THE MEANING OF IMMIGRANT WOMEN’S EXPERIENCE OF CHILDBIRTH FOR THE FIRST TIME IN A UNITED STATES HOSPITAL

A Dissertation
Presented to the Faculty of the
School of Nursing
Widener University

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
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School of Nursing

December 2018
School of Nursing

Title of Dissertation: The Meaning of Immigrant Women’s Experience of Childbirth for the First Time in a United States Hospital

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Date: December 7, 2018

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
Dedication

I would like to dedicate this work to the immigrant mothers who openly shared their childbirth experiences with me. Your strength and courage are admirable. Your stories will contribute to the care of countless other immigrant women.

I would also like to dedicate this work to my husband, Carl. Without your constant support, this accomplishment would not have been possible.

Finally, I dedicate this work to my Lord and Savior Jesus Christ, without whom nothing is possible and through whom I can do all things.
Acknowledgements

Throughout this long journey, the ongoing support of many individuals have made this accomplishment possible. I would like to thank and acknowledge my dissertation committee, Drs. Anne Krouse, Esther Brown and Mary Anne Peters. My sincerest gratitude to each of you for your patience, guidance and encouragement. I have learned so much with your guidance and support. I would also like to thank my readers, Drs. Normajean Colby and Lorraine Igo for your time and constructive feedback. I am grateful for your assistance.

My sincere gratitude to Dr. Jane Tang. Your assistance, support and prayers have made it possible to complete this work. Thank you to Dr. Mary Baumberger-Henry for your assistance in the recruitment phase.

Thank you to my husband, Carl, and daughters, Melanie and Faith, who have loved and supported me throughout this journey. You are my greatest treasures on this earth.

I would also like to thank my dear friend, Irene. You have blessed me and encouraged me, faithfully prayed for me, and have made the completion of this journey a reality through your generosity. May God richly bless you.
Abstract

The increasing population of immigrants in the United States is largely comprised of immigrant women, whose first contact with the health care system is often to seek maternity care. The literature suggests that immigrant women frequently do not receive the same quality of care and satisfactory experiences from maternity care as their native population counterparts. This study described the experience of maternity care from the perspective of immigrant mothers who gave birth in the United States for the first time. A purposive sample of mothers, who were born outside of the United States, and who have given birth to a baby within the past year, were interviewed in person by the researcher. Using an interpretive descriptive design, the data were analyzed for emergent patterns and themes. The three themes that emerged were: perceptions of support, feeling vulnerable, and respecting my cultural preferences. The study’s findings hold significance because of their potential to impact the nursing care of this rapidly expanding immigrant population. This study contributes to the existing body of knowledge about how immigrant women in the United States perceive their maternity care experiences.
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Chapter 1
Introduction

Global migration has dramatically increased in recent years, resulting in a rapidly rising immigrant population in the United States (Migration Policy Institute [MPI], 2015a). The influx of immigrants to the United States has resulted in a significant rise in foreign-born women giving birth in this country (MPI, 2015a). Immigrant women bring their cultural beliefs and practices related to pregnancy and childbirth to their new country. The experience of childbirth in the United States may be confusing to foreign-born mothers and may conflict with their cultural practices and beliefs. In the United States, most births occur in the hospital, where medical interventions such as Cesarean sections, epidural anesthesia, and induction/augmentation of labor are becoming more commonplace (Brown, Carroll, Fogarty, & Holt, 2010). Since most cultures view childbirth as a natural process, these medical interventions may be viewed negatively by immigrant women and may result in avoidance or refusal of maternity care (Lewallen, 2011).

The literature supports that immigrant women face barriers to equity in maternity compared with non-immigrant women in the United States. These barriers include low socioeconomic status, inadequate information to make informed choices, and communication difficulties with health care providers (Merry, Small, Blondel, & Gagnon, 2013; Small et al., 2014). These cultural and social factors place immigrant mothers at greater risk for maternal and newborn health complications, resulting from inadequate maternity care, or avoidance or refusal of care (Lewallen, 2011).
The American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), and Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) recognize the need to provide maternal-child care that is culturally competent and modified to the unique cultural needs of each client (Cooper, Grywalski, Lamp, Newhouse, & Studlien, 2007). Modifying maternity care practices to incorporate the cultural needs of immigrant women may increase compliance with prenatal and perinatal health care, resulting in healthier maternal and newborn outcomes.

The focus of this study was to describe the experiences of immigrant women from diverse cultural backgrounds, in their perceptions of their labor, delivery, and postpartum recovery experience in a United States hospital. This investigation may add to the understanding of how to best meet the health care needs of culturally diverse populations during the perinatal hospitalization period. By adding to the existing knowledge about the potential barriers to healthcare equity faced by immigrant women, this study may lead to better understanding of the healthcare services received by immigrant women giving birth in United States hospitals. The analysis of the data may inform clinical nursing care of culturally diverse patient populations, enhancing the provision of more culturally appropriate and equitable care.

**Background**

**Demographics**

The United States had an estimated 41.3 million immigrants living in the country in 2013, representing 13 % of the population (MPI, 2015b). Immigrant women comprise 51 % of the nation’s foreign-born population, totaling an estimated 21.2 million people
(MPI, 2015b). The Migration Policy Institute (MPI) uses the terms “immigrant” and “foreign-born” interchangeably to describe people born without U.S. citizenship. Included in this population are refugees and those seeking asylum, lawful permanent residents, naturalized citizens, persons with temporary visas, and unauthorized aliens (MPI, 2015b).

The U.S. Census Bureau reported that foreign-born mothers accounted for 20% of the 4.3 million annual births in this country from the 2010 census (U.S. Census Bureau, 2012). With recent events in the Middle East and the influx of refugees from war-torn countries like Syria, these numbers may increase dramatically. The United States has resettled 18,000 Syrian refugees between October 1, 2011 and December 31, 2016 (MPI, 2017). This refugee population, alone, will bring more foreign-born mothers to seek maternity care services in their new country.

While patient populations become more diverse, the nursing workforce remains predominantly White/non-Hispanic. According to a 2013 survey conducted by the National Council of State Boards of Nursing (NCSBN) and The Forum of State Nursing Workforce Centers, the registered nurse (RN) workforce is comprised of 83% White/Caucasian nurses (AACN, 2015). The cultural differences between nurses and their patients from diverse backgrounds can affect the nurse-patient relationship, and ultimately lead to disparities in the provision of equitable care (Ardoin & Wilson, 2010; Institute of Medicine [IOM], 2013).
**Barriers to Health Care Equity**

Immigrant women giving birth in a foreign country face challenges including disparities in health care options, cultural biases from their health care providers, and childbearing risks associated with low socioeconomic level, high stress levels, and lack of family support (Merry et al., 2013; Small et al., 2014). Language and communication difficulties between the women and healthcare providers, lack of adequate information and options for care, and disregard for their cultural preferences are some of the factors cited by immigrant women that negatively affected their birth experiences in foreign hospitals (Small et al., 2014).

The Department of Health and Human Services (USDHHS) Office of Minority Health has acknowledged that healthcare disparities in the nation exist among culturally diverse populations, and the provision of culturally and linguistically appropriate services (CLAS) is important to reducing disparities in care (USDHHS, 2015). Healthy People 2020 defines *health disparity* as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage” (USDHHS, 2015, p.7). People who have experienced obstacles to health care services due to ethnicity or race, socioeconomic status, or religion are among those adversely affected by health disparities. Healthcare professionals can help bring about positive health outcomes by aligning services with the individual's cultural and language preferences. According to the national CLAS standards, “the provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes” (USDHHS, n.d., p.1).
Patient-centered care

The provision of patient-centered care has been recognized as an important factor in meeting the needs of diverse patients. Nursing and healthcare organizations have cited patient-centered care as necessary for improving the quality of and satisfaction with care. The Quality and Safety Education for Nurses (QSEN) Institute defines patient-centered care as that which “recognizes the patient as the source of control and full partner in providing compassionate and coordinated care, based on respect for their preferences, values, and needs” (QSEN, 2014, http://qsen.org/competencies/pre-licensure-ksas).

The QSEN (2014) competencies for providing patient-centered care are based on the combination of nurses’ knowledge, attitudes, and skills. According to the competencies, nurses need to understand how diverse cultural, ethnic, and social backgrounds shape patient and family values. Active involvement of patients and families in their healthcare can improve the quality, cost effectiveness, and safety of their care. In order to provide care that is sensitive to, and respectful of human diversity, nurses should examine their own personal attitudes about caring for patients from diverse backgrounds. Additionally, nurses should seek learning opportunities with patients from diverse backgrounds and value active partnership with patients in providing care. In order to reduce barriers to patients’ active involvement in their care, patient preferences and the preferences of their families or designated surrogates must be considered (QSEN, 2014).

The Institute of Medicine (IOM) has also acknowledged the importance of partnering with patients in order to provide informed, shared care decisions. According
to an IOM 2013 report, “Evidence strongly indicates that when patients are fully informed and engaged in making decisions about their care, patient satisfaction goes up, results improve, and health care costs go down” (IOM, 2013). The report further states that “prepared, engaged patients are a fundamental precursor to high-quality care, lower costs, and better health” (IOM, 2013). While the report did not specify how healthcare costs are decreased, the implication is that patient-centered care results in overall benefits that include economic savings through better use of healthcare resources.

With the increasing number of immigrant women giving birth in U.S. hospitals, it is important for nurses to understand the cultural factors associated with each patient’s perception of maternity care. This understanding may lead to clearly communicated information which would help patients to make informed choices, and to the provision of safe care that is individualized to women’s needs (Lewallen, 2011).

**Cultural Sensitivity**

The American College of Obstetricians and Gynecologists (ACOG) cited the need for cultural sensitivity on the part of healthcare providers in overcoming the language and cultural barriers that can lead to unsafe care. Lack of cultural sensitivity of healthcare providers is cited by ACOG as one of the reasons that many immigrant groups receive no medical care, or receive inadequate medical care (ACOG, 2011).

The Joint Commission (TJC) considers effective communication and cultural competence to be necessary components of safe, quality health care (TJC, 2010). The process of cultural competence encompasses the cultural skills, knowledge, and awareness gleaned from cultural encounters and driven by cultural desire, that can bridge
the gap between patients’ worldviews and the nurse’s worldview (Campinha-Bacote, 2011; Purnell, 2005). The provision of culturally competent care to immigrant women during childbirth can reduce the barriers that prevent them from receiving the same safe, holistic care as non-immigrant women (Small et al., 2014).

**Research Gaps**

Despite the statistics that show that birth rates in the Western Hemisphere among immigrant women can exceed one-fifth of all births in some countries, there have been relatively few population-based studies in Western Hemisphere countries focused on the women’s experiences of their maternity care (Merry et al., 2013; Small et al., 2014). The majority of studies conducted on experiences with care have been from the United Kingdom and were based on secondary analyses. Studies of immigrant women’s birth experiences in the United States tended to focus on one ethnic minority group, Somalian immigrants (Brown et al., 2010; Hill, Hunt & Hyrkäs, 2012).

Immigrant women often belong to minority ethnic groups. Women from minority ethnic groups have been linked with poorer childbirth outcomes than their White counterparts in developed countries of Europe and North America. Henderson, Gao, and Redshaw (2013) reported significantly higher mortality rates in the United Kingdom among Black African women, higher numbers of low birth weight (<2500 g) babies among mothers born in South Asia, and higher incidence of very low birth weight (<1500 g) babies among mothers born in West Africa and the Caribbean. Lack of access to prenatal care is thought to be one possible link between ethnicity and poor perinatal
outcomes, since women from minority ethnic groups tend to have fewer prenatal care visits and less prenatal testing performed (Henderson, Gao, & Redshaw, 2013).

A review of the literature has demonstrated that lack of understanding about how to access health care, cultural beliefs about obtaining prenatal care, and women’s stress related to separation from family and lack of support contribute to immigrant women’s poorer birth outcomes (Chalmers, 2012; Collins, Zimmerman, & Howard, 2011; Henderson et al., 2013; Small et al., 2014). Previous studies have also concluded that maternity care practices, such as rooming-in with the newborn after birth and initiation of breastfeeding immediately after birth, may not align with the cultural beliefs of immigrant mothers, therefore affecting their experience of childbirth (Wikberg & Bondas, 2010). The nurse-patient relationship has also been shown to play a significant role in women’s perceptions of maternity care provided. Nurses who have demonstrated flexibility in providing care, respecting or incorporating the cultural beliefs of new mothers, were cited by immigrant patients as providing more satisfactory experiences (Wikberg & Bondas, 2010; Wikberg, Eriksson, & Bondas, 2012). Studies regarding immigrant women’s perceptions of their maternity nursing care experiences in the United States were not found in the literature.

**Statement of the Problem**

The impact of global migration on the rising number of immigrant women who give birth in the United States necessitates the delivery of maternity care that meets the needs of these women. Since childbirth is a cultural phenomenon, shaped by the learned beliefs and practices of the mother’s culture, it is important that nurses are culturally
aware and culturally knowledgeable about tailoring maternity nursing care to their patients’ beliefs (Cooper et al., 2007). Qualitative studies aimed at understanding immigrant mothers’ perceptions of their maternity care experiences are needed to add to the knowledge of how to best meet the needs of patients from diverse cultural backgrounds.

Research studies aimed at describing the maternity care experiences of immigrant women have been conducted primarily in countries outside of the United States (Henderson et al., 2013; Jomeen & Redshaw, 2013; Lee et al., 2014; McFadden, Renfrew, & Atkin, 2012; Small et al., 2014). In the United States, relatively few studies describing immigrant women’s experiences of maternity care have been completed, and no studies appear in the literature related to the labor, delivery, and postpartum care experiences of immigrant mothers. The review of the literature found only three studies related to immigrant women’s experiences of childbirth in the United States (Brown et al., 2010; Hill et al., 2012; Kang, 2014). There is a paucity of studies concerned with the hospital maternity care experiences of multiple immigrant population groups.

In order to ensure that barriers to healthcare equity and patient-centered care are addressed and minimized, it is critical for nurses and healthcare professionals who care for patients from diverse backgrounds, such as immigrant mothers, to become aware of these barriers and strive to reduce them as much as possible (ACOG, 2011). More research into the perceptions of immigrant women about the maternity care services they received, and what barriers they faced, is needed to improve both the quality of and satisfaction with healthcare.
Purpose of the Study

The purpose of this research was to describe and find meaning in immigrant women’s maternity care experiences during the birth of a child for the first time in a U.S. hospital. The descriptions of the participants’ experiences were analyzed for patterns of shared experiences and interpreted for common meanings. The interpretive description of these experiences adds to the understanding of this clinical phenomenon and informs nursing practice related to the care of immigrant populations (Thorne, 2008).

The Research Questions

The first research question was: “What are the experiences of immigrant women who give birth for the first time in a U.S. hospital?” This study also explored “What are the patterns of meaning among immigrant women’s childbirth experiences in a U.S. hospital?”

Definitions of Terms

The major terms used in this study are childbirth experience, immigrant women, and hospital.

- *Childbirth experience* in this study will refer to the women’s perception of the labor, delivery, and recovery events during the birth of a living child (Murray & McKinney, 2014).

- *Immigrant women* in this study refers to women, ages 18 and older, who were born in a country other than the United States, and are either currently residing in, or visiting the United States for a period of five years or less at the time of their child’s birth.
• **Hospital** is defined by the World Health Organization as “health care institutions that have an organized medical and other professional staff, and inpatient facilities, and deliver medical, nursing and related services 24 hours per day, 7 days per week” (WHO, 2015).

**Interpretive Description**

Interpretive description has been chosen by this researcher to frame the study and analyze the data collected. “Interpretive description is a qualitative research approach that requires an integrity of purpose deriving from two sources: (1) an actual practice goal, and (2) an understanding of what we do and do not know on the basis of empirical evidence” (Thorne, 2008, p. 35). The focus of interpretive description is on the subjective human health experience of clinical phenomena for the purpose of generating “new insights that shape new inquiries as well as applications of ‘evidence’ to practice” (Thorne, 2008, p. 35). The knowledge gained through interpretive description is not intended to generate theory, but rather to increase contextual understanding of the phenomenon in order to guide future clinical decisions (Thorne, 2008).

Interpretive description is built on the naturalistic inquiry methodology described by Lincoln and Guba (1985). Naturalistic inquiry suggests the study of phenomena holistically, through inquiry into the multiple realities experienced by human beings interacting with the phenomenon. The conduction of the research in the natural context in which the phenomenon occurs, inclusion of the researcher as a “human instrument” of the data collection process, and the use of qualitative methods for inquiry into the
multiple realities of participants utilized in interpretive description align with the axioms of naturalistic inquiry (Lincoln & Guba, 1985, p. 39).

The foundational underpinnings of interpretive description are philosophically consistent with naturalistic inquiry and constructivism, utilizing an inductive approach to the study of human phenomena. Human health experiences are viewed as socially constructed events, which are shared and shaped by all of the individuals involved in the phenomenon. Interpretive description holds that the socially constructed elements of human experiences are inseparable from the phenomenon’s core nature (Thorne, 2008, p. 74). In this study, the researcher strived to gain understanding of the meaning of immigrant women’s birth experiences through reporting their experiences in order to capture these multiple constructed realities of the phenomenon.

Interpretive description research acknowledges the value of both subjective and experiential knowledge in the development of clinical insight (Thorne, 2008). Consistent with naturalistic inquiry, the “knower” and the “known” are viewed as inseparable from one another, meaning that the phenomenon itself is shaped by the individual experiencing it (Lincoln & Guba, 1985; Thorne, 2008). Interpretive description further holds that there are both commonalities and “individual expressions of variance” within a shared experience (Thorne, 2008, p. 74). The collection of data through open interviewing in this study allowed the participants’ own views of the hospital birth experience to be reported. Data analysis attempted to capture both the commonalities and variances of their experiences.
Thorne (2008) uses the term “interpretive authority” to describe how qualitative researchers can enhance the credibility of their findings. Interpretive authority refers to the ability of the researcher’s interpretations to “illustrate or reveal some truth external to his or her own bias or experience” (Thorne, 2008, p. 225). The essence of interpretive description is to capture the meanings of personal health experiences, including the symbols which contribute to the constructed understanding of them.

An atheoretical approach to the research design has been chosen for this study in order to allow the data to drive the interpretation of the phenomena. Interpretive description eschews an *a priori* theoretical approach to the data, since entering the study with *a priori* theory does not allow the researcher to encompass the multiple realities of humans experiencing the same phenomenon (Thorne, 2008). This researcher believed that approaching the investigation without a theoretical lens before data collection and interpretation allowed a more robust analysis of participants’ meanings of the phenomenon. The results of data analysis were then examined for the presence of theoretical linkages with one or more theory.

