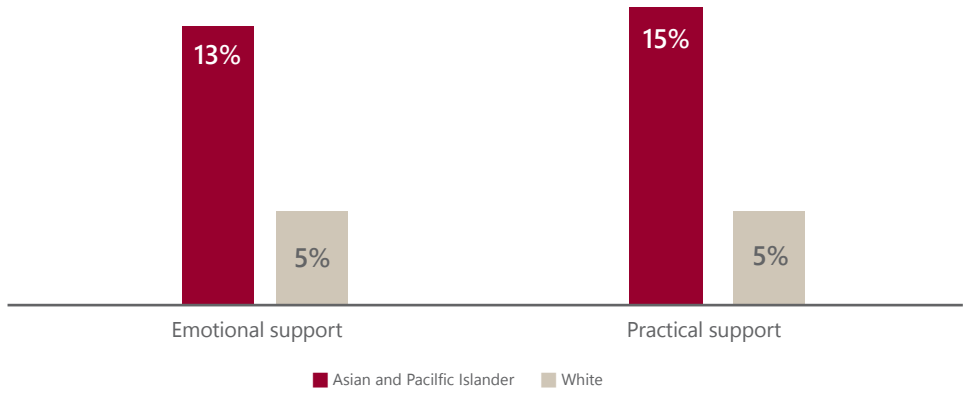
The postpartum period is a time of physical, emotional and social transition for women. Many of these transitions can come with challenges such as lack of sleep, fatigue, pain, breastfeeding difficulties and stress.[16] Postpartum care, as well as emotional and practical support, are critical to help women navigate the postpartum period. Research shows that women with minimal social support, such as the ability to rely on their own mothers, partners and friends tend to experience childbirth as a greater overall life challenge than women who had adequate social support.[17]

In the survey, API women were more likely than white women to report a lack sources of emotional or practical support (Figure 1).

"I wish I had more info about what life is like caring for a newborn. People say it's rough, but it's difficult to know how rough until you're in it."

Figure 1. Percent of Women Who Reported No Postpartum Emotional or Practical Support, by Race/Ethnicity

Since the birth of your baby, how often have never had someone you can turn to for emotional or practical support, such as listening to your concerns?



p<.01 for difference by race/ethnicity

- Nearly 13 percent of API women said they never had someone to turn to for *emotional* support in the period between giving birth and completing the survey, compared to five percent of white women.*
- Fifteen percent of API women said they never had someone to turn to for *practical* support in the period between giving birth and completing the survey, compared to approximately five percent of white women.*

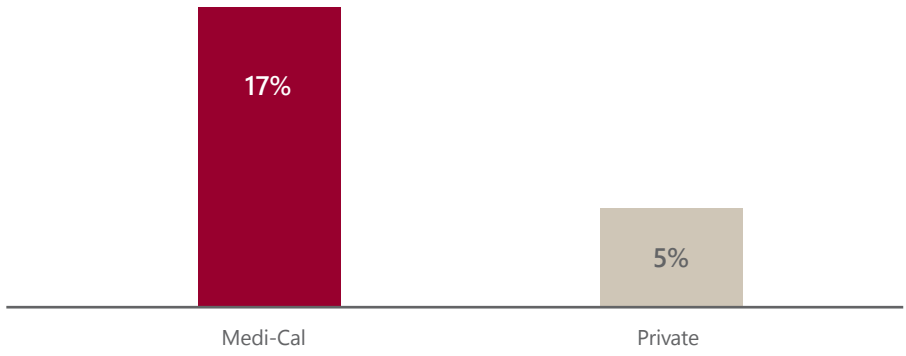
Asian and Pacific Islander women reported a high number of postpartum health care visits.