**Researcher’s Background**

I have practiced as a staff nurse on a maternal-child health unit for the past 24 years. My roles included delivering nursing care to pregnant mothers hospitalized for high-risk pregnancies, recovering new mothers from childbirth on the postpartum unit, and providing care to well newborns in the nursery. During those years, the demographics of the women giving birth in a community hospital have shifted, from
predominantly White females to women of diverse ethnic and cultural backgrounds, including many recent immigrants from other countries.

In my practice, I have encountered both challenging and enlightening experiences while caring for immigrant families at the time of birth. The sociocultural beliefs and practices of women surrounding childbirth experiences have been observed in their preferences for labor and delivery care, as well as gender of health practitioners and support persons present for the birth. Circumcision of male babies, naming the newborn, and beliefs about breastfeeding are also influenced by the cultural beliefs of parents. Through the provision of nursing care to culturally diverse patients and their families, I have developed interest in learning more about cultural beliefs related to pregnancy, childbirth, and recovery. The works of Madeline Leininger, studied during my Master of Science in Nursing program, sparked further interest about providing culturally congruent care to all patients.

In addition to maintaining my staff nurse position in maternity nursing, I continue to serve as an adjunct professor in a university school of nursing, teaching maternal-child nursing in the clinical setting and both laboratory and didactic courses at the undergraduate level for the past seven years.

**Researcher’s Worldview**

As a follower of Jesus Christ, I ascribe to a Christian worldview that includes the nursing metaparadigms of person, health, environment, and nurse (Fawcett, 1995). The Christian worldview of nursing’s metaparadigm includes God as the creator of the world
(environment) and human beings (persons). Nursing strives to promote health among individual persons and the community (Shelly & Miller, 2006).

In the Christian worldview, God created human beings in His own image (Gen. 1:26 New International Version). Each person is holistically viewed as a spiritual being, with a mind, will, and emotions housed in a physical body. We are loved by God, and those who love God are expected to love one another (1 Jn 4:7-8). Loving others, and putting the needs of others before my own, has guided my personal life and my professional nursing career.

In accordance with the Christian worldview of nursing, I believe that nursing is a ministry. This ministry includes the compassionate care of the whole person, the promotion of health, and the comforting of the suffering and dying. The ministry of nursing is providing compassionate care for anyone in need, regardless of their race, ethnic identity, age, gender, social status, or ability to pay (Shelly & Miller, 2006).

**Researcher Assumptions and Biases**

**Assumptions**

- Immigrant women from other cultures will express beliefs and practices about childbirth related to their cultural backgrounds, and they will have expectations about childbirth from these cultural backgrounds (Chalmers, 2012).

- Immigrant women want to receive culturally appropriate care during their hospitalization, including the ability to give birth in accordance with their own cultural practices and beliefs (Brown et al., 2010).
Acculturation is the adaptation of individuals to the customs, language, attitudes, and behavioral norms of a cultural in which they are living (Fuentes-Afflick, Odouli, Escobar, Stewart, & Hessol, 2014). The process of acculturation occurs over time, increasing with length of time spent living among the new culture.

The ability to recall the details of an experience, such as childbirth, tends to fade over time. The selection of participants who have given birth within the past 12 months will allow for greater recall of the phenomenon.

Biases

- Immigrant women will report that they experienced barriers to receiving adequate maternity care services.
- The participants’ report of their childbirth experience will differ from their expectation of giving birth in a U.S. hospital.
- Immigrant women will report that the nursing staff during their hospital stay was not as supportive of their cultural beliefs and practices related to childbirth as they expected.

Significance of the Study

In light of the burgeoning immigrant population in the United States, it is important that nurses gain awareness of how to meet the healthcare needs of patients from diverse cultural backgrounds. This study focused on immigrant women’s maternity care during childbirth, in order to reduce the barriers to receiving equitable maternity care services faced by immigrant mothers in the United States. The provision of more
culturally competent and patient-centered maternity care will improve patient satisfaction, compliance with prescribed care, and cost effectiveness of healthcare.

**Nursing Science and Research**

Practice theories aimed at meeting the cultural needs of immigrant women during childbirth are absent from the current body of nursing knowledge. The findings from this study may serve as a foundation for developing practice theories for the culturally competent care of immigrant women, especially during the perinatal period. The study will add to the existing literature about immigrant women’s experiences of maternity care. At the conclusion of the study, the findings were linked with existing nursing theory related to the provision of culturally competent care, thereby contributing to clinical applications of nursing theory.

Research concerned with improving maternal and newborn outcomes in immigrant and other minority populations is sparsely represented in the literature. Previous studies have identified disparities in maternity care services provided to immigrant women (Henderson et al., 2013; Lee et al., 2014), and demonstrated the impact of patient satisfaction on compliance with prenatal and postpartum healthcare services (Hill et al., 2012; Small et al., 2014). This study will add to the existing literature about improving the maternal and newborn outcomes of immigrant women in the United States, through the description of the women’s perceptions of their experiences. Additionally, the findings will lead to implications for further research into meeting the needs of immigrant and other minority women’s maternal and newborn healthcare needs.
Improving patient satisfaction with care and minimizing risk factors for maternal and newborn outcomes is of prime importance in meeting the needs of immigrant women, as reflected in the literature. This study’s findings will have clinical implications for improving immigrant patients’ satisfaction with the maternity care they receive through informing nurses about what women experienced during childbirth. It will add to nurses’ understanding of immigrant women’s perceptions of their experiences, as well as their expectations and cultural beliefs. The literature reviewed for the study will add to nurses’ understanding by reflecting the barriers to receiving equitable care, and the higher risks for perinatal complications faced by immigrant mothers and their newborns.

The findings from this study will build an awareness of the need for nurses to become more culturally competent, in order to meet the needs of the increasing immigrant population. Awareness of the unique needs and desired care practices of immigrant women is necessary in order to improve cultural competence in the care of diverse populations, strengthen communication, and improve patient satisfaction with care. Cultural awareness and understanding are important to strengthening the nurse-patient relationship, and to facilitate the provision of culturally appropriate, safe nursing care (ACOG, 2011; Small et al., 2014; Ardoin & Wilson, 2010).

The study findings will contribute to nursing administration decisions about patient care delivery. The Institute of Medicine (IOM) reported that “evidence strongly indicates that when patients are fully informed and engaged in making decision about their care, patient satisfaction goes up, results improve, and the health care costs go
down” (IOM, 2013, p. 1). The IOM (2013) further emphasizes the need for building trust and understanding with patients, along with clear communication to improve the quality of the care experience and better utilize available resources for patient care.

Nurse midwives and women’s health nurse practitioners will also benefit from the evidence generated from the qualitative study of immigrant mothers’ maternity experiences. The mothers’ descriptions of their birth experiences will guide midwives and nurse practitioners in planning and providing more culturally appropriate care during the labor, delivery, and postpartum periods.

**Nursing Education**

This study will add to pre-licensure nursing faculty’s understanding about caring for the expressed needs of multicultural patients, facilitating innovative approaches to curricula addressing these needs. The study’s findings will assist in planning simulations that incorporate strategies for improving the quality of nursing care to culturally diverse women, particularly during the perinatal period. Nursing students may increase their cultural competence through practicing communication with culturally diverse patients in simulation scenarios, and through planning effective care strategies that overcome cultural barriers.

**Continuing education.** Continuing education programs are needed to add to the cultural awareness and understanding of nurses about meeting the needs of an increasingly diverse population. The findings from this study may contribute to the development of continuing education programs aimed at meeting the cultural needs of immigrant, and other culturally diverse women, during childbirth. Additionally, the
findings may contribute to the development of clinical competencies for the care of immigrant women during childbirth. Clinical competencies are needed at the institutional and professional nursing organization levels in order to impact the quality and safety of the care of culturally diverse patients.

**Chapter Summary**

In this chapter, the implications of increasing numbers of immigrant populations in the United States on the delivery of maternity care have been introduced. The health care disparities often faced by culturally diverse immigrants have been discussed and will be further detailed in the literature review.

The purposes of this research were to describe and find meaning in immigrant women’s maternity care experiences during the birth of a child for the first time in a U.S. hospital. The research questions were: a) “What are the experiences of immigrant women who give birth for the first time in a U.S. hospital?” and b) “What are the patterns of meaning among immigrant women’s childbirth experiences in a U.S. hospital?”

The significant terms *childbirth experience, immigrant women, and hospital* have been defined for the purposes of this study.

The background and worldview of this researcher have been described in this chapter. The researcher acknowledges the potential impact of these influences on the collection and analysis of data in the study. The selection of interpretive description as the approach for conducting the research will incorporate the researcher as human instrument, with disclosure of these biases on interpretation of the data. The researcher’s assumptions about the study sample and research questions have been outlined and
include the assumption that immigrant women hold culturally acquired expectations about childbirth. The main researcher bias regarding the study findings is that these expectations about childbirth are not always met during their hospital birthing experiences.

This qualitative study of immigrant women’s experiences will enhance the understanding of the barriers to receiving equitable maternity care services faced by immigrant mothers in the United States. Reporting the perceptions of their childbirth experiences will contribute to the understanding of how to provide more culturally competent, patient-centered care. The findings from this study will influence clinical nursing practice, contributing to the standards of practice and delivery of nursing care to the growing population of immigrant mothers. The potential implications for nursing science, nursing research, and nursing education have been suggested.
Chapter 2

Literature Review

The purposes of this research were to describe and find meaning in immigrant women’s maternity care experiences during the birth of a child for the first time in a U.S. hospital. The descriptions of the participants’ experiences were analyzed for patterns of shared experiences and interpreted for common meanings. The interpretive description of these experiences adds to the understanding of the clinical phenomenon and informs nursing practice related to the care of immigrant populations (Thorne, 2008).

This chapter will highlight the role that culture plays in maternity care experiences, the barriers to receiving equity in maternal care, and the reported perceptions of immigrant mothers about their maternity care experiences. Literature concerned with women who gave birth outside of their native country provides compelling support for caregivers to understand how these women interpret the experience in light of their own worldviews.

Search Strategies

Using a computerized electronic database approach, the following databases were included in the search: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Nursing and Allied Health, Medline, and Academic Search Premier. The search was limited to peer-reviewed, professional journals from the years 2005 through the present in order to obtain articles related to the research topic. Articles published between 2007 and 2015 were selected for review, based on the availability of relevant literature to the research topic in the most current time frame.
Key words and search terms for conducting the search were “maternity care and culture,” “culture and competence,” and “culture and safety.” From the key words “maternity care and culture,” a total of 21 articles which met the inclusion criteria were reviewed, and 18 articles were found by the researcher to be the most relevant to the nursing care of immigrant women during labor, delivery, and immediate postpartum recovery. The keywords “culture and competence” resulted in the selection of only two of the articles, based on relevance to the nursing care of immigrant populations during childbirth. Six articles related to the key words “culture and safety” were selected for their contributions to the safe delivery of care to diverse patient populations.

**Immigrant Women’s Experiences of Maternity Care Services**

The 18 articles selected for inclusion in the review of the literature were organized into two main categories, immigrant women’s experiences of maternity care services, and patient safety in relation to cultural diversity. Immigrant women’s experiences of care were examined according to maternity care services that were patient-centered and equitable with care provided to non-immigrant populations. Patient-centered care was further organized into immigrant women’s perceptions of their maternity care experiences, their satisfaction with their maternity care experiences, and the provision of more culturally competent maternity care. Healthcare equity articles addressed the factors that often predispose immigrant women from receiving the same maternity care as non-immigrant women. The second main category, patient safety and cultural diversity, reflected on the positions of global, medical, and nursing professional organizations on ensuring that culturally diverse patients receive healthcare that is safe.
Patient-centered care

Active involvement of patients and families in their healthcare can improve the quality, cost effectiveness, and safety of their care (QSEN, 2014). The literature about the maternity care of immigrant women suggested that patient-centered care was desired by mothers, and their perceptions of the degree in which care was patient-centered affected their experiences.

Experience of maternity care. Several of the articles selected for review discussed women’s perceptions of their maternity healthcare experiences. Small et al. (2014) conducted a systematic literature review of 22 studies related to immigrant and non-immigrant women’s experiences of maternity care across five countries. The questions for review were “What do women want from their maternity care?” and “How do immigrant and non-immigrant women’s experiences and ratings of care compare?” Studies of immigrant women’s experiences of maternity care in Australia, Canada, Sweden, the United Kingdom, and the United States were included in the review. Electronic databases, including Ovid, CINAHL, and Medline, were searched for population-based studies of both immigrant and non-immigrant women. A descriptive thematic analysis was conducted on the extracted data (Small et al., 2014).

Both immigrant and non-immigrant women shared the same desires about their maternity care. The mnemonic ‘QUICK’ was used to describe the desired aspects of their care: (a) quality care with a focus on individual needs, (b) unrushed caregivers who spend time giving information and support, (c) involvement in decision-making, (d)
continuity of care from caregivers, and (e) kindness and respect (Small et al., 2014, p. 152). Less satisfaction with care was reported by immigrant women from countries where English was not the principal spoken language. These women were found to have more difficulty obtaining the information and support necessary for satisfactory care. Communication difficulties were cited as a significant issue in all of the studies, affecting the relaying of information that participants felt necessary for decision-making. The participants stated that they felt unfamiliar with how maternity care was provided in their new countries and were made to feel unwelcome when presenting to the hospital in labor (Small et al., 2014).

One of major strengths of the Small et al. (2014) literature review was the inclusion of studies collected over 24 years from five countries, with over 55,000 women included in the samples. The importance of clarity in communication with immigrant women was well-illustrated in the article. During the vulnerable period of childbirth, the need for information that is both clear and useful to the new mother is essential. The ‘QUICK’ mnemonic is a useful tool for caregivers to provide care that is more satisfactory to all patients. A finding from Small et al.’s review of the literature was the limited number of population-based studies of immigrant women’s experiences of their maternity care published globally. Relatively few countries have undertaken such studies, and only one of the included studies utilized multiple languages to include non-English speaking immigrants.

An examination of the childbirth practices that are common in various world cultures is beneficial to understanding the perspective of immigrant women born in these
countries. Chalmers (2012) examined the findings from surveys of women's reports of their labor and birth experiences, collected across seven countries. The purpose of the secondary analysis of the literature was to compare and contrast mothers’ labor and birth experiences in different parts of the world. The findings from 10 surveys, conducted from 1995 through 2006, were examined for similarities in demographics and birth practices. The surveys were conducted in Canada, the United States, the United Kingdom, Azerbaijan, Lithuania, Moldova, and the Russian Federation. The article did not discuss the instruments used for the surveys but concentrated on comparing the findings related to labor and birth in the different countries.

The surveys were completed by mothers after the birth of a baby, from the first few days after birth to within the first year after birth. Samples for the surveys were drawn through stratified random sampling of national census data, random sampling of birth register data, and through voluntary online invitation, depending on the country. Data collection methods included computer-assisted telephone interviews, mailed questionnaires, online surveys, home interviews, and distribution of paper questionnaires, according to the study country. The mean response rate for all surveys was 74.8 %. The sample sizes, or total sample size (N) was not reported (Chalmers, 2012).

Hospital births were reported by 97 % of the sample, 79 % of which were vaginal births. Forty-eight percent of mothers reported being very satisfied with their birth experience (Chalmers, 2012). Medicalized treatments during labor and birth (induction of vaginal birth, electronic fetal monitoring, cesarean birth) were lowest in the former Soviet Union countries (Azerbaijan, Lithuania, Moldova, Russian Federation). The
presence of the mothers’ partners during labor was also lowest in these countries. Approximately one-third to one-half of mothers were induced for vaginal births. With the exception of Azerbaijan mothers, most mothers had electronic fetal monitoring of labor. The highest rates of induction, electronic fetal monitoring, epidural anesthesia for vaginal birth, and cesarean birth were reported in the United States and Canada.

The comparison of childbirth practices and patient satisfaction rates across cultures reflects the more medicalized approaches to labor and delivery in North American and United Kingdom hospitals, which contrasted with the more globally held belief that childbirth is a natural process (Chalmers, 2012). The failure to report the sample sizes of each survey, and the total sample, is a major limitation of Chalmers’ report. No discussion of the instruments used for data collection, or validity and reliability information, was provided. Satisfaction rates were generally high in most women surveyed. The researcher did not address the cause of the high satisfaction rates.

Immigrant women’s experience with their obstetrical care in the United States has been studied only in specific ethnic groups, rather than multicultural populations. Statistics from the United Nations Refugee Agency demonstrate that the third largest increasing refugee group in the United States, Canada, and other world countries is Somalis (Hill et al., 2012). Two studies conducted in the United States focused on Somali immigrants (Brown et al., 2010; Hill et al., 2012). The study by Brown, et al. (2010) focused on women’s satisfaction with their care and will be described separately.

The first reviewed study to describe immigrant women’s experiences with their maternity healthcare in the United States focused on the Somali population in Portland,
Maine. In a qualitative descriptive study, Hill et al. (2012) described the healthcare experiences and beliefs about pregnancy and birth of immigrant Somali women. Since 2009, there has been an influx of Somali refugees due to the unstable political climate, lack of humanitarian conditions, and traumatic living conditions in Somalia. A convenience sample of Somali women was recruited from an obstetrics and gynecology clinic in Portland. Participants were selected from women age 18 years or over, who were 20 weeks or greater in gestation, or who had delivered in the United States in the past two years and received prenatal care at the clinic. Data were collected through focus group interviews with the participants, regarding their healthcare experiences and birthing beliefs. The data were analyzed using thematic content analysis (Hill et al., 2012).

Six major themes were uncovered from the thematic content analysis: (a) “the natural experience of pregnancy; (b) value of prenatal care; (c) lack of familiarity and control with delivery; (d) conflicting desire to breastfeed with practical barriers and concerns; (e) discomfort with mental health issues; and (f) challenges in the system” (Hill et al., 2012, p. 75). The Somali participants reported their beliefs about pregnancy as a natural part of life and did not see the relevance of seeking prenatal care. The belief that pregnancy and childbirth are natural conditions led to a preference for home births over hospital deliveries. Furthermore, it was believed that C-sections are harmful to the health of the mother. Despite these beliefs, the participants reported being comfortable with their prenatal, birth, and breastfeeding experiences in the United States. Navigating the complex healthcare system was challenging for the women. The Western healthcare
procedures and information received by the participants were interpreted through their own worldview and cultural beliefs (Hill et al., 2012).

One of the strengths of the study by Hill et al. (2012) was the experience of the authors in working with Somali and other refugee populations. Two of the authors had 18 years of clinical nursing experience with these populations. The third author had expertise in qualitative research, particularly with the analysis of data from focus group interviews. The selection of thematic content analysis represented another strength, because of its concern with linking the underlying meanings of data into themes. The themes produced through the study’s analysis clearly reflected the culturally-based perceptions of the sample population. A limitation, however, may have been the variance in the participants’ fluency with English, requiring translation into Somali and back into English, with possible loss of meaning in the double translation process.

While the study by Hill et al. (2012) focused on one ethnic immigrant group, a descriptive quantitative study by Henderson, Gao, and Redshaw (2013) examined the use of maternity care services and women’s perceptions of their maternity care experiences across women from eight ethnic categories (White, Mixed, Indian, Pakistani, Bangladeshi, Black Caribbean, Black African, and Other). The “Mixed” category consisted of the following groups: White and Black Caribbean, White and Black African, White and Asian, Asian or Asian British, and any other mixed background. The authors conducted a secondary analysis of questionnaires from a 2010 national study in England (Henderson et al., 2013). The research question was “How do minority ethnic women’s experiences of maternity care differ from the experiences of White women?” The
purpose of the study was to examine the use of maternity care services, and women’s perceptions of maternity care, among mothers who self-identified as belonging to one of the ethnic groups. The sample consisted of more than 24,000 women, over the age of 16, who had recently given birth and were living in England in 2010. Using the national birth registry records, questionnaires in 20 different languages were mailed to 50,000 new mothers, for a response rate of 52 % \( N=24,319 \) (Henderson et al., 2013).

The questionnaire contained questions concerning antenatal care, labor and delivery, and postnatal care. The authors did not clarify whether they developed the instrument or used an existing one. No validity or reliability information was reported for the questionnaire. Women rated their experiences of care in each category on a 5-point Likert scale, ranging from “excellent” to “poor.” Logistic regression was used to compare the responses of each ethnic group with Whites, calculating odds ratios and 95 % confidence intervals (CI). The sample consisted of White respondents (80.9 %), Chinese or other (2.7 %), Black African (2.6 %), Pakistani (2.3 %), Indian (2.3 %), Mixed (1.2 %), Bangladeshi (0.6 %), and Black Caribbean (0.6 %) (Henderson et al., 2013).

The results of secondary analyses revealed that women in all of the minority ethnic groups reported a poorer experience of maternity care than White women. Antenatal care experiences were significantly less satisfactory in minority ethnic groups compared to White women, especially for women in the Pakistani and Other ethnicity groups (Pakistani \( n = 515 \), 87.1 %, \( aOR \) 0.54, 95% CIs [0.42-0.70]; Other ethnicity \( n = 1084 \), 91.2 %, \( aOR \) 0.80, 95% CIs [0.64-0.99]). Minority ethnic women reported being
less likely to have been spoken to in a way they could understand, being sufficiently involved in care decisions, and less likely to always receive the help they needed.

Perceptions about intrapartum care were significantly less likely to be rated as good by minority ethnic group women across all groups, compared to White women. Most notably, confidence and trust in staff, and clear communication were reported significantly lower among women from Pakistani and Bangladeshi groups (trust/confidence Pakistani $n = 549$, 93.8%, $aOR$ 0.61, 95% CIs [0.43-0.88]; Bangladeshi $n = 145$, 92.4%, $aOR$ 0.50, 95% CIs [0.27-0.92]; communication Pakistani $n = 558$, 96.2%, $aOR$ 0.60, 95% CIs [0.38-0.94]; Bangladeshi $n = 146$, 94.8%, $aOR$ 0.46, 95% CIs [0.22-0.97]) (Henderson et al., 2013).

Perceptions of postnatal care were also less positive overall for minority ethnic women, in comparison to White women. There were significantly poorer ratings reported among the Indian ($n = 481$, 84.5%, $aOR$ 0.67, 95% CIs [0.53-0.85]), Pakistani ($n = 485$, 82.6%, $aOR$ 0.61, 95% CIs [0.48-0.76]), Bangladeshi ($n = 122$, 76.7%, $aOR$ 0.42, 95% CIs [0.29-0.62]), Black Caribbean ($n = 126$, 79.7%, $aOR$ 0.54, 95% CIs [0.36-0.80]), and Other ethnicity groups ($n = 1010$, 86.3%, $aOR$ 0.75, 95% CIs [0.63-0.90]) (Henderson et al., 2013).

The findings from the Henderson et al. (2013) study of ethnic minority women reporting poorer maternity care experiences than White women during antenatal, intrapartum, and postnatal stages are consistent with the findings of two similar large studies reported by the authors (Jayaweera, Joshi, & Macfarlane, 2005; Raleigh, Hussey, Seccombe, & Hallt, 2010). The large sample size, and detailed breakdown by ethnic
groups contributed to the study’s strengths. Limitations of the study included the failure of the authors to report the validity and reliability of the instrument, the low response rate for ethnic minority women, failure of the authors to report levels of significance for the statistics, and lack of information about length of residence in the United Kingdom for ethnic minority respondents (Henderson et al., 2013).

A similar study of ethnic minority women’s experience of maternity care was conducted by Jomeen and Redshaw (2013). In contrast to the Henderson et al. (2013) study, Jomeen and Redshaw explored the maternity care experiences in England of Black and minority ethnic groups collectively. The descriptive qualitative study used secondary analysis to explore the perceptions and experiences of maternity care of Black and minority ethnic women. Using national birth registration records, a questionnaire and leaflet was mailed to 4800 women in England three months after they gave birth. The overall response rate was 63 %, with 13 % of respondents identifying themselves as belonging to Black or ethnic minority groups. The survey consisted of three open-ended questions: (a) “during labor and the birth of your baby, was there anything that you felt you needed in the way of support, help or information that you did not have; (b) if there was anything about your postnatal care in the hospital that you could change, what would it be; and (c) is there anything else you would like to tell us about your care?” (Jomeen & Redshaw, 2013, p.282)

A total of 219 women, who self-identified as Pakistani, Indian, Black African, Asian, Mixed White, Bangladeshi, Black Caribbean, Mixed Other, or Black Other, responded with open text to at least two of the survey questions. Themes identified from
data analysis were (a) “feeling cared for,” (b) “staff attitudes and communication,” and (c) “ethnicity and culture” (Jomeen & Redshaw, 2013, p. 283). A predominant theme of the participants was the need for sensitivity, reassurance, and care during the perinatal period. Participants’ perceptions reflected feelings of vulnerability and unmet support from hospital staff during labor, birth, and recovery. The women who reported unmet expectations often described staff as being “uncaring, unhelpful, and absent” (Jomeen & Redshaw, 2013, p. 292).

The findings from the Jomeen and Redshaw (2013) study demonstrate that ethnic minority women’s expectations of maternity care frequently differ from their perceptions of care received from hospital staff during childbirth (Henderson et al., 2010; Small et al., 2014). Being left alone by staff after the birth of the baby, having requests for support ignored or denied, difficulty with communication, and feeling disrespected resulted in a poorer experience of care. The sample size of 368 women who self-identified as coming from Black and minority ethnic groups is a major strength of the study (Jomeen & Redshaw, 2013). Limitations of the Jomeen and Redshaw (2013) study include the failure to report how trustworthiness of the findings was established, and lack of a specified methodology for approaching the data.

Individual immigrant populations were also studied regarding their experiences of maternity care services. Lee et al. (2014) explored the experiences of immigrant Chinese women in Toronto, Canada in accessing maternity care services, utilization of maternity services, and the perceived barriers to obtaining care faced by participants. In their descriptive phenomenology study, Lee et al. recruited a purposive sample of immigrant
Chinese women from the Chinese community in Toronto. Chinese immigrants represent the second largest immigrant population in Canada (Lee et al., 2014). The sample of 15 participants were interviewed using a semi-structured, one-on-one technique. The transcripts were analyzed using Colaizzi’s method, resulting in the extraction of six themes: (a) “preference for linguistically and culturally competent healthcare providers; (b) strategies to deal with the inconvenience of the Canadian healthcare system; (c) multiple resources to obtain pregnancy information; (d) the merits of the Canadian healthcare system; (e) the need for culturally sensitive care; and (f) the emergence of alternative supports and the use of private services” (Lee et al., 2014, p. 116).

The first theme, “preference for linguistically and culturally competent healthcare providers,” reflected Chinese immigrant women’s desire to receive maternity care from obstetricians who spoke their own language and were knowledgeable about their culture. Obstetricians were preferred over midwives, since many Chinese immigrants believe that obstetricians provide superior maternity care. The Canadian healthcare system presented several inconveniences to immigrants in accessing their preferred obstetricians, which differed greatly from the healthcare system in China. These inconveniences included lengthy transportation to access the physicians, and long wait times to see their physicians. The participants reported needing to access multiple resources in order to obtain sufficient information they felt they needed about pregnancy. Overall, Chinese immigrant women were satisfied with the care they received from their obstetricians. However, they reported that there was cultural insensitivity on the part of hospital maternity staff in providing their intrapartum and postpartum care. For example, ice
packs were applied to the perineum postpartum, which violates the Chinese belief that nothing cold should touch the mother after giving birth. Alternative supports and use of private services referred to the need for Chinese immigrant mothers to sometimes hire a “Yue-Sao” to help with caring for the home and baby after birth, since they were geographically separated from family and friends (Lee et al., 2014).

The strengths of the Lee et al. study (2014) included the use of a descriptive phenomenological methodology, in order to identify the barriers that immigrant women face in obtaining adequate prenatal and perinatal health care. The phenomenological approach allowed for immigrant women’s own stories regarding their maternity care experiences to be heard. Data collection was strengthened by one of the researchers being fluent in Mandarin, who conducted the interviews in the participants’ native language. Weaknesses of the study were the homogenous sample of well-educated participants, and failure to report how trustworthiness of the data was obtained.

The influence of cultural and community influences on immigrant women’s birth and perinatal care practices has been suggested from the previous literature in this review. Kang (2014) reported on these influences from the perspectives of doulas. Kang’s qualitative descriptive study was conducted among doulas, practicing in the state of Washington. Doulas are non-medically trained women who assist mothers before, during and after childbirth through physical comfort measures, emotional support, and assistance with infant care and feeding. The sample consisted of 11 professional doulas, with diverse cultural backgrounds and experience with culturally diverse women. The study aimed to describe the perspective of the doulas regarding cultural and community
influences on immigrant women’s birth and perinatal care experiences. Following the transcription of the personal audiotaped interviews, content analysis was used to identify themes. Trustworthiness of the data interpretation was enhanced through peer debriefing, negative case analysis, and consultation with a knowledgeable insider.

The doula participants identified “good” childbirth experiences as those which enabled mothers to make informed choices about care, use natural childbirth methods, and receive care from providers who made mothers feel respected and supported. The participants stressed the relationship of the ability of pregnant women to make decisions about their perinatal and birth care with having sufficient information about their options. Access to care options and information about perinatal services was greatly diminished by immigrant women’s low income status, poor health insurance coverage, and by differences in culture and language. Having maternity care providers who listened to mothers, communicated with them about their options, and honored their cultural practices was reported by participants as essential to positive experiences. The doulas also reported that immigrant mothers tend to interpret their childbirth experience through comparison to other women in their families or social networks (Kang, 2014).

Weaknesses of the Kang (2014) study included the vaguely described methodology, which did not provide any description of the sampling criteria or the interview questions. The researcher’s biases, due to her being an immigrant woman with a culturally diverse and non-healthcare background were acknowledged, but also may have contributed to weaknesses in interpreting the data. Data analysis of interview transcripts followed conventional content analysis. The researcher’s methods to ensure
trustworthiness of the data through peer debriefing, consultation with a knowledgeable insider, and a negative case analysis contributed to the strengths of the study.

**Satisfaction with maternity care.** The preceding articles were concerned with immigrant women’s experiences of their maternity care. Closely tied with the experience of care is the level of patient satisfaction with care. Three of the articles reviewed were concerned with immigrant women’s satisfaction with their maternity care. Patient satisfaction with care is a vital component of quality healthcare and is measured through standards such as HCAPS (Hospital Consumer Assessment of Healthcare Providers and Systems) to ensure that healthcare organizations provide the highest levels of satisfaction (Kerfoot, 2007).

Somali refugee women represent a growing immigrant population in the United States. Maternal-child health practitioners have recognized poor compliance with recommended medical procedures among this immigrant group, as well as reports of poor patient satisfaction with the maternity care they received. In a study to explore the sources of resistance to common prenatal and obstetrical interventions among Somali women, Brown et al. (2010) conducted an ethnography of Somali refugee women living in the Rochester, New York area. The study’s objectives were to explore elements of prenatal and obstetrical care, which could lead to dissatisfaction or resistance to care among immigrant Bantu and non-Bantu Somali women in Rochester, N.Y. The Bantu Somali group represents the largest resettled African refugee group, maintaining cultural, linguistic, and ethnic differences from other Somali refugees. The researchers also sought to explore previous birth experiences of the sample in Africa to ascertain whether
previous dissatisfaction could affect opinions currently. Additionally, the study sought to
determine if there were differences among the Somali groups in terms of dissatisfaction
or resistance to maternity care. The sample consisted of 44 Somali refugee women, over
the age of 18, who were born in Somalia but relocated to the Rochester area.

Data analysis and interpretation revealed an overarching fear of dying as a result
of having a cesarean birth from both participant groups. Participants described personal
knowledge of mothers who died in Somalia during cesarean births. The fear of death
resulted in most participants refusing to have cesarean sections. Participants also
reported that the medical interventions during labor, including induction and Pitocin to
hasten labor, were contrary to their beliefs of natural birth processes and God’s will
regarding the timing of delivery. Resistance to obstetrical care was often linked with the
conflicting desires of the women to allow ‘nature to take its course’ and clinicians to
‘speed things along’ (Brown et al., 2010, p. 225). Dissatisfaction with care was further
attributed to obstetrical practitioners not allowing Somali women to utilize traditional
birthing techniques to assist their peers during labor and delivery. The study found no
differences between the Somali groups in dissatisfaction or resistance to care factors.

The strengths of the Brown et al. (2010) study included the sampling techniques.
Recruitment of the sample was conducted through key informants, word of mouth, and
snowball technique to reach as many Somali refugee mothers in the area as possible.
Another strength in the collection of the data was the use of language interpreters during
the interviews, and for the review of transcripts. The authors provided adequate
description of the grounded theory approach for data analysis, checking for
trustworthiness through focus groups and triangulation of the data. Limitations of the study were acknowledged by the authors, and included possible reporting bias, possible participant bias (only women who had positive experiences may have chosen to participate), and limited potential for generalizability to other resettled Somali populations.

While the study by Brown et al. (2010) explored the perspective of satisfaction with maternity care in relation to sources of resistance to common interventions, another study looked at the nurse-patient relationship as a source of patient satisfaction. Wikberg and Bondas (2010) completed a meta-ethnography to explore intercultural caring in maternity care from a patient perspective. Meta-ethnography differs from other forms of qualitative meta-analyses in that it is an interpretive analytic process. The researcher compares, analyzes, and reports primary research findings, translating them into metaphors that are compared to metaphors from other studies. The result is the creation a new comprehensive interpretation of all of the studies (Paterson, Thorne, Canam, & Jillings, 2001). The aim of Wikberg and Bondas’ meta-ethnography was to “explore and describe a patient perspective in research on intercultural caring in maternity care” (Wikberg & Bondas, 2010, p. 2).

The Wikberg and Bondas (2010) study was framed by Wikberg and Eriksson’s (2008) intercultural caring model, in which a patient and nurse from different cultures form a mutual relationship to promote health and well-being. The intercultural caring model views the caring relationship between a patient and nurse from different cultures
as mutual but influenced by the acculturation of the patient and the nurse’s cultural background.

The sample consisted of 40 studies selected by the researchers for relevance to maternity nursing, caring/uncaring, and cross-cultural or transcultural nursing. Patients whose cultural backgrounds differed from their nurses reported both caring and non-caring behaviors from them. Caring behaviors included respect, kindness, attentiveness, and presence. Non-caring behaviors included not talking with or listening to patients, not asking, not informing, or leaving patients alone. Language and communication problems were described as barriers to perceived caring in almost all of the studies. Many women who experienced traumatic and painful situations in their homelands including torture, rape, circumcision, and maternal or infant mortality expressed feelings of vulnerability and loneliness during their birth experiences (Wikberg & Bondas, 2010).

The overarching metaphor of giving birth in a foreign country was described as being like “Alice in Wonderland,” where the women found themselves in a strange land of different views and communication barriers (Wikberg & Bondas, 2010, p. 10). Implications for improving intercultural care included increasing cultural knowledge of populations commonly served, using language interpreters and professionals with a working knowledge of clients’ cultures, and respecting cultural preferences to maternity care practices whenever possible.

One of the strengths of this study was the use of meta-ethnography to interpret the findings from 40 separate studies into a comprehensive understanding of the phenomenon (Wikberg & Bondas, 2010). The study reinforced the unique needs of each woman
during childbirth, stressing the need for caring and accepting attitudes on the part of the professional nurse when caring for patients from different cultural backgrounds. A limitation of the study was the inclusion of only seven articles conducted in the United States. Transferability of the findings from foreign studies to American settings could be a limitation of the small sample of U.S. studies.

In a similar study, Wikberg, Eriksson, and Bondas (2012) employed a focused ethnography design to describe and interpret foreign mothers’ perceptions of caring in Finland. The sample in their focused ethnography consisted of 17 new mothers from 12 countries, who experienced maternity care in Finland. Eriksson’s theory of caritative caring was used as the theoretical framework for analysis of the data. The theory holds that humans want to “experience love, hope, and faith through caring. Caring is seen as the core of nursing. Caring serves life by alleviating suffering and promoting health and well-being” (Wikberg et al., 2012, p. 639).