Postpartum health care visits are an important opportunity for health care providers to identify signs of postpartum depression and counsel women on lactation, contraception and ongoing health care. Although many mothers view postpartum visits as a valuable resource,[18] not enough women access postpartum care.[19] According to national recommendations, postpartum care should be an ongoing process. It is recommended that women have contact with their maternity care providers within three weeks after giving birth, followed by ongoing care as needed, and concluding with a comprehensive postpartum visit no later than 12 weeks after birth.[20]

In the eight weeks following the birth of their babies:

- Twelve percent of API women reported three or more postpartum visits; a similar percentage of white women reported the same number of visits.
- Nine percent of API women reported no postpartum visit. Low-income API women were at greatest risk of reporting no postpartum visits. API women enrolled in Medi-Cal were three times more likely to have no postpartum visits than API mothers with private insurance (Figure 2).*

Figure 2. Percent of Asian and Pacific Islander Women Who Reported No Postpartum Visit, by Payer



Asian and Pacific Islander women (n=327)
p<.05 for difference by payer

- At their postpartum visits, almost one-third of API mothers said they were not asked if they needed help breastfeeding, almost 15 percent were not offered assistance with birth control, and 1 in 5 were not asked if they were feeling depressed. These rates were similar to what white women reported.

Many Asian and Pacific Islander women returned to or started paid work earlier than they wanted.

All workers, including mothers, need adequate time away from paid work to care for themselves and their families. Paid family and medical leave has well-documented positive effects on maternal and child health, parent-child bonding, families' financial security and maternal workforce attachment.[21] California is one of the few states that has a paid family and medical leave program for workers, meaning that many of the survey respondents had access to leave through that program.

- API women reported that they stayed home an average of 14 weeks following the birth of their babies, the same amount of time as white women.
- Fifty-five percent of API women reported being able to take as much leave as they wanted, compared to only 39 percent of white mothers.*
- At the time of the survey, 54 percent of API mothers, slightly more than white mothers (50 percent), reported returning to or starting a new paid job either full- or part-time, and another 16 percent said they planned to return or take on paid work in the coming months.
- Only 30 percent of API mothers reported plans to stay home with their babies full time, whereas about 36 percent of white mothers did.

Conclusion: Asian and Pacific Islander women are not receiving the health care or the nonmedical support they need to thrive before, during and after childbirth.

The survey found that many API women reported not receiving the high-quality, culturally sensitive, unbiased care that all women need. API women's reports of harsh or unfair treatment reflects a health care system that discriminates against and devalues API women and too often ignores their health care needs. Similarly, the high rates of pressure API women reported during birth underscore that their voices are not respected in our health care system. Discrimination and pressure to have interventions during childbirth have detrimental effects on the health of women and their children. Unbiased treatment, culturally sensitive care, clear communication and participatory decision-making during childbirth are vital, as they allow for more empowered experiences and better health outcomes for both mother and infant.[22]

API women reported attending the same number of postpartum visits as white women, but almost 10 percent did not have a postpartum visit at all. The postpartum period is a critical time for the health of new mothers and their babies. During this period, all women need comprehensive health care that addresses physical and mental health, as well as family planning.[23]

API women's needs extend beyond the health care setting. The high rates of API women reporting they lacked practical and emotional support after childbirth indicate that more attention must be paid to nonmedical needs in order for API women and new mothers to achieve better health and wellness. Addressing the underlying causes of this lack of support must include combatting discrimination based on ethnicity, gender and immigration status as well as better addressing the social determinants of health such as social isolation, poverty, access to affordable and nutritious food, and stable housing.[24]

California is a pioneer in paid family and medical leave, implementing the first statewide program in 2004. Under this program, new mothers can typically take up to 10 weeks of paid pregnancy disability leave for an uncomplicated pregnancy and birth, as well as up to six weeks of paid parental bonding leave.[25] But 45 percent of API women in the survey reported being unable to take as much time away from paid work after childbirth as they wanted. All women need adequate time off from paid work to recover from childbirth and care for their families, particularly given the high rates of cesarean birth and symptoms of anxiety and depression found in the survey. The postpartum period is a time for mothers to rest, heal and bond with their babies. Mothers should not be forced to return to paid work before they are ready to do so. Paid family and medical leave enables employed women to take the time they need to recover from childbirth and care for their new child.

The *Listening to Mothers in California* survey findings make clear that the health care system is falling short for all women, with distinctive concerns about API women and other women of color. If we are serious about ensuring that API women thrive before, during and after childbirth, we must do more to eliminate bias and discrimination in health care and address their clinical and nonclinical needs.