Although most of the participants in the study reported positive maternity care services, those reporting uncaring experiences fell into one of four themes. Some participants described tension between their expectations and their experiences of caring from Finnish maternity care providers. Unfamiliarity with the Finnish health care system, miscommunication between mothers and nurses who spoke different languages, and varying degrees of cultural knowledge and skills among nurses were cited as reasons for tension. The second theme revolved around the immersion of immigrant mothers into their new culture. Concepts of caring were viewed as cultural and subject to change as immigrants lived longer within the new culture (Wikberg et al., 2012).
Some participants felt that maternity care traditions of Finnish caregivers were imposed on immigrant mothers and affected their perceptions of caring. Personal expression of pain, expectations to room in with their infants, and independent care of themselves and their babies were examples given of imposed nursing traditions. In the fourth theme, participants stated that female nurses were seen as professional friends, who helped to resolve the conflicts encountered by them. This resulted in promotion of caring behaviors (Wikberg et al., 2012).

The major strength of the Wikberg, et al. (2012) study was the consistent use of Eriksson’s theory in extracting themes from immigrant mothers’ own perspectives about their birth experiences in a foreign country. Caring versus non-caring behaviors were clearly defined through the emergent themes and direct quotes from participants. Although it was conducted in Finland, it is conceivable that similar themes might emerge from immigrant mothers in the United States, where immigrants commonly encounter both caring and non-caring behaviors from maternity caregivers. A major limitation of the study was inconsistent use of translators when participants did not speak the same language as the interviewer, possibly leading to miscommunication of data.

**Cultural competence.** Recognizing that childbirth is a cultural phenomenon, the American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) have cited the need to provide maternal newborn care that is family-centered and culturally sensitive (AAP/ACOG, 2011). The Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN) stated that “culturally competent care must recognize and be aware of the cultural perspective of those who are
served. Providers must be willing to modify their treatment approach in order to provide care that is culturally acceptable to the client” (AWHONN, 2004, p. 5). Five articles concerning the provision of more culturally competent maternity care were selected for this review.

Coast, Jones, Portela, and Lattof (2014) conducted a systematic mapping of the literature in order to identify interventions that have been implemented to address the effects of cultural factors on women's utilization of maternity care services. Mapping the literature describes all of the literature relating to the research topic, in order to produce a coherent representation of the evidence available (Coast et al., 2014). The researchers searched ten electronic databases and two websites for published literature dated between 1990 and 2013. From 33,227 items extracted for screening, 96 items were selected for inclusion in the map.

The results of the map included literature from 35 countries, which were organized into five categories: service delivery models, service provider interventions, health education interventions, participatory approaches, and mental health interventions. Service delivery models describe measures designed to provide culturally-appropriate services for targeted cultural groups. These measures include adaptations to the service setting, practices, and language, as well as 21 other items. Service provider interventions are those targeting the providers of maternity health services, such as “peer health workers” to assist specific target populations with communication. Health education interventions are strategies aimed at designing health education activities that are culturally appropriate. Participatory approaches are interventions geared to include
participation of a population in designing interventions for addressing cultural factors. Mental health interventions are those designed to address the psychological effects of culturally dissatisfactory provision of healthcare services (Coast et al., 2014). A total of 96 items related to these intervention categories were included in the map. In the interest of remaining brief, the details of these items have been omitted, and only the categories described here.

Systematic mapping of the literature is a methodology used in the social sciences to study a broader scope of literature than a systematic review. The mapping included both empirical and anecdotal evidence and followed a protocol that was approved by a panel of method and content experts (Coast et al., 2014). The article provided clear descriptions of the search strategy, inclusion and exclusion criteria, and analytic processes. The authors acknowledged the conceptual challenges presented by the many definitions of “culture,” and by seeking what the interventions sought to address rather than what was done. The study by Coast et al. demonstrates that there is worldwide understanding of the importance of meeting the needs for maternity care services of women from all cultural and social backgrounds. As stated in the article, it is not simply a matter of making healthcare services available but bridging the gap between the cultural factors which prevent women from using the available services. The findings illuminate those interventions which have proved successful in specific contexts and highlight the existing gaps in the current literature. Interventions to improve usage of maternity care services that meet the cultural needs of pregnant women are the key to improving maternal and newborn outcomes for all women.
One of the most important nursing interventions in providing maternal-newborn care is providing breastfeeding support. Beliefs and practices regarding breastfeeding are culturally acquired and may be shaped by the nurse-patient relationship during hospitalization. In a qualitative study of Bangladeshi mothers and health care practitioners in the United Kingdom, McFadden, et al. (2012) explored breast feeding support experiences and the extent of cultural factors on these experiences. The sample included 23 Bangladeshi women living in the United Kingdom who breastfed within the previous five years, and 28 maternity practitioners. Interviews and focus group discussions contributed to the collection of data, which were analyzed using open coding for development of themes.

Women of Bangladeshi ethnicity are among the most socioeconomically deprived groups in the United Kingdom (McFadden et al., 2012). According to McFadden et al., stereotyping of ethnic groups and making assumptions about their beliefs results in barriers to informed decision making about health care. Successful breast feeding can improve both maternal and infant health outcomes but is dependent upon mothers receiving adequate information and support.

The findings of the study included diversified meanings of what it means to be ‘Bangladeshi’ or ‘Muslim’ according to the participants surveyed. Some participants identified with being Bangladeshi despite being born in another country. Although all mothers reported being Muslim, their religious beliefs and practices also varied. The majority of the Bangladeshi mothers reported that they received less breast feeding support from hospital staff during the early days after giving birth than they expected.
Participants felt that the nursing staff expected them to return to normal activities soon after giving birth, while their culture promotes total rest for mothers after giving birth. The mothers expected more ‘hands-on’ support with breast-feeding, like holding the baby to the breast. Their concerns about producing enough milk for their babies were often met with inadequate information, with staff readily providing formula instead of breast feeding support. Grandmothers played an important role in infant feeding decisions. Mothers’ attitudes about breast feeding were usually shaped by the attitudes of grandmothers, since they care for newborns during the mother’s recovery period (McFadden et al., 2012).

Maternity practitioners studied failed to recognize the similarities and differences among Bangladeshi patient populations. Practitioners also failed to associate the needs of Bangladeshi women for breast feeding support as being the same needs faced by mothers of the majority population. The major implication of the study was that exploring the individual needs and expectations of each patient is necessary to providing breast feeding support that is culturally appropriate (McFadden et al., 2012). The authors did not report what measures they used to ensure trustworthiness of the findings, which limits the study’s credibility.

The provision of more culturally competent nursing care is dependent on the acquisition of cultural awareness and knowledge about the patient populations served (Campinha-Bacote, 2011). One of the articles reviewed contributed to the understanding of the clash that often occurs between the philosophies about childbirth in the United States versus other world cultures. Lewallen (2011) cited the standards of maternity care
in the United States in the 21st century as significant factors in caring for women from foreign cultures. Although anecdotal, this article presents pertinent information regarding the maternity care of immigrant women. The cesarean birth rate in the United States has been increasing rapidly since 1996, reaching 32.7% in 2013 (CDC, 2015). The use of medical interventions during labor and delivery has also increased dramatically and includes the induction of labor and epidural anesthesia. Maternity care delivery is focused on the prevention of complications. Electronic fetal monitoring, intravenous fluids, oxytocin for induction or augmentation of labor, and artificially rupturing fetal membranes interfere with the natural progression of labor embraced by most cultures.

Childbirth is viewed as a natural life process in most world cultures, with medical intervention conflicting with traditional methods of giving birth. Patients who resist medical interventions are labeled as “non-compliant” without regard to their cultural beliefs. Lewallen (2011) recommended in her article that nurses acknowledge the maternity health care system may clash with the cultures of many clients and offer clear rationales for procedures along with choices to care when available. She further suggested that nurses have a responsibility to be aware of the cultural traditions of population groups who live in our neighborhoods in order to incorporate them into maternity care whenever possible.

Lewallen (2011) describes the conflict that often occurs between obstetrical care providers and immigrant women when medical interventions during labor and delivery are utilized in American hospitals. Many of these interventions are designed to “speed up” the labor process for the convenience of the practitioner and prevention of litigious
complications. Lewallen’s recommendations for nurses are appropriate for all maternal-child professionals.

While the Lewallen (2011) article provided an overview of the common cultural clashes between maternal health practitioners in the United States and their immigrant patients, another article discussed the culturally competent care of one particular immigrant group, Black Africans. An anecdotal article by Esegbona-Adeigbe (2011) explored the issues affecting the health of Black African immigrant mothers in the United Kingdom. The author reviewed the findings of the government report, ‘Saving Mothers’ Lives’ conducted by the Centre for Maternal and Child Enquiries. The implications of cultural competence in providing maternity care to the black African population were also discussed.

Black African mothers have an increased mortality rate compared to other population groups in the United Kingdom. There are several factors which may account for the higher rate. Black African immigrants may have medical conditions, including malaria, HIV, or tuberculosis, which affect mortality. Insufficient knowledge about how to access health care services in their new country can also lead to inadequate care. Risk factors for pregnancy complications present in the Black African population include a higher risk for pre-eclampsia and gestational diabetes, tendency to commence childbearing at a very early age, and tendency toward many pregnancies in their lifetime. Religion can heavily impact the health beliefs and practices of African groups and may vary by tribe or clan. Language and communication barriers may affect quality of care. A reliance on traditional medicines, spiritual treatments, and divination may be prevalent.
There is a tendency toward late or no prenatal care in the population group, perhaps because of the reliance on traditional practices (Esegbona-Adeigbe, 2011).

Esegbona-Adeigbe (2011) stated that midwives in the United Kingdom, who provide most maternity services, need cultural knowledge and intercultural care to bridge the gap of health care disparities for this population. Understanding the barriers to safe care, and tailoring care to the needs of patients, may result in the provision of more culturally appropriate maternity care and less perinatal mortality.

The ethnic and cultural implications of care discussed by Esegbona-Adeigbe (2011) may reflect those for patients in the United States, along with the identified barriers to care. Although anecdotal, the article brings out valid points about the need for maternity practitioners to develop understanding of the barriers to safe care, and the unique ethnic and cultural needs of the Black African immigrant population in the United States.

In contrast to the Esegbona-Adeigbe (2011) article’s discussion of one immigrant population, another article examined the culturally competent maternity care of several cultural groups. Luce et al. (2011) reviewed the cultural and ethnic factors that may lead to disparities in maternity care based on four common populations groups in Wisconsin: African American, Latina, Hmong, and Amish. The anecdotal article helps clinicians understand the ethnic and culturally specific implications to care, in order to improve the delivery of more patient-centered maternity services.

African American mothers face an increased risk of maternal morbidity (2-3 times greater than white mothers) from hypertensive pregnancy disorders, postpartum
hemorrhage, and cardiomyopathy. Infant mortality rates are also higher, related to more preterm births and low birth weight infants. Sickle cell disease may lead to an increased risk for miscarriage, stillbirths, preterm labor, and intrauterine growth restriction. These predispositions are also present in immigrant women from Africa. African American women are 3 times less likely to have prenatal care, possibly because of less access to care (Luce et al., 2011).

Latina women often do not seek prenatal care until late in the pregnancy. They have a 2 times higher rate of preeclampsia than white women, greater incidence of neural tube defects and gestational diabetes, and a higher risk for Cesarean section delivery. The Hmong population, which is native to Laos, is a patriarchal society. Decisions are made by the eldest male family member. Language represents the greatest barrier to care, as many Western medical and anatomical terms do not translate into the Hmong language. Physical examinations are perceived by Hmong women to violate the patient’s modesty, which is extremely important to them. The Hmong believe that ultrasounds and examinations early in the pregnancy may cause miscarriage. Women are often late in seeking prenatal care. In addition, the Hmong believe in hot and cold states, with birth being a cold state that could lead to the loss of the mother’s soul (Luce et al., 2011).

Amish women typically have large families and have similar infant mortality rates as white mothers. Barriers to safe maternity care arise from reliance on lay providers for prenatal care and rejection of medical interventions in favor of natural remedies instead. It is the husband’s role to make health decisions for his wife, and he may speak for his wife, decline treatment, or create concerns about spousal abuse. Genetic disorders are
more prevalent among the Amish, due to their descending from a small population in which inter-marriage is commonplace (Luce et al., 2011).

The review by Luce et al. (2011) describes population groups commonly encountered in the United States during maternity care. Although not all of the populations discussed in the article are immigrants, the information regarding the care of African, Latina, and Hmong women may be useful in providing care to immigrants from these populations. The authors highlighted both physical and cultural risks for safe maternal infant care in their review, which constitutes essential knowledge for maternal care clinicians.

**Healthcare equity**

Among the perinatal health disparities that have been observed between immigrant and non-immigrant women in industrialized countries is the rate of cesarean births. There has been a significant increase in cesarean births during the past 15 years in the United States, Canada, Australia, and parts of Europe. Additionally, global migration rates have been increasing dramatically, with migrant women contributing to as much as one fifth of all births in some Western countries (Merry et al., 2013). Merry et al. conducted a systematic literature review and meta-analysis to determine whether the rate of cesarean births differed among countries. The researchers used the Meta-analysis of Observational Studies in Epidemiology (MOOSE) guidelines for the review of cross-sectional and cohort studies comparing cesarean rates between migrant and non-migrant mothers. The systematic search included electronic data bases, web searches, and hand searches of identified literature, resulting in over 8,000 citations, which was narrowed to
76 studies. Data was reported on over 1 million migrants across Europe, Australia, the United States, Canada, and Israel.

Meta-analyses were performed in order to estimate the effect of migrant status on the outcomes of overall, emergency, and elective cesarean rates. Heterogeneity of the studies was assumed due to the range of migrant groups and host countries in the studies. Effect sizes of each study were calculated as odds ratios (OR), comparing the event/total for migrants and receiving-country women. The comparison of cesarean rates showed that there were differences among migrant and non-migrant groups in 69% of the studies. Emergency cesarean rates tended to be higher for migrant vs. non-migrant groups in more than half of the studies. Cesarean rates overall were consistently higher for Sub-Saharan African and Somali women in comparison with non-migrant groups, OR 1.41, 95% CIs [1.19, 1.66], and OR 1.99, 95% CIs [1.44,2.75] respectively. South Asian migrant women also had overall higher cesarean rates in the countries studied, OR 1.25, 95% CIs [1.17, 1.33]. Lower overall cesarean rates were reported among Eastern European and Vietnamese women, but samples were too heterogeneous to calculate a summary point estimate (Merry et al., 2013, p. 16).

Merry, et al. (2013) found the most commonly reported risk factors for cesarean births among migrant women were barriers in language and communication, low socioeconomic status, maternal health problems (anemia, parasitic infections, TB), high body mass index (BMI), gestational diabetes, lack of prenatal care, and cephalo-pelvic disproportion.

The methodological strengths of Merry et al.’s (2013) systematic literature review
and meta-analysis included the selection of an initial sample of more than 8,000 citations. The sample examined cross-sectional and cohort studies, in order to gather data connecting cesarean rates with migrant and non-migrant populations in five major areas of the world. Merry et al. provided a thorough description of the search criteria for included studies. The resulting sample of 76 studies provided ample data collected across Europe, Australia, the United States, Canada, and Israel. The study was further strengthened by the meta-analyses performed on the data, which included estimating the effect of being a migrant on emergency, elective, and overall cesarean rates. The meta-analyses were limited on data from U.S. studies, due to heterogeneity in the samples, or lack of data for the countries of migrant origin included in the study. The authors acknowledged this limitation, which affected the ability to combine data for meta-analysis (Merry et al., 2013).

In addition to higher risk for cesarean births, immigrants also face higher risk for postnatal depression. Postnatal depression (PND) represents one of the most common childbirth complications, affecting the new mother, infant attachment and behavior, and family dynamics. Immigrant women are at particular risk for PND due to the presence of risk factors including insufficient social support, stressful life events, and previous history of depression (Collins et al., 2011). The detection of risk factors for PND prior to delivery, early intervention when symptoms occur, and support for the family are critical to achieve recovery without long-term consequences. Women who deliver a baby in a foreign country may not receive adequate prenatal and postnatal screening for presence of risk factors due to unfamiliarity with available resources.
Collins et al. (2011) examined postnatal depression rates and risk factors among immigrant, refugee, and asylum seeking women in developed countries. The literature review conducted by Collins, et al. (2011) identified risk factors for PND and rates of PND among immigrant women in developed countries. Ten databases were searched resulting in a total of 1,174 articles, which were further reviewed to meet the inclusion criteria of experiences of motherhood, reference to refugee, asylum seeking, or immigrant women, culture and PND, and PND risk factors. The search resulted in the selection of eight research studies pertaining to risk factors and prevalence of PND among women born outside of the countries studied (Australia, Canada, and Taiwan).

The results indicated higher rates of PND in immigrant women compared with native-born women in the study countries (24% to 42%), and the presence of more risk factors for immigrant women than the general population (Collins et al., 2011). Risk factors common to immigrant, asylum seeking, and refugee women include lack of social support, stressful life situations, and previous depression history. Lack of social support often occurred when women left family members behind in their native country, leading to feelings of loneliness and isolation. Stressful life situations, such as natural disasters, war, or economic crisis, included the reasons for having to leave their native country. Previous history of depression was a risk factor for all mothers for PND.

The study by Collins et al. (2011) confirmed the greater risk of PND for non-native women giving birth in another country, but only cross-sectional design studies obtained primarily from Canada and Australia were examined. The researchers did not analyze the quality of the studies, creating a major limitation to validity. Furthermore,
definitions of ‘immigrant women’ varied in the studies reviewed, and usually did not distinguish between ‘asylum seeking,’ ‘refugee,’ and ‘immigrant women’ who may have varying experiences with PND. The study does contribute to the need to provide ongoing assessment and treatment resources to non-native mothers as a part of comprehensive maternal care.

Preterm birth rates have been increasing in recent years in both the United States and Sweden, leading researchers to question whether there is an association with country of mothers’ birth and delivering a preterm infant. In Sweden, Li, Sundquist and Sundquist (2013) conducted a descriptive quantitative study using data retrieved from the Swedish Medical Birth Register. Pregnancy, birth and death records in Sweden from 1982 through 2006, representing more than 2 million births, were analyzed for risks for preterm (<37 weeks) or very preterm (<33 weeks) births. Socioeconomic factors included immigration status, period of birth (5-year groupings during the inclusion period), area of residence, family income, and maternal smoking history. Logistic regression was used to analyze the data using SAS version 9.2. Statistics were presented as odds ratios (ORs) with 95% confidence intervals (Li et al., 2013). Levels of significance were not presented in the article.

Babies of native-born Swedish mothers represented the largest group in the survey sample, totaling 1,874,567 babies; preterm births accounted for 91,849 of the babies, and very preterm births 15,172. Preterm born babies whose mothers were born outside of Sweden totaled 15,893, and 2,868 very preterm babies were born to foreign-born mothers. A significantly increased risk for preterm birth was found among children
born to Austrian ($OR$ 1.37, 95% CIs [1.04, 1.81]), Yugoslavian ($OR$ 1.09, 95% CIs [1.02, 1.16]), Romanian ($OR$ 1.28, 95% CIs [1.09, 1.50]), Central European [Poland and Hungary] ($OR$ 1.29, 95% CIs [1.21, 1.37]), and Iranian ($OR$ 1.11, 95% CIs [1.03, 1.21]) mothers. The risks of very preterm birth were found to be increased among children born to mothers from Yugoslavia ($OR$ 1.40, 95% CIs [1.22, 1.61]), Central Europe ($OR$ 1.83, 95% CIs [1.54, 1.98]), Africa ($OR$ 1.24, 95% CIs [1.10, 1.40]), and Iran ($OR$ 1.33, 95% CIs [1.12, 1.59]) (Li et al., 2013).

Universal healthcare is the standard in Sweden, and maternity care is free to all pregnant women in all urban and rural areas. Despite the availability of healthcare, low socioeconomic status mothers had a higher frequency of preterm or very preterm births (5.1% and 0.9% respectively for low income mothers). This finding is consistent with data from other countries, including the United States and Canada. The association of risk for preterm birth and mother's country of origin is a new finding from this study, implicating the need for further study to determine what factors may contribute to higher preterm birth rates in the identified populations (Li et al., 2013).

One of the limitations of the Li et al. (2013) study was the lack of information about maternal risk factors known to be associated with preterm birth risk, such as alcohol and drug abuse. The statistical association between mother's birth country and preterm risk provides valuable information for planning maternity care for women from the populations identified.
Patient Safety and Cultural Diversity

The same barriers which may affect the provision of culturally appropriate care may also impact the delivery of safe patient care. The influence of cultural factors on patient safety was approached in the literature from global, medical, and nursing viewpoints. The World Health Organization (WHO) identified patient safety as a worldwide concern to public health. Maternal and neonatal care is a top safety priority for patients globally. Recommendations for developed countries in addressing the safety of culturally diverse patients include developing understanding of the underlying processes that can lead to unsafe care. These processes are related to both human and organizational factors, from communication to improvement of the culture of safety for patients (WHO, 2012).

The American Academy of Obstetricians and Gynecologists (ACOG) Committee on Health Care for Underserved Women (2011) has reported the need for increased cultural awareness and sensitivity in providing women’s health care. The committee cited the changing demographics of the United States towards a more culturally diverse society as a primary need to increase cultural competence in health care providers. Without cultural competence, health care disparities among immigrant and culturally diverse groups may result in these populations receiving inadequate medical care. Recommendations of the committee include addressing language barriers through translators, and written translations of educational materials. Involvement in local community health activities is also suggested to increase cultural competence and trust with local populations.
The Joint Commission (2010) addressed the need for considering patients’ cultural needs in the provision of safe care in their booklet, “Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care.” Some of the recommended measures for promoting the safe care of patients from diverse cultural backgrounds include identifying and addressing any communication needs upon initial assessment, identifying cultural or spiritual practices or beliefs that may impact patient care, determining the use of any alternative medicines or practices for healthcare, and respecting patient and family preferences for privacy or same-sex caregivers. Identifying and addressing the cultural needs of patients and their families improves the provision of safer, patient- and family-centered healthcare.

The Quality and Safety Education in Nursing (QSEN) Institute described the safe care of patients as a combination of knowledge, skills, and attitudes of providers and organizations. Prevention of harm to patients is maximized through individual knowledge of the factors that create a culture of safety. Awareness of the cultural barriers to patient safety, clear communication skills, and vigilance in preventing errors are cited as part of the process of reducing threats to safety (QSEN, 2014).

Ardoin and Wilson (2010) reported anecdotally that patients with minority cultural and language backgrounds tend to receive quality of care that is poorer than that received by majority population groups. Six areas of potential safety barriers in caring for culturally diverse patients were discussed: communication, space, social organization, time, environmental control, and biologic variations.
Communication, both verbal and non-verbal, may be a source of misunderstanding and adverse events. A major contributing factor to poor management of medical conditions and cultural misinterpretations is limited English proficiency. In addition to the language barriers created when patients and caregivers speak different languages, verbal communication may be further affected by euphemisms and jargon which imply different meanings when translated. Non-verbal communication includes the use of personal space. Cultures differ in what is considered an acceptable distance to stand from another person. Violating the personal space preferences of a patient or family member may result in the perception of disrespect and may lead to refusal of health care (Ardoin & Wilson, 2010).

Social organization is regulated by cultural norms, dictating decision-making roles for patients. Many cultures view the husband or male head of the household as the primary decision-maker. Female patients may refuse to answer questions and defer health care decisions to their husbands. Some cultures defer decision-making to the community or tribal leader. Worldviews and time orientation are two other areas which vary according to culture. For example, patients from cultures with a fatalistic worldview may refuse to interfere with nature, or ‘God’s will,’ by not seeking and adhering to preventive health care measures. Cultures which view time orientation in the present or past time sense, and do not believe in the ability to change the future, may also refuse preventive health care. In addition to the cultural beliefs of patients, there may be physiologic differences among ethnicities which predispose individuals to certain
diseases or drug metabolism disorders. Sickle cell anemia and Tay Saks disease are examples of ethnic predispositions for physiologic disorders (Ardoin & Wilson, 2010).

The anecdotal examination of the role of cultural diversity on patient safety and healthcare equity presented by Ardoin and Wilson (2010) highlighted important nursing considerations for improving the care of culturally diverse populations. Although it is not based on empirical evidence, Ardoin and Wilson’s article contributes to the body of literature about meeting the needs of culturally diverse patients.

**Synthesis of the Literature**

Studies were conducted across several world countries regarding immigrant women’s experiences of maternity care. They indicated that women from varied cultural backgrounds reported that they faced challenges in receiving satisfactory maternity care, received care that they rated of poorer quality compared to non-immigrant women, and experienced problems with discrimination or prejudice in their experiences of care (Henderson et al., 2013; Jomeen & Redshaw, 2013; Small et al., 2014). The challenges they faced included communication and language problems, unfamiliarity with the healthcare system, and difficulty obtaining all of the information necessary to make informed decisions (Henderson et al., 2013; Lee et al., 2014; Small et al., 2014). Immigrant women expressed the desire for maternity care that was respectful of their cultural needs, clearly communicated, and sensitive to their individual needs (Henderson et al., 2013; Jomeen & Redshaw, 2013; Lee et al., 2014; Small et al., 2014; Wikberg & Bondas, 2010). Their poor experience of maternity care sometimes included stereotyping and racism, feeling rushed into making decisions about their care, and not feeling ‘cared
Immigrant women’s satisfaction with the maternity care they received was the focus of three of the reviewed studies. The sources of dissatisfaction centered around women’s fears of surgical and other interventions to labor, feeling vulnerable and lonely, and lack of communication or caring on the part of maternity care providers (Brown et al., 2010; Wikberg & Bondas, 2010; Wikberg et al., 2012). Immigrant women described the experience of giving birth in a foreign country as feeling like “Alice in Wonderland,” finding themselves surrounded by strange and different worldviews and barriers to being understood (Wikberg & Bondas, 2010).

Providing maternity care that meets the needs of immigrant women requires the acquisition of cultural competence. Some of the common mistakes in providing culturally competent care to immigrant groups are stereotyping and making assumptions about individual women’s beliefs (McFadden et al., 2012). Cultural knowledge about the birth beliefs and practices of diverse cultures improves the provision of more culturally competent care, but healthcare providers must assess each patient’s beliefs in order to prevent barriers to safe care (Esegbona-Adeigbe, 2011; Lewallen, 2011; McFadden et al., 2012). Recognition of the view of most world cultures of childbirth as a natural process can add to the understanding of how medical and surgical interventions to childbirth clash with immigrants’ beliefs, leading to avoidance of healthcare or refusal of care interventions (Coast et al., 2014; Esegbona-Adeigbe, 2011; Lewallen, 2011; McFadden et al., 2012).
Research has identified specific risks to maternal and child health outcomes present in immigrant women. The cesarean birth rate has been found to be significantly higher for some immigrant populations, compared to non-immigrant women in the receiving countries (Merry et al., 2013). The risks for postnatal depression and preterm births have also been associated with immigrant women (Collins et al., 2011; Li et al., 2013). Other factors which predispose immigrants to complications of childbirth include the maternal presence of anemia, parasitic infections, tuberculosis, gestational diabetes, and high body mass index (Merry et al., 2013).

Chapter Summary

The existing literature regarding the maternity care of immigrant mothers was searched, and articles found by the researcher to pertain to the study topic were included in the review. Evidence from the literature was included both empirical studies and anecdotal articles, which were organized into categories: immigrant women’s experiences of maternity care services, and patient safety and cultural diversity. The subcategories for experiences of maternity care contained literature concerned with the provision of patient-centered care, and equity in healthcare services for immigrant women. Patient-centered care literature was divided into articles about maternity care experiences of immigrants, their satisfaction with maternity care, and the provision of more culturally competent care to immigrant populations. Healthcare equity literature was concerned with the perinatal health disparities that have been observed between immigrant and non-immigrant women.
The cultural considerations for patient safety were also examined in this review. National and world health organizations have recognized the need to enact measures that ensure the safe care of patients from other cultures, including the safe maternity care of immigrant women. Professional nursing organizations, including the American Nurses’ Association, have further recognized the need for nurses to provide care that protects the safety of culturally diverse populations.

It is known from the existing literature that immigrant women face barriers to maternity care services that are equitable with those of non-immigrant women. This researcher found very little empirical evidence in the literature from the United States. Of the 18 empirical studies reviewed, only three were conducted in the United States. The demographic data from the U.S. Census Bureau, showing increasing migration rates particularly among foreign-born women, reinforces the need for further research regarding the provision of maternity care to immigrant women in this country.
Chapter 3

Methodology

The purpose of this research was to describe and find meaning in immigrant women’s maternity care experiences during the birth of a child in a U.S. hospital. The research questions were: “What are the experiences of immigrant women who give birth for the first time in a U.S. hospital?” and “What are the patterns of meaning among immigrant women’s childbirth experiences in a U.S. hospital?” A description of the underlying principles of interpretive description will be presented in this chapter. The sample and setting, methods of data collection and data analysis, protection of human subjects, and measures of trustworthiness will also be described.

Interpretive Description

Interpretive description is a methodologic approach to the study of human health and illness experiences (Thorne, 2008). The aim of interpretive description is to investigate subjective perceptions of clinical phenomena, to capture themes and patterns of meaning that may inform clinical practice (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004). Research questions amenable to interpretive description involve those which extend beyond qualitative description, seeking relationships and patterns among descriptions of a phenomenon (Thorne, 2008). Interpretive descriptive research acknowledges the clinical expertise of the researcher and previous knowledge of the clinical phenomenon. Both clinical expertise and experience with the phenomenon are viewed as beneficial to designing interpretive descriptive research studies that will inform clinical practice (Hunt, 2009). Sufficient knowledge in the discipline is required in order
to make observations in the field, make sense of those observations, and shape the observations for disciplinary practice (Thorne, 2008).

Interpretive description provides more than pure description of a phenomenon, instead investigating inductively the patterns and relationships of the underlying meanings of it. According to Thorne (2008), “We seek patterns and themes within subjective human experience not so much as to grasp its essence as to understand what we are likely to encounter in future clinical practice and to have some meaningful sensitivity around it” (Thorne, 2008, p. 79).

Interpretive description of human health experiences begins with an examination of the existing knowledge (literature review). Thorne, Reimer Kirkham and MacDonald-Emes (1997) suggest that an analytic framework, constructed through critical analysis of what is known, forms the foundation for conceptual linkages of an interpretive descriptive study’s findings with the work of others. The analytic framework “orients the inquiry, provides a rationale for its anticipated boundaries, and makes explicit the theoretical assumptions, biases, and preconceptions that will drive the design decisions” (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997, p. 173). The literature review further assists the researcher in determining what is yet unknown about the topic of interest, and how to design the study to uncover what is not yet known (Thorne, 2008).

The foundational underpinnings of interpretive description are philosophically consistent with naturalistic inquiry, utilizing an inductive approach to the study of human phenomena. Lincoln and Guba (1985) presented the naturalistic paradigm of research, utilizing five axioms.
Naturalistic Inquiry

The first axiom of naturalistic inquiry asserts that there are multiple constructed realities, and that meanings are derived from studying the constructed realities of humans who experience a phenomenon (Lincoln & Guba, 1985, p.p. 37, 84). Thorne (2008) further suggests that interpretive descriptive studies are conducted in their natural context, particularly with respect to the comfort and ethical rights of participants (Thorne, 2008). In this study, the multiple constructed realities of giving birth in the United States were explored through the contexts of immigrant women with varied cultural backgrounds. The comfort and ethical rights of the participants were respected by conducting personal interviews in a private, mutually agreeable site such as a private office.

The second axiom of naturalistic inquiry asserts that the “knower” and the “known” interact with and influence each other (Lincoln & Guba, 1985, p. 37). The role of the researcher in a naturalistic inquiry is the “human instrument” for primary data collection. The human instrument can interact with the object of inquiry to evaluate meaning. The researcher must play an active role in the collection of data, since ongoing meaningful interaction is required to construct what constitutes data (Lincoln & Guba, 1985, p.p. 39, 107). This researcher was the sole investigator in this study, interacting with participants during live interviews and constructing meaning from the phenomenon of giving birth in a new country through the perspectives of immigrant women participants. This researcher was the primary source of data collection, in congruence with the second axiom of naturalistic inquiry.
The third axiom of naturalistic inquiry states that there can be no generalization of research findings, since there is continuous mutual shaping between phenomena and observers (Lincoln & Guba, 1985, p. 38). Since the intent of sampling is not representation of a population, purposive sampling is suggested to increase the likelihood of uncovering the full spectrum of multiple realities (Lincoln & Guba, 1985, p. 40). A purposive sampling technique was utilized in this study to recruit a diverse sample of immigrant women who had recently given birth for the first time in the United States. The findings from this study were not developed with the intention of generalization to a specific population, but rather for the clinical care of diverse immigrant women with similar experiences.

Lincoln and Guba’s (1985) fourth axiom of naturalistic inquiry implies that causality is not possible in investigations, since there is “mutual simultaneous shaping” of phenomena and observers, making it impossible to determine cause vs. effect (Lincoln & Guba, 1985, p. 38). Likewise, interpretive description approaches the analysis of data inductively and concurrently with data collection. Constant comparative methods are applied to maintain the researcher’s engagement with the data, to uncover and understand the relationships and patterns within them (Thorne, 2008). In this study, an inductive, concurrent approach to analyzing the data was utilized to construct meaning from the experiences of participants. The data was continuously analyzed for emergent similarities (patterns), which was further organized into themes in keeping with both interpretive description and naturalistic inquiry methodologies.
The fifth axiom of naturalistic inquiry concerns the role of values in inquiry, asserting that inquiry is “value bound” and not “value free” (Lincoln & Guba, 1985, p. 38). This researcher maintained a reflexive journal of personal thought processes, philosophical position about the phenomenon, and decision-making processes as data was collected and analyzed in accordance with the fifth axiom (Lincoln & Guba, 1985, p. 109). The reflexive journal facilitated the incorporation of this researcher’s own values into the understanding of the meaning of the phenomenon.

Sample and Setting

Characteristics of Sample

A purposive sample of immigrant women who had given birth for the first time in a U.S. hospital was recruited for this study. The inclusion criteria consisted of women, 18 years of age and older, who were born in countries outside of the United States. Fluency in English was an inclusion criterion, since translation services were not available to the researcher. Immigrant mothers who had given birth within the past 5 years in a hospital setting in the United States for the first time were eligible for participation.

Exclusion criteria included women who were born in the United States, or in Canada, the United Kingdom, and Australia where birthing practices are consistent with American hospital maternity care, women who were unable to speak, understand, or read English without a translator, women who gave birth more than 5 years prior to the recruitment period, and women who had more than one child in the United States. The
determination of eligibility for the study was made by the researcher using a screening tool (Appendix A) for inclusion criteria.

The 5-year postpartum period for inclusion was selected by the researcher to ensure that sampling included mothers with recent birthing experiences, and to prevent lack of memory recall about the hospital experience. The 5-year time frame also allowed for participation by mothers with both very recent birth experience and more distant experiences, thus enriching the obtainable data. Participants with varying ethnocultural backgrounds were sought to provide more diverse perspectives of the phenomenon, in accordance with interpretive description (Thorne, 2008).

Sample

The sample was comprised of seven participants born in Africa, Saudi Arabia, and China. A majority of the sample identified themselves as Chinese (57.1%), were married (85.7%), worked full-time (57.1%) and were college-educated (71.4%) (Table 1). The sample varied in the demographic characteristics for participants’ age (28-45 years), length of residency in the United States (2-20 years), and age of youngest child (2-48 months) (Table 2).

The participants all gave birth by vaginal delivery, received epidural analgesia, and delivered full-term babies. All mothers received prenatal care. There were no maternal birth complications reported, but two participants’ babies had been admitted to the Neonatal Intensive Care Unit (NICU) for brief observations. Most of the participants (85.7%) breast fed their babies. There was only one participant who had given birth to a previous child in Canada, but she declined to specify the older child’s age.
Table 1

**Demographic Characteristics of the Sample**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth Country</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>China</td>
<td>4</td>
<td>57.1</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td><strong>Ethnic Identity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>Black or African</td>
<td>2</td>
<td>28.6</td>
</tr>
<tr>
<td>Chinese</td>
<td>4</td>
<td>57.1</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
<td>85.7</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic (8th grade)</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>College 4 yr. (in progress)</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>College 4 yr. degree</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>4</td>
<td>57.1</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
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<tr>
<td>Unemployed</td>
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<td>28.6</td>
</tr>
<tr>
<td>Part-time</td>
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<td>14.3</td>
</tr>
<tr>
<td>Full-time</td>
<td>4</td>
<td>57.1</td>
</tr>
</tbody>
</table>

Table 2

**Participants’ Age, Length of U.S. Residency, and Child’s Age**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Range</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>28-45</td>
<td>33.6</td>
<td>6.24</td>
</tr>
<tr>
<td>Residency (years)</td>
<td>2-20</td>
<td>8.9</td>
<td>7.26</td>
</tr>
<tr>
<td>Child’s Age (months)</td>
<td>2-48</td>
<td>19.9</td>
<td>16.65</td>
</tr>
</tbody>
</table>
Description of Setting

The interviews were conducted in person, in a mutually acceptable meeting place suggested by the researcher for the comfort and privacy of the participant. The meeting places included private rooms in local churches, a university library private room, and a private office. The participants declined to be interviewed in their homes, requesting sites where childcare was available to them and distractions were minimized.