APPENDIX A: METHODOLOGY

Following a series of groundbreaking and widely cited national *Listening to Mothers* surveys led by Childbirth Connection since 2002, *Listening to Mothers in California* is the first state-level *Listening to Mothers* survey to explore the views and experiences of childbearing women. With its in-depth focus on maternity care, this survey is a complement to California's annual Maternal and Infant Health Assessment (MIHA) survey, which prioritizes public health topics.

Listening to Mothers in California included numerous innovations relative to previous national *Listening to Mothers* surveys. For the first time, we were able to offer the survey in Spanish as well as English. We adapted the survey for mobile devices, enabling women to participate on any device or with a trained interviewer. In addition, we were fortunate to receive support from the relevant California agencies to access birth certificates for sampling, data weighting and other purposes.

We developed, field-tested and refined the 30-minute survey questionnaire, which covers the prenatal through postpartum and newborn periods. A representative sample was drawn from birth certificate files, excluding teens under age 18, women with out-of-hospital births, women with multiple births and non-residents of California. Black women, women with midwifery-attended births and women with vaginal birth after cesarean were oversampled to better understand their experiences.

Women were invited to participate through a series of mailings with elements of informed consent, information about how to participate and an offer of a thank-you gift card. Non-respondents were contacted again by mail, telephone, text message and email, as available, using contact information from multiple sources. The survey was conducted from February 22 through August 15, 2017 with 2,539 women – including 327 Asian and Pacific Islander women – who completed the questionnaire when their babies were 2 to 11 months old. As resources were not available to offer the survey in any Asian or Pacific Islander languages, some sampled women were unable to participate due to language barriers.

Visit NationalPartnership.org/LTMCA and chcf.org/listening-to-mothers-CA for the full *Listening to Mothers in California* report, more on the methodology and many related resources. Find reports and related materials for previous national surveys at NationalPartnership.org/ListeningtoMothers.

The Listening to Mothers in California *survey was led by the National Partnership for Women & Families and developed in collaboration with investigators from the University of California, San Francisco Center on Social Disparities in Health and the Boston University School of Public Health. Quantum Market Research, Inc. administered the survey. The California Health Care Foundation and Yellow Chair Foundation funded this work.*

This issue brief was supported by the California Health Care Foundation and Yellow Chair Foundation as part of the Listening to Mothers in California *survey project. The brief was a collaborative endeavor that relied upon the work of many individuals. The primary authors were Stephanie Glover and Dawn Godbolt, with assistance from Carol Sakala and Lauren Sogor. The authors also thank our external partners who provided review and input on our interpretation and analysis.*

ENDNOTES

[1] We use the term "women" throughout this issue brief, but recognize that people of many gender identities – transgender, nonbinary and cisgender alike – need and receive maternity care.

[2] Women were asked to identify as Hispanic or Latina; white; Black or African American; Asian, American Indian or Alaskan Native; Native Hawaiian or other Pacific Islander; or other. Survey analyses of Asian and Pacific Islander women include those who selected Asian and/or Native Hawaiian or other Pacific Islander and did not select Hispanic or Latina.

[3] The API population is incredibly diverse and includes over 20 million people in the United States who trace their heritage to more than 50 different countries and speak more than 100 different languages. Our survey results aggregate this data across API subgroups. We believe this provides an important starting point and context for including API women's voices in these policy discussions, but acknowledge that our results likely mask variation across subgroups.

[4] Participants of the *Listening to Mothers in California* survey are representative of California residents 18 years and older who gave birth to a single baby in California hospitals in 2016, were living with their baby at the time of the survey and could participate in English or Spanish. Nationally, 1 in 3 APIs are limited English proficient, but we were unable to offer the survey in languages other than English or Spanish.

[5] All quotes in this document are from Asian and Pacific Islander women who participated in the *Listening to Mothers in California* survey.

[6] National Partnership for Women & Families analysis of the 2017 Current Population Survey, Annual Social and Economic Supplement.

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[12] Ibid.

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[19] See note 16.

[20] See note 15.

[21] Ibid.; see also, ZERO TO THREE & National Partnership for Women & Families. (2017, January). *The Child Development Case for a National Paid Family and Medical Leave Program*. Retrieved 6 June 2018, from http://www.nationalpartnership.org/research-library/work-family/paid-leave/the-child-development-case-for-a-national-paid-family-and-medical-leave-insurance-program.pdf

[22] See note 13.

[23] See note 16.

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