Sample Size

Thorne (2008) suggests a range of minimum to maximum sample sizes needed for an interpretive description study. The sample size should be fluid to allow for inclusion of enough cases to answer the research question and allow for maximal variation of cases (Lincoln & Guba, 1985; Thorne, 2008). In this study, a sample size of ten participants was sought for recruitment. The actual sample size was seven, a smaller sample than anticipated. The recruitment of the study sample was originally planned to occur through the assistance of physicians and midwives in a large obstetrics-gynecology practice in Southeastern Pennsylvania. The practitioners were provided with letters of instruction to distribute the recruitment brochures to interested patients who had recently given birth. Recruitment brochures were placed in treatment rooms and the waiting room of one of the providers’ offices. The researcher inquired of the providers and their office staff periodically about the distribution of the brochures. After a period of one year, there were no contacts to the researcher from any interested parties.

The decision was made by the researcher after a six-month period without any recruitment contacts to search for local churches with large immigrant populations for
assistance with recruitment. The rector of one local church agreed to speak to members of his congregation who fit the description of the inclusion criteria. One participant was recruited through the congregation, and the researcher screened three other potential participants who did not meet the inclusion criteria.

The sample inclusion criteria originally stated that participants must have lived in the United States for less than five years and had their first baby in a hospital within the previous 12 months. When it became evident that recruitment under these criteria was too limited, the decision was made to revise the inclusion criteria to include immigrant women living in the United States for an unspecified period, who had given birth within the previous five years.

The researcher continued to search for local churches with large immigrant populations, inquired of personal and professional acquaintances, and obtained permission to display recruitment brochures in a local office of the Women, Infants, and Children (WIC) program. Two pediatric practices near a local hospital also agreed to distribute recruitment brochures. The researcher screened three interested mothers from one of the practices, who unfortunately did not meet the inclusion criteria.

During the recruitment phase, two participants were recruited through personal acquaintances of the researcher at two local universities. Another personal acquaintance of the researcher, who was a member of a local Chinese church, provided five additional contacts who were screened for eligibility by the researcher. Four of the interested parties met the inclusion criteria for the sample.
After a recruitment period of approximately 18 months, a sample of seven participants from diverse cultural backgrounds had been selected for participation and interviewed for the study. The researcher concluded after analyses of the data that no new themes were being discovered, and the decision was made to conclude recruitment for the sample.

The concept of data saturation is not recommended as a data collection stopping point in interpretive description. Thorne (2008) states that “in the disciplinary context of health research, the idea that one can claim that no new variation could emerge seems antithetical to the epistemological foundations of practice knowledge” (Thorne, 2008, p. 98). Smaller interpretive description studies with arbitrary sample limits have been deemed as effective, so long as such studies reflect the recognition that there will always be more to study (Thorne, 2008, p. 98). The rationale for concluding sampling and data collection was based on this researcher’s conclusion that the desired depth of the information had been explored.

**Instrumentation**

**Researcher as Human Instrument**

In this study, the researcher conducted all interviews and data analysis personally. The researcher became the human instrument of data collection and data analysis, continuously interacting with participants and data during the research process and evaluating meaning from these interactions.

Subjective and experiential knowledge are valued by interpretive description as sources of clinical insight (Thorne, 2008). The researcher’s experiential knowledge,
related to her professional background in maternal-child nursing, may have added to the interpretation of meaning in this study. Naturalistic inquiry also values the utilization of tacit knowledge by the researcher, holding that knowledge is shaped by our experiences and the interactions between the “knower and the known” (Lincoln & Guba, 1985).

**Demographic Information Questionnaire**

Demographic data was collected through participant completion of the Demographic Information Questionnaire (Appendix B). The participants completed the form following the signing of the informed consent form, prior to the initiation of the interview. This data was used by the researcher to describe the sample characteristics allowing for transferability of the findings.

**Semi-structured Interview Guide**

A semi-structured interview guide (Appendix C) was used during the interviews. Questions regarding the participants’ feelings about their childbirth experience and their hospital experience were included to elucidate the participants’ childbirth experiences in a United States hospital. To gain greater understanding of the participants’ cultural perspectives on their childbirth experiences, this researcher also asked each participant to describe any cultural beliefs or practices related to childbirth in her native country. The question reflects revision of the semi-structured interview guide, which originally stated the intent to ask the question of participants who had delivered previous children in another country. The decision was made to ask all participants about their culture’s childbirth practices when it became apparent from the interviews that there were cultural
ties to their perceptions of their experiences in the United States with past experiences in their native countries.

**Protection of the Rights of Human Subjects**

Permission to recruit participants for this study was obtained from the Widener University Institutional Review Board.

**Informed Consent**

Prior to the start of the interview, the participants were given a copy of the consent form (Appendix D). The study was explained to the participants, any questions were answered, and signed informed consent was obtained. The researcher emphasized that their participation in the study was voluntary, and that they had the right to withdraw from the study at any time. Participants in the study consented to take part in a personal interview lasting approximately one hour in length. The interview was audio recorded, with the knowledge and consent of the participant. The participant was given a copy of the signed consent form. The Flesch-Kincaid grade level of the consent form was 5.1, with readability score of 82.6. None of the participants had any questions or expressed any difficulty reading the consent form.

In a separate data management form, the participants’ name and the associated researcher assigned pseudonym were entered. The researcher randomly selected a pseudonym from a list of common American girls’ names in order to minimize connection to the participants’ actual identities. The participants were asked to complete the Demographic Information Questionnaire (Appendix B). The pseudonym assigned to the consent form was used for identification on this questionnaire.
Risks and Discomforts

The recollection of childbirth experiences carries the potential for emotional upset, especially if unpleasant memories are recalled. Due to the concern for emotional upset during the interview, the researcher offered the participant the opportunity to decline to answer any question. If requested by the participant, the researcher would have immediately concluded the interview, and provided contact information for obtaining psychological counseling. There was also a potential for participants to feel embarrassment from the revelation of sensitive information. The participant was given the opportunity to decline to answer any question deemed to be too personal, or to ask that the interview be concluded at any time. One participant became visibly upset during the interview while recalling an unpleasant event, but she wished to proceed with the interview. She continued with the interview and was provided with the information for psychological counseling. None of the participants appeared or stated that they were embarrassed by the interview questions.

Benefits

There were no direct participant benefits to participating in this study. The indirect benefit is the contribution to the body of knowledge about the quality of healthcare that immigrant mothers receive, and the effects of that care on patient satisfaction and the health of mother and baby.

Confidentiality

Participant privacy was protected by conducting the interviews in a quiet, mutually acceptable location with only the researcher and participant present. The
confidentiality of information was protected through the assignment of a predetermined pseudonym to all data. Pseudonyms will be used in any publications resulting from this research.

**Data Storage**

Identified data was stored in the researcher’s own home office in a locked file cabinet. The identified data will be destroyed at the completion of the study. Raw digital data was stored in a password protected file on the researcher’s personal computer. De-identified data will be kept in perpetuity.

**Termination of Participation**

Study participants were advised of their right to withdraw from the study at any time or for any reason, without fear of retribution or consequences. None of the participants requested to withdraw from the study.

**Compensation and Costs**

Participants were informed that participation in the study was voluntary. There was no cost to the participant associated with being in the study. Each participant received a $25 gift card to Babies R Us as a token of the researcher’s appreciation for their participation at the end of the interview.

**Data Collection**

**Recruitment**

The recruitment of a purposive sample for this study was initially sought through the assistance of key informants (practicing obstetricians-gynecologists, midwives, and pediatricians) who provide maternity or pediatric care to culturally diverse women in
local, hospital-based practices. The physicians and midwives were provided with informational letters, as well as personal information sessions by the researcher, to orient them to the study and their role in the recruitment process (Appendix E). Informational brochures were distributed in the providers’ offices, with the providers requested to share the brochures with interested patients (Appendix F). The informational brochure has a Flesch-Kincaid grade level readability score of 5.7 and reading ease score of 78 (http://www.readability-score.com). The recruitment began through the cooperation of one large obstetrics-gynecology practice and was expanded to the two pediatric practices when there were no contacts from interested participants after a period of 8 months. After an additional 8- month period, there were still no contacts from participants from any of the 3 provider practices.

Additional recruitment strategies included the placement of the recruitment brochures in a local Women, Infants and Children office, which also did not result in any contacts from interested participants. The rector of a local Catholic church offered his assistance with recruitment in his congregation, which resulted in one participant who met inclusion criteria. Recruitment continued through key informants, who were acquaintances of the researcher. The remaining six participants were recruited through these key informants at two local universities, one of whom belonged to a local Chinese church and provided contact information for potential participants.

The researcher contacted each prospective participant by email or telephone. The eligibility screening tool (Appendix A) was completed, and in-person interviews arranged at the convenience of the participant.
Interviews

Each participant was interviewed at a private, mutually acceptable location. The interviews were audio-recorded and were submitted to Verbal Ink® for verbatim transcription. Data was collected using a semi-structured interview guide (Appendix C). The length of each interview was approximately 60 minutes. The researcher recorded field notes after each interview.

The semi-structured interview technique utilized in this study followed the framework described by Rubin and Rubin (2005). Rubin and Rubin described the work of interviews as being the gentle guiding of the conversation by the researcher, to encourage the participant to provide the level of depth and detail about the experience desired. The semi-structured interview guide assisted the researcher in maintaining the focus of the interview. The term “responsive interviewing” was applied by Rubin and Rubin to the in-depth interview technique where the researcher responds to what they hear the participant say, and base further questions on these responses rather than pre-selected questions. Responsive interviewing involves asking main questions, probing questions, and follow-up questions.

The participants were asked to describe what it was like for them to have their baby in the hospital in the United States (the main research question). A series of probing questions were asked during the interview to elicit further explanations, and to encourage richer descriptions of the experience from the participant. Open-ended questions regarding the participants’ feelings about the birth, the hospital experience, and the nursing care they received were asked by the researcher (follow-up questions). The
interview continued until the participants felt that there was no further information to add. The participants were personally thanked and given the gift card as a small token of appreciation.

The researcher maintained a reflexive journal to assist with ongoing reflection on the data, document the researcher’s thoughts and preconceptions, and to provide information about the methodological decisions made throughout the research process (Lincoln & Guba, 1985; Thorne, 2008).

**Data Analysis**

Naturalistic inquiry suggests an inductive approach to data analysis, such as constant comparative analysis and grounded theory, to increase the likelihood of identifying the interacting mutually shaping influences (Lincoln & Guba, 1985, p. 40). At the end of each interview, this researcher began the process of analyzing the recorded data, verbatim transcripts, and analytic journal, reflecting repeatedly and in depth on the data. Reflective questions, such as “What am I seeing?” and “Why am I seeing that?” guided this researcher in stepping away from the data and acknowledging the presence of different perspectives on the phenomenon (Thorne, 2008).

Data analysis in interpretive description occurs through repeated immersion in the data, seeking overall meaning rather than in-depth coding. Broad-based coding of the data was accomplished by highlighting transcripts of data, reflecting on similarities or patterns consistent with evolving analytic thought (Thorne, 2008). Data bits with similarities were recorded onto color-coded index cards, which were organized by patterns. The patterns which began to emerge from the data were further analyzed for
meaning and constructed into categories. Analysis of the categories continued until themes emerged from the data.

Upon the identification of themes among the data, organization of the study findings commenced with the objective of reporting a thematic summary of the phenomenon. Thematic summaries produce a higher level of abstraction than topical surveys, which consist of an inventory of the topics which participants covered in response to interview questions. In contrast, thematic summaries “reveal latent patterns that have been discovered within the data through the application of the interpretive analytic process” (Thorne, 2008, p. 164). Such a summary provides a means for displaying the main elements of the phenomenon in relationship with one another.

**Trustworthiness**

Trustworthiness is defined in naturalistic inquiry as the ability of the researcher to demonstrate that the findings of the investigation are significant and reliable. Lincoln and Guba (1985) described four aspects of determining the trustworthiness of qualitative research: credibility, transferability, dependability, and confirmability.

**Credibility**

Credibility in qualitative research addresses the consistency between the angles of vision of the participants (constructed realities) and how the researcher has represented them (McBrien, 2008). Lincoln and Guba (1985) also refer to credibility as “truth value.”

To ensure the credibility of the findings in this study, the following methods were applied:
• “Prolonged engagement” with the phenomenon by spending adequate time interacting with participants from various cultural backgrounds (Lincoln & Guba, 1985). Through these interactions, the researcher sought to build trust and develop relationships with participants to gain understanding and facilitate co-construction of the meanings of their experiences by the researcher (Cohen & Crabtree, 2006).

• “Negative case analysis” to search for and describe bits of data which did not support the patterns emerging from much of the other data (Cohen & Crabtree, 2006).

**Transferability**

Lincoln and Guba (1985) also refer to transferability as “applicability,” meaning the ability to demonstrate how the findings from an inquiry might apply to other contexts or with other participants. Naturalistic inquiry eschews the use of thick description of the data, to allow other investigators to make judgments about transferability.

The analytical findings in this investigation included verbatim data gathered through participant interviews. Thick description of the data was included in the findings, to allow other investigators to make decisions about their transferability.

**Dependability**

Dependability is the ability to demonstrate that the findings of an investigation might be consistently replicated in another inquiry, using similar subjects and contexts (Lincoln & Guba, 1985). Lincoln and Guba suggest the use of an “inquiry audit,” whereby an auditor examines the process and the products of the investigation to
establish dependability (Lincoln & Guba, 1985, p. 317). Thorne et al. (2004) suggest the “thoughtful clinician test,” whereby the findings will be reviewed by clinicians who have expert knowledge of the study phenomenon to determine if the findings are plausible and representative of new relationships and understandings.

In this study, dependability was demonstrated through application of the “thoughtful clinician test.” The methodology and study findings were audited by an expert faculty clinician, with knowledge of maternal child nursing and qualitative research methodologies, to verify the ability to replicate the findings consistently using similar subjects and contexts.

**Confirmability**

Lincoln and Guba (1985) discussed the criterion of confirmability as being able to establish that the findings of an inquiry have been determined by the participants, and not by the researcher’s biases or perspectives. In accordance with the suggestion of naturalistic inquiry, this researcher maintained a reflexive journal to record her own thoughts and decisions throughout the processes of data collection and analysis. The reflexive journal tracked the researcher’s reflections on the study phenomenon to acknowledge one’s own perspectives along with the participants’ perspectives (Thorne, 2008).

In addition to providing reflexivity, this researcher maintained an audit trail throughout the planning, data collection, and data analysis phases of the research. Lincoln and Guba (1985) suggest including raw data, the products of data reduction and analyses, process notes, data reconstruction and synthesis products, and all procedural
steps in the audit trail to confirm the study findings. The dissertation committee has served as an external audit process for confirming the trustworthiness of the study findings.

Chapter Summary

This chapter has presented the methodology which was applied to answer the research questions. The research questions sought the understanding of a clinical human phenomenon, the experience of childbirth, in accordance with the purpose of interpretive description inquiries. This study utilized interpretive description as the methodological approach to understanding the data. The sampling method, setting, instrumentation, recruitment procedures, data collection, data analysis, and measures to ensure trustworthiness have been designed in accordance with the axioms of naturalistic inquiry and interpretive description.
Chapter 4

Findings

In recent decades, there has been a sharp increase in the immigration birth rate in the United States. The experience of childbirth is a significant life event that is impacted by the healthcare providers who deliver maternal child care. Despite the rapid growth of immigration to the United States, there has been little research on the perceptions of immigrant mothers on the maternity care they received when delivering their first child in this country. The purpose of the current study was to describe and find meaning in immigrant women’s maternity care experiences during the birth of a child for the first time in a United States hospital. The research question was: What are the experiences of immigrant women who gave birth for the first time in a United States hospital? This chapter provides the findings that have emerged after analysis of the data.

The participants in the sample were international immigrants (Table 3). All the participants gave birth in hospitals located in Southeastern Pennsylvania. Each participant was randomly assigned a pseudonym by the researcher.

Table 3

<table>
<thead>
<tr>
<th>Participants</th>
<th>Birth Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>Nigeria</td>
</tr>
<tr>
<td>Patricia</td>
<td>Saudi Arabia</td>
</tr>
<tr>
<td>Linda</td>
<td>Sierra Leone</td>
</tr>
<tr>
<td>Barbara</td>
<td>China</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>China</td>
</tr>
<tr>
<td>Jennifer</td>
<td>China</td>
</tr>
<tr>
<td>Maria</td>
<td>China</td>
</tr>
</tbody>
</table>
Thematic Findings

The three themes that emerged from analysis of the data were: perceptions of support, feeling vulnerable, and respecting my cultural preferences.

Perceptions of Support

The first theme that emerged from the data, perceptions of support, encompasses the meaning of emotional support as well as physical support to the participants. The theme includes a description of how participants perceived the emotional support that they received from their maternity nurses during their childbirth experience, and how the nurses’ support influenced their overall perceptions about the quality of the experience. The perceived level of support from their nurses was especially important to the participants, who were separated from family members still living in their home countries, and therefore caused them to feel alone. In addition to being separated from family members, some of the participants discussed how the experience of giving birth in their new country was frightening for them, due to not knowing the customs of childbirth in the United States. The participants expected that their nurses would provide the level of support needed to ease their loneliness and fears.

The meaning of support for Patricia, who has resided in the United States for only three years, was closely tied to missing her mother. She talked about how difficult it was to not have her mother and other family members with her, stating several times during the interview how she wished that her mother could have been by her side during her labor and birth. Her feelings of loneliness were compounded when her husband was
unable to attend the birth. Patricia appeared melancholy as she described the experience of delivering her first baby without her mother’s presence.

No one was near to me. My husband was busy, he’s studying. And my mom was not near to me. I’m in a different culture, a different country, different language, and I wouldn’t say it was easy, it was very difficult. I hoped that my mother could have been with me; I think it would be different.

As she talked about missing her mother, Patricia’s body language emphasized her feelings of loneliness. Her eyes were downcast, her shoulders drooping, and her voice soft as she spoke. Patricia reported feeling that she did not receive the level of emotional support that she was expecting from her nurses, and she stated that she believed the lack of support affected her perception of the childbirth experience. Her expectations of the level of emotional support provided by nurses may have been shaped by cultural childbirth practices in her native country. Patricia clarified that in her culture, most women deliver their babies in the hospital, but a nurse provides one-on-one care to the mother. The nurses in her country stay close to the mother, talking with them personally and listening to their concerns. She was left feeling unsupported when her labor nurses did not provide one-on-one care or exhibit caring behaviors. As she talked about not receiving the amount of support she had expected, Patricia’s voice became louder and she seemed angry.

I expected the nurse would be like one-to-one, like at home. She would sit near you, she would talk to you, but here, it’s different. I was alone, and I expected
more support from the nurses. There wasn’t support there, maybe because there are a lot of women and there is a workload, I don’t know.

Patricia shared that she was expecting to get support from the lactation consultant when she attempted to breastfeed. Her perception was that the lactation consultant did not spend enough time with her and was not helpful in assisting her to breastfeed her baby.

I was excited to breastfeed. I brought my own machine pump, since I studied and saw many videos about breastfeeding, and wanted the benefits of breastfeeding my child. I was very ready, and then my daughter was sucking, but she wanted something very fast, and I didn’t have enough milk for her.

Patricia asked for help with breast feeding from the lactation consultant:

She came for just 10 minutes. The lactation consultant didn’t give me and the baby time. I was alone and in pain, and the baby wanted something very fast. I think there was not enough milk for her. My baby didn’t want to breastfeed, and I felt sad.

Because of her disappointing experience with breastfeeding assistance, Patricia stated that she abandoned her attempts to breastfeed and decided to bottle feed exclusively.

Patricia compared her experience with her nurses to those of a friend, who had delivered her baby in another United States hospital. She reported that she observed a nurse taking care of her friend, who demonstrated the level of support that she would have liked to have been shown.
I was observing. I feel that they (the nurses) provided more care than here. They showed they care about you; the time is for you. I remember when she finished, she sat with her talking. I think if I had that emotional support, my experience would have been different.

Patricia also compared her childbirth experience with that of her sister, who delivered her baby in her home country. Unlike Patricia, her sister had the emotional support of her mother and healthcare providers from her own culture during her labor and delivery. Patricia stressed how important it was to her to have her mother by her side to feel emotionally supported.

My sister delivered back home, in Saudi Arabia. She had my mother with her, and it was different. She delivered in her culture, so to her, she just had the experience of delivering. When you’re near to someone who understands your language, understands your culture, understands if there’s something you need during the birth – we need at that time, someone who will listen to us, someone who will talk with us. It’s not an easy experience to just go through, and that’s it. It will live with us. I was expecting more care, more emotional support from nurses.

Because she did not feel adequately supported, Patricia stated that she would not choose to give birth in the same hospital where she had her first baby. She indicated that she wanted to tell her story so that other immigrant women might be helped by her experience. Her advice to healthcare providers was to have cultural support groups in place to provide immigrant mothers with someone who understands their language and
culture. She suggested that a list of contact persons from various cultures be kept on the unit, in case an immigrant mother requests a woman from her own culture to support her during or after childbirth.

In contrast, several participants felt they were more supported during their childbirth experience in the United States than they would have been in their native countries. Mary, Linda, and Maria reported that they felt the nurses were more supportive during their childbirth experiences than nurses in their native countries. Linda shared how her understanding of what it is like to give birth in her country, Sierra Leone, impacted her perception of the support she received when she gave birth in the United States.

In my country, most people don’t have money to go to the hospital, so they end up having their child at home, or in something we call “uppal,” which means “native medicine.” We call those midwives “nani.” Back home, the money has to be there before treatment is offered to you in a hospital. People die. I saw a video about a nurse dying. They couldn’t do surgery on her because she couldn’t afford to pay. She died in front of the hospital. She was nine months pregnant and she was bleeding. She died with her child.

In contrast, Linda shared that she was impressed that maternity care was offered to anyone at the United States hospital where she delivered; no one is turned away. Linda summarized her perception of the support she received from her nurses in one word: “encouragement.” Feeling supported through encouragement was meaningful to Linda because of the lack of encouragement from midwives in her native country. She
stated that in her native country, “if you yell too much, they will yell at you to keep quiet. There is not much encouragement. Maybe they could try to be a little more sympathetic with the mom.” In contrast to her expectations, she described how her nurses provided encouragement and support during her own childbirth experience. Linda was so moved by the support she received from nurses during her experience that she is studying to become a maternity nurse. She plans to return to Sierra Leone to try to help to improve healthcare conditions for women in her native country.

The pain was so intense, but the encouragement, the care – everybody was just trying to see how they could best help me to go through the process smoothly. I had a lot of help from the staff in the hospital. They would ask “How are you doing? Do you think you’re okay? If you need help, let us know.” I remember my blood pressure kept going up, and I was having some issues with my ex-boyfriend. This nurse came and was talking to me. She said, “We don’t want to let you go [home] if you think you are not okay.” Then she tried to explain so many things that would calm me down. I’m praying I’ll be successful in school, so I can become a nurse and offer the same care that was offered to me to other moms.

The meaning of support for Maria was impacted by a visit with a friend, who had recently delivered by Cesarean birth in China. She stated that in her native country, there are not enough nurses to provide care to the patients, so family members are expected to take care of them. Along with the shortage of personnel, the nurses’ attitudes are not
very supportive. Maria related that her nurses during her U.S. childbirth experience demonstrated more support to her by their willingness to help her.

I think the nurses in China do not give good service. We don’t have too many nurses, so they don’t have much time to take care of patients. Unless you call her, and she can be there, your family members take care of you, not the nurses. So just if you have an emergency, you can call her. Also, the nurses in China don’t have a very good attitude. We need to talk to them very gently and politely, like “Could you please help me?” If they are happy, they will help. If they are not happy, they’ll just ignore you. But the nurses here surprised me. The first night, there was only one nurse with me. Once I called her, she would be in my room very quickly and told me no matter what time, if I need anything, just call her. All the nurses made me feel very satisfied. It was a very good experience.

Mary was a lay midwife in her native country, Nigeria. The meaning of support for her was related to attitudes of compassion and empathy from healthcare providers. In telling her story, she compared her own childbirth experience with her observations assisting the traditional midwives back home. Her memories about the way the midwives treated women in labor when they were in pain left her with fear about how she would be treated during labor, and how her own pain would be managed.

In my culture, back in Nigeria, I was a midwife. Where we delivered the babies, sometimes some of the midwives beat the mothers, especially when they refused to push. And they don’t use epidural; most of them deliver by natural birth. In Africa, it seems as if the process is longer and more painful. So initially, I was
scared, wondering “How am I going to make it with the birth?” I have a low pain threshold, so I was really scared. I’m thankful I didn’t go through that, because the little I endured for two days was hell. Thank God I opted for the epidural. That helped me a lot with the pain. I was confident [about having a baby in the United States] because I learned about America and the way they take care of you. And if there was a hitch, it would probably be taken care of. So, if nothing else, that assured me that everything was going to be fine.

Mary recalled the negative attitudes toward their patients that she observed from the lay midwives in Nigeria.

In Nigeria, some of the midwives are not well-cultured. What I mean is that they are kind of arrogant. They talk to these women like, “How you come here?” And they look at them like, “I don’t like this person. I don’t like that person. I want this person.” But the nurses here were welcoming. They showed compassion, they were empathetic. There was no one who was indifferent to me. Everybody looked kind of angelic, and their outlook was respectful. The nurses were the best. They encouraged me. They met my needs with empathy and compassion. My experience was a very good one. So, for me, they exceeded what we had back home.

Mary added that there are some good nurses in Nigeria who are comforting to their patients, but the nurses where she delivered her baby eased her anxiety and were respectful in their demeanor.
A lot of them have the same attitude, like arrogant or mean back home. I think that here [in the U.S.], it is culturally dense. Their [the nurses’] basic outlook is respectful. When we get there [the hospital], we are anxious. We get more apprehensive when these caregivers look at us with indifference, and when they don’t, we relax. My experience in the hospital was a very good one. We had some good nurses there. I didn’t spot anybody [who seemed that they didn’t like me].

Mary described the unexpected level of support that she received from her nurses during a difficult time, when her husband became upset with her for vomiting.

I was nervous and in a lot of pain. I had literally vomited everywhere, I couldn’t contain it. He said, “You should bear it, be able to hold yourself together.” He was mad. So, that was an awkward moment. And I reminded him, “Look, you’ll have to leave if you’re not going to be patient. I’m going to tell them to take you out, and you’re not going to come back.” I didn’t get that look from the nurses telling me that what I did was bad. Instead, I got the feeling of empathy and understanding from them. They encouraged me and said, “We understand your situation. Take it easy. We don’t look at your husband, we look at you. You’re supposed to be happy. Bear with me.” That time that I vomited, I thought because my husband reacted that way… But, they never showed any sign of ill treatment or any kind of reaction that shows you’re not happy.

Another participant, Elizabeth, felt physically and emotionally supported by the assurance of adequate staffing and prompt attention to her needs. Elizabeth delivered her
first child in Canada, where she had encountered some issues with the hospital staff. Although childbirth procedures in Canada are like those in the United States, staffing of physicians and nurses was not as adequate and negatively affected her first childbirth experience. She contrasted that experience with her second child’s birth in the United States hospital.

In Canada, we had a little bit of an issue with the case. I required an epidural, but I didn’t get it until I had the baby. So, maybe they are too busy with different things. And I was so worried with my due date being on a Friday, because the availability of staff after hours wasn’t as good as the U.S. I remember when our first son came out, there were only two people, a doctor and a nurse, and that’s it. And I required about 20-30 stitches after the delivery. At first, the doctor didn’t know how to do it; he had to find out and call more experienced people to come in to do the repair. And especially at night, I would have to pull the call bell for the nurse several times. I would have to have my husband help me to the bathroom; I didn’t see her. So, I was pretty impressed that in the U.S. at 10:00 in the evening, I had nine people in my room to help me deliver this baby. The availability of staff after hours was much better than in Canada. I think the nurse did a good job. When I pulled the bell, she showed up very quickly. I think that’s good. I do like the safe experience.

The meaning of support to Jennifer seemed to stem from being able to trust her nurses. As an older first-time mother, Jennifer was aware of the high-risk pregnancy and birth that accompanies advanced maternal age. She was concerned at first when the
nurse explained that her physician would not be staying with her throughout her labor, however she was reassured that the nurses would be with her. Throughout the interview, Jennifer repeated that she trusted her nurses.

I think the nurses know what they’re doing. I trust their care. The nurse helping me was really very experienced. She really helped me and then said the doctor would not be there all the time when you’re pushing. When the doctor went away, I was a little concerned if I could be helped with just a nurse there. The nurse was very, very experienced. She pretty much did everything to help me after the doctor left.

The nurse reassured her that she would stay with her and would have the physician return as soon as it was necessary. Feeling that she could trust her nurses and feeling that they supported her when she was afraid, helped to shape her positive perception of the experience.

Another aspect of feeling supported that was discussed by four of the participants seemed to coincide with the need for rest after childbirth. The participants said that the need for sleep became especially important to them during the days immediately following the birth. Physical exhaustion from the efforts of labor was described by each of the four participants, but they also described how their nurses either accommodated their need for rest or did not accommodate it. The one participant who reported a positive experience with getting enough rest was Maria. She stated, “For the two nights I stayed in the hospital, I got very good rest. [The nurses] let me put the baby in the nursery, and in the morning, they sent him back so that I could have a good rest.”
In contrast to Maria’s positive experience with her nurses allowing her to get sufficient rest, Jennifer, Barbara and Patricia reported negative experiences. Jennifer and Barbara both connected their insufficient rest in the hospital with too many interruptions from the nursing staff. Jennifer said:

There was no way I could get rest at night. They (the nurses) want you to sleep, but every hour they come and check if everything is okay. The nurse helping us the first night let us sleep a few hours, then she would bring the baby back to try to help me breast feed.

Similarly, Barbara felt there were too many interruptions from the nurses to achieve the rest she needed.

I thought the nursing care was very good, but also very tiresome. I didn’t like how every 15 minutes, someone would come in and prick your finger to test your blood sugar, or heart rate, or the baby. You don’t really get a lot of rest when you’re in the hospital. [My baby] wasn’t in the nursery very often, just the first night because I wanted to get some rest. The next time, my baby’s going to be in the nursery the entire time, so I can completely recover.

Patricia related her story about how a nurse left her feeling unsupported when she requested to rest.

I didn’t get enough sleep. It was my first morning after the delivery. I asked [the nurse] just to take the baby because I was in pain and tired. She said ‘no.’ I don’t know why she said ‘no;’ it made me feel sad. I wasn’t aware that if I didn’t want the baby, I could call the nurse. No one told me that.
Having her request for rest denied by the nurse added to Patricia’s poor perceptions of receiving support from her nurses.

To summarize the theme *perceptions of support*, the meaning of “support” varied for each participant. Feeling encouraged, assured, or less lonely was important to some participants, while trust, compassion, and caregivers’ attitudes were listed by others. Many participants also talked about whether their nurses accommodated their need for increased rest while they were in the hospital, supporting their physical needs. All participants identified the need to feel supported in meaningful ways during their childbirth experience in the United States.

**Feeling Vulnerable**

The second theme, *feeling vulnerable*, illustrates the perceptions that the immigrant women had about being unable to control some of the events that occurred during their childbirth experience. In addition to feeling vulnerable due to lack of control over these events, some of the participants reported that there were occasions during their childbirth experiences when their stated wishes were not respected, which left them feeling vulnerable. Although there were circumstances during childbirth when the emergent care of the mother or newborn required interventions that may not have aligned with the mothers’ wishes, there were also times when they could have been accommodated. The participants also mentioned feeling vulnerable due to pain, being unclothed during labor, being persuaded in decision-making, or feeling that a nurse did not believe that their pain was real.
Patricia felt vulnerable when she was not given any other options for pain relief during labor, except epidural anesthesia. She stated that she had read about the nonpharmacologic pain relief strategies that are used during labor in the United States, expecting that she would be offered these choices when she delivered her baby. These comfort measures included relaxing in a bath, using a birthing ball, or being permitted to ambulate to reduce the pain of labor. For Patricia, being able to maintain some control over how her pain was managed was important to her feeling less vulnerable during labor. However, she stated that despite her requests to try these relaxation techniques, she was not given the option. Patricia indicated that whenever she asked for something to relieve the pain, she was told to “just take the epidural analgesia.” She also shared that epidural analgesia is frowned upon in her culture, which made her more reluctant to agree to receiving it. As she described her experience, Patricia spoke in a more rapid and excited tone.

I was reading about how the U.S. is different from my country; they will use different painkillers and the last choice would be epidural. I didn’t experience that. They told me, “We just have epidural.” It came to my mind, “Where are the other strategies, like taking a bath, sitting on the [birthing] ball, walking?” They didn’t allow me to do that and they didn’t offer these options. They just told me to take the epidural every time I said there was pain. I was patient, like I wanted to do it without pain killers. I stopped for one moment and then I was thinking, maybe if I had the emotional support, I would not have gone through with the epidural, but I missed that. The reason that I took the epidural wasn’t the pain, it
was the emotional pain. I wanted to relieve the pain so that I could control my emotion. I didn’t want to be in emotional pain and actual pain.

Patricia went on to discuss other situations that left her feeling vulnerable. She said that in Muslim culture, men are not permitted to see women unclothed, except for their wives. She reiterated that women avoid male healthcare providers, especially during the most vulnerable circumstances of exposure of their bodies, like childbirth. Patricia reported feeling vulnerable when a male provider was called into her labor room to provide care to the baby, who had aspirated meconium. She stated that she understood the need for medical support for the baby, but having her body exposed to a male was disconcerting for her. On another occasion, Patricia felt vulnerable when she was exhausted and in pain. She requested help from a nurse, but the nurse declined her requests, leaving her with the impression that her feelings were not validated. Patricia loudly tapped her fingers on the table, then teared up and became very emotional as she told her story.

I had a bad experience with a nurse. She caused me to cry because she didn’t want to help me. I was in pain and she said that “You are not in pain. You are like every woman here; they are in the same way you are in.” So, I think she didn’t believe me that I was in pain. I was in pain and my child was crying. I didn’t get enough sleep; it was my first day after delivering. I asked her just to take the baby back to the nursery and she said “No.” I don’t know why she said no; she made me feel sad.
Another participant also stated that she felt vulnerable when a male provider was called to her labor room. Linda reported that she chose to receive prenatal care from a midwife out of discomfort with receiving care from a male provider. In her culture, female midwives deliver most of the babies. During the repair of her episiotomy, Linda’s midwife required help with the suturing. She said that she felt uncomfortable when her midwife called for assistance from a male physician. Linda objected, stating that she only wanted to have women present. She was told that there was no choice because the midwife needed assistance, and the male physician was the only one available. Despite her cultural preferences to not have any males present, Linda was placed in a vulnerable situation where she had no other choice but to acquiesce.

I remember she actually called a doctor because she gave me an episiotomy. She called a doctor just to know if she was trying to stitch the right way. And because I go to the midwife – I’m not comfortable with men. So, I said, “No, I will only stick with women.” Well, when it came to that particular time, she said, “Well, I have no choice. I need to call someone to help.” So, the doctor came. I said, “Well, yeah, you do this.” I remember they said something about “you stitch this way, not this way.” But apart from that, everything was great.

While some participants felt vulnerable when they were not able to have control over certain circumstances during their childbirth experience, others felt vulnerable because they were unable to eat the hospital food and had little control over what they were served. The Chinese participants discussed being unable to digest “American
food.” The food choices in the hospital were not accommodating to what their bodies are accustomed to eating, leaving them unable to eat anything. Barbara explained:

Physically, Caucasians are built differently from Asians. It might be fine for you to eat ice cream, or hamburgers and hot dogs all day, but it’s not good for us. In the U.S., it is challenging for a person with an Asian body to give birth in the hospital. You almost have to bring your own food. Even though the food was free for the two or three days that I was there, I didn’t eat any of their food, except for the fruits or a yogurt. Everything else, my mother-in-law made at home and brought for me.

Maria and Jennifer also spoke about being unable to eat the hospital food. Maria stated that, “They’re all cold foods. We really like the warm and hot foods to make our stomachs feel comfortable. But they only had cold ones, so my husband cooked at home and sent it to me.” Jennifer added, “I wasn’t really eating that much. The food is not Chinese style. After the delivery, I would rather have had some hot soup or something. I have a Chinese stomach.” Elizabeth did not comment on being unable to eat the food that she was served in the hospital, but rather the insufficient quantity of the portions.

I didn’t eat anything for the first day [when I was in labor]. When the baby came out, it was very late in the evening and there was literally no food. The nurse brought me a muffin, but it was very little. In the morning, I called for breakfast. There was a variety of things, but very small portions – only one or two bites. I asked for soup or broth, and there was fruit and burgers instead.
Some participants also felt vulnerable during times when they perceived that their wishes were not being respected. Jennifer stated that she preferred not to have any students present during her labor and delivery. Jennifer said that she signed admission forms declining to have any students when she went to the hospital in labor, and that she made her wishes clear. Despite her expressed wishes, a medical student followed the physician into the labor room as he was performing a procedure. She felt that she was placed in a vulnerable situation by having to defer to the student’s presence during a time when she felt that she was too exhausted to argue against it.

There’s one thing I was unhappy about. We signed into the hospital and they had so many forms, and then we said, “We don’t want any of the students.” Like, they have residents or fellowships, or whatever. They wanted practice while I’m delivering my baby. I said, “No, I don’t want any students while I’m delivering the baby. I don’t want the new hands on me.” But they did that. I don’t think they really read my forms that carefully, but I had no energy to really fight against it at that time. So, the doctor went out when I’m trying to push, and I didn’t know. I was kind of surprised. I took the anesthesia and then the doctor came over and the student came over as well. So, she – a young girl, I think she was a medical school student – and the doctor were there. He is very experienced, so he was trying to do it the first time and then he was showing that girl how it was working out, and I [thought] “I don’t want that girl here, but I just want my baby to be safely delivered.”
Another participant told about an experience that left her feeling vulnerable to do anything and feeling that her wishes were not being respected. Mary and her husband experienced a misunderstanding with a neonatologist over their baby’s blood glucose management. Despite her best attempts to breastfeed her newborn, the baby’s blood glucose was below normal. Mary’s husband did not want the baby to receive any formula, but Mary understood that it was necessary for the baby’s health. The baby was admitted to the NICU for observation and blood glucose management. Mary spoke about feeling vulnerable as the neonatologist made the situation more difficult for her and her husband. As she told her story, Mary appeared visibly upset.

The experience was a bad one. The chief pediatrician of that unit gave us a tough time. She was so mean. She didn’t want to be understanding. She told us that if our baby’s blood sugar could be maintained at this level [we could be discharged]. Our baby’s blood sugar got maintained at that level, then she shifted again. We were like, “This is what you told us at the onset. Now you’re making us stay longer.” She even blamed us, and at times, got into arguing with my husband. I will remember her face. I even dreamed of her; it was a nightmare. When you have a bad experience with people, and you go home at night and dream about them, you never want to see them again for the rest of your life.

The participants’ perceptions about situations that left them feeling vulnerable included physical circumstances, like being naked with men present, and emotional circumstances, such as feeling that their wishes were not respected. The lack of choices while hospitalized, not having control over the food they were served or the
circumstances of labor, or being in pain also contributed to participants’ feelings of vulnerability. Some of the participants who spoke about feeling vulnerable also described ways in which certain healthcare providers contributed to their feelings.

**Respecting my Cultural Preferences**

The third theme, *respecting my cultural preferences*, encompasses the meaning of the participants’ cultural preferences in shaping their perceptions of their childbirth experiences. Since most cultures embrace the experience of giving birth through unique rituals, several of the participants wanted to share about their cultural customs or preferences, and how they were or were not respected by the nurses taking care of them. The participants expected that nurses would demonstrate cultural understanding to them about their customs and preferences.

The four Chinese participants talked about their cultural preferences for warm foods and drinks, and the avoidance of cold things, following childbirth. In their culture, new mothers are served only warm beverages. They were all surprised that their nurses served them ice water and other very cold items. Barbara explained:

> They serve you ice water, and you can have ice cream right after you give birth, which is unheard of in China. Over there, you get hot water, and you’re not supposed to drink anything cold for, like a month, which I did. I guess for an average American, they don’t know anything else, so they think it’s fine to drink ice water and eat ice cream after giving birth.
The Chinese participants also talked about their culture’s restrictions on the types of foods that postpartum mothers can eat, and the foods that are typically served to new mothers. Barbara elaborated further about these foods:

There’s almost like a very strict regimen that you eat the food, the kind of food that you eat after giving birth. You eat a lot of protein. There’s lots of chicken soups, a lot of pork feet soups, to also help bring out the milk, because if you drink a lot of soup with fat in it, then your milk production will also improve. Jennifer also talked about preferring more warm foods. She brought up the fact that her nurses were not accommodating to her preferences.

I got used to the cold water, but after the delivery, I would rather have some hot soup or something. I can take a lot of American food. I don’t have trouble with that, but on that particular day, you might want more big bowls of soup, but they’re just saying to you, “Drink water.”

Similarly, Elizabeth talked about preferring warm foods and beverages.

In Chinese culture, everything needs to be warm. You drink hot water and you stay warm. On the second morning, it was like 7:00 or 9:00 and I called for the breakfast to come in. There were a lot of things. I asked for the soup, or broth and there’s the fruit and burgers on there. I think it’s just one of those things in Chinese culture, after you have a baby everything needs to be warm. You drink hot water and you stay warm.

Barbara, Jennifer, and Elizabeth each concluded that their cultural preferences were not respected with regards to the food and beverages served to them in the hospital.
Barbara summarized her experience with the hospital diet, that caused her to rely on foods brought in from home.

I just think, in the U.S. it is challenging for a person with an Asian physical body to give birth in the hospital. You almost have to bring your own food and my mother-in-law did. Even though the food was free for the two or three days that I was there, I didn’t eat any of their food except for the fruits, maybe a banana or a yogurt. Everything else, my mother-in-law made at home and brought for me.

Maria also noted that she was served only ice water, along with cold foods. As noted by the other Chinese participants, she referred to a preference for hot water and soups. Although food service is not managed by nursing personnel, the participants associated the foods and beverages that were served to them with their nurses. They associated being served cold foods and beverages with not having their cultural preferences respected. Maria wanted to remind nurses to consider the cultural preferences of Chinese women after giving birth.

They just gave me ice water. Remember to give us warm or hot water, because we Chinese people don’t like ice water. After delivering the baby, all the foods were cold. We really like warm and hot food, like hot soup to make our stomachs comfortable. Maybe, the next time, the nurse could focus on the different culture, and provide some hot food.

Barbara elaborated further on her culture’s belief that new mothers should follow specific practices for the 30-day period following childbirth. Her explanation about the
30-day confinement period for postpartum women in Chinese culture clarifies why the temperature of food and drinks are meaningful in the experience of childbirth for them. They say that after a woman gives birth and she has a good 30-day confinement period, it completely renews her body as though she has a new life. I grew up in the U.S., and I didn’t really believe it, but my husband convinced me to do it. And I did see the effect, because before I had the baby, I used to get sick a lot, cold after cold, and very easily got sick. After I had the baby, I just feel like my body is stronger. I’m not as cold when I’m outside and I just don’t get sick often. There’s almost a very strict regimen that you eat certain kinds of food after you give birth. Technically, you’re not allowed to leave your house or apartment for all 30 days. Actually, you’re not even supposed to take a shower or wash your hair either. The food that you eat – you eat a lot of protein and soups. Usually, someone makes meals for the ladies. I had a couple who delivered a premade meal every day, and it was made just for me to recover. It was all very delicious; it was bland because you’re not allowed to eat a lot of salt. Some of the foods were porridges, chicken soup, pork feet soup, and fish soup. It’s like a special kind of fish that’s fatty and makes good congee.

Patricia related that in Arabic culture, there are also specific food rituals observed to relieve pain during childbirth. Additionally, she talked about her culture’s belief in natural childbirth, and no epidural anesthesia during labor. Patricia was unhappy that medical interventions were used to initiate and augment her labor. She also stated that she felt that she was coerced into receiving epidural anesthesia for pain relief.
I needed to be hospitalized for induction. She started giving me a pill, and when it didn’t work, she put me on IV Pitocin. In my culture, we also have a baby in the hospital, but with a more natural delivery. I was expecting my delivery to be very smooth; I wasn’t expecting to have to take some pill and IV just to start the labor. My uterus started contracting after that, and the pain was getting worse. In my culture, we believe in specific water -matzamzam. It comes from the holy Mecca. If you drink it, it will relieve some pain. In my culture and religion, if you eat dates, the process of birth will be easier. Here, they told me “You cannot eat anything. You must be fasting.” I told them I didn’t want an epidural, I wanted something different. I want to feel my leg. They just told me to take the epidural every time I said there was pain. The belief about epidural in my country is that it will make the woman suffer from headaches, back pain and stuff like that. I remember when I told my sister-in-law that I went for the epidural, she told me, “You should have controlled yourself and controlled your pain.”

Patricia summarized her childbirth experience by stating that she would not choose to deliver a baby again at the same hospital where she had her first child. She felt that her cultural preferences were not respected or understood by the nurses who took care of her, and that she was expecting more care and emotional support from them than she received.

Other participants also mentioned that natural childbirth, without epidural anesthesia, is the preferred method of childbirth in their native country. All the participants received epidural anesthesia during their labor and delivery in the United
States. Maria talked about how she was given epidural anesthesia even though she felt that she could handle the pain of contractions.

In China, we don’t commonly have epidurals. Most women deliver the baby by the natural way. After my water bag came out, the contractions were really painful. I could handle it. I took a hot shower and it worked well for the pain. Then when my cervix was open two fingers, they gave me the epidural.

Jennifer discussed how a nurse persuaded her into agreeing to receive epidural anesthesia, despite her preference not to have one.

I was thinking about how people told me not to take any epidural, because it’s not good for the baby. And the scary part is that they put a needle in your spine. I was struggling [about whether to take it], but a nurse encouraged me to take the anesthesia. I just stopped thinking; whatever you said, I’d do it. So, I took the anesthesia.

Five out of the seven participants shared about their cultural preferences that were not respected by their nurses and healthcare practitioners during their childbirth experiences. The main cultural preference discussed by the participants was related to the foods and beverages that they were served, which did not align with their beliefs and was difficult for them to digest. The preference for natural childbirth was also mentioned by participants as not being respected. Furthermore, Patricia added that she felt pressured into receiving epidural analgesia by her nurses when her culture frowns upon it and she told the staff that she did not want it. The participants reported that their cultural preferences were not always respected.
Chapter Summary

There were three emergent themes from the data analysis. The theme, *perceptions of support*, was concerned with participants’ perceptions about the emotional and physical support that they received from their maternity nurses, and how that support impacted their overall childbirth experience. Apart from one, all the participants reported very positive perceptions of support and childbirth experiences.

The theme, *feeling vulnerable*, illustrated the perceptions that the immigrant women had about being unable to control some of the events of labor. Three participants were disappointed that their wishes were not followed at some point during their labor.

The third theme, *respecting my cultural preferences*, encompassed the experiences of the immigrant mothers in the sample of nurses’ awareness and understanding of their cultural customs and preferences related to childbirth. Each theme was illustrated using the participants’ own words.
Chapter 5

Discussion of the Findings

There has been a significant increase in the immigrant birth rate in the United States over the past decades, yet few studies have been conducted on the perceptions of immigrant mothers about their experience of giving birth in their new country. The purpose of this study was to describe and find meaning in immigrant women’s maternity care experiences during the birth of a child for the first time in a U.S. hospital. The perceptions of immigrant women of their first childbirth experience in the United States were analyzed for patterns of meaning, with the objective of informing nursing practice in providing maternity care to immigrant populations. A purposive sample of immigrant women who had given birth for the first time in a U.S. hospital within the past five years was obtained. The participants’ reflections on their childbirth experiences, perceptions of support received from nurses, and overall perceptions about the experience were analyzed and described using the participants’ own words.

This chapter will include a discussion of the thematic findings that emerged from the data analyses. The thematic findings will be linked to the literature review, with similarities among the findings from the current study and past studies highlighted. In addition, a discussion of how the findings may be displayed through a conceptual model for intercultural nursing will be provided. The methodological issues encountered during the study will be reviewed, and implications for future research discussed. A description of the implications of the study findings for nursing research and science, nursing
Discussion of Thematic Findings

The childbirth experiences of immigrant women in this study were similar to childbirth experiences of non-immigrant women. The meanings of their experiences, however, reflected their unique perspectives of experiencing childbirth in a new country.

Three themes emerged from the data analyses:

The first theme, perceptions of support, encompassed what emotional support meant to each of the participants and their own views of how nurses impacted their childbirth experiences. Feeling vulnerable illustrated the participants’ perceptions of events during their childbirth experience which left them feeling vulnerable or without control. Respecting my cultural preferences reflected the meaning of the participants’ cultural preferences in shaping their perceptions of the experience of childbirth. These thematic findings support the findings from previous qualitative studies related to culturally diverse immigrant or minority women and their childbirth experiences.

Perceptions of Support

The theme, perceptions of support, demonstrated the different perceptions of the participants about the emotional support that they received from their nurses during their childbirth experiences. The meaning of emotional support was viewed differently by each participant. The participants talked about needing to feel encouraged, less lonely, or assured that everything was going to be all right during childbirth. Support was also described by the participants as having trust in their nurses. They described supportive
nurses as being compassionate and demonstrating caring attitudes. Some of the participants viewed support as the ability to meet their physical needs, including pain relief and sleep. Showing genuine care delivered in an unrushed manner was also identified by participants as being important to feeling supported.

Some of the participants needed emotional support from their nurses to allay their fears about childbirth in the United States, which were shaped by experiences from their native countries. They talked about their previous knowledge of childbirth from other women’s experiences in their native countries. Whether they had personally witnessed women giving birth in their native countries, or heard accounts of childbirth from other mothers, some of the participants indicated that they entered their childbirth experiences with fears from others’ experiences. The situations that they encountered during childbirth sometimes left them feeling more alone and frightened.

These fears about what childbirth in the United States would be like affected their experiences and their expectations about the nursing care they would receive. The emotional support provided by their nurses had significant effects on decreasing their fears during childbirth and improving perceptions about the experience for most of the sample. The participants in the current study credited their nurses for providing the reassure and encouragement they needed when they felt frightened.

The findings about the fears of immigrant women during childbirth supports the previous findings of Wikberg and Bondas (2010), who conducted a qualitative meta-ethnography to explore and describe patient perspectives on intercultural caring in maternity care. Forty studies about intercultural caring in maternity care conducted in
multiple countries, including the United States, United Kingdom, Australia, and the Scandinavian countries were reviewed. More than 1160 women from over 50 cultures were sampled in the 40 studies, who migrated from other countries and came from different cultural background than their nurses. Seven opposite metaphors were found from the data, including vulnerable women with painful memories vs. racism, and caring vs. non-caring. Participants in the studies described situations that caused them to feel vulnerable and lonely: fear and anxiety about childbirth, separation from loved ones, and painful memories from experiences in their past such as torture, rape, or female circumcision. Memories of other women in severe pain, or who died during childbirth may be rekindled by their own childbirth experience. Unfortunately, vulnerable immigrant women were often met by healthcare professionals who exhibited cultural stereotyping, discrimination, or racism instead of the caring behaviors that were needed.

Wikberg and Bondas (2010) described “professional caring” as “kindness, feeling cared for, professional knowledge, personal touch, being attentive to and explaining, presence, respect for culture, religion, and family, and continuity.” Non-caring was experienced “when staff is not talking to patients, not listening, not asking, not understanding, or not informing” (p. 7). The participants in the current study felt that their nurses treated them with kindness and respect, and were knowledgeable and caring. The participant who had a negative childbirth experience felt that her nurses did not talk to her, did not listen to her, and did not adequately inform her.

The current study findings regarding cultural influences on women’s fears and expectations during childbirth also support the work of Brown, et al. (2010) who
conducted a qualitative study of 34 Somali immigrant women in Rochester, N.Y. to examine sources of resistance to prenatal and obstetrical care elements. The researchers found that the participants expressed aversion to Cesarean section delivery due to fear of dying and the belief that doctors should not rush the progression of labor. The fear of dying was associated with the participants’ knowledge of women who had died from Cesarean section deliveries, from observations in Somalia and refugee camps, and from community hearsay.

The role of culture in shaping expectations about childbirth was also found among the participants’ discussions of their experiences. Several of them compared their childbirth experience with the experiences of other women in their family or native countries. The experiences of other women during childbirth contributed to their own meaning of the childbirth experience.

The phenomenon of cultural influences on childbirth expectations was discussed anecdotally by Lewallen:

Culture consists of integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and/or institutions of racial, ethnic, religious, and/or social groups. Childbearing has always been rooted in culture. In each culture, there are unique meaning and customs associated with pregnancy, childbirth, and the puerperium. (Lewallen, 2011, p. 4)

An example of a phenomenon shaped by the participants’ cultural beliefs was pain perception. The experience of pain during labor is viewed differently and managed
differently by diverse cultures. While some cultures instill the expectation that people in pain remain stoic, people in other cultures are very expressive in response to pain. The management of labor pain also varies globally from no interventions or natural childbirth, to medical interventions including medications and anesthesia. The current study’s participants talked about their cultural expectations about pain management during labor. Some were expecting natural childbirth, without the use of medication, anesthesia, or instrumentation. They were surprised when they were encouraged to receive epidural anesthesia, or were induced for labor, since these procedures are not encouraged in their cultures. They viewed the nurses who provided care to them during childbirth as integral to supporting their needs for culturally acceptable pain management.

The findings from the current study about how the western model of maternity healthcare often conflicts with immigrant women’s cultural practices support those from Higginbottom, Hadziabdic, Yohani, and Paton (2013). The qualitative systematic review and meta-ethnography of 22 qualitative research studies was conducted to synthesize data on immigrant women’s experiences of maternity services in Canada. Conflicts between immigrant women’s cultural practices and the delivery methods of childbirth care were cited due to the western model of healthcare not accommodating the various cultural practices of many immigrant women. Most notable were the roles of technology during childbirth and the attitude of nurses in affecting these cultural conflicts. Some of the participants in the current study felt rushed into receiving Pitocin for labor induction or consenting to epidural anesthesia, preferring to allow nature to guide their childbirth
experiences. They cited the practices of their cultures to not hasten the use of these interventions to labor.

The need for rest after childbirth is another example of a culturally shaped expectation. In many cultures, new mothers are cared for by other female family members, who take care of the other children and household chores for an extended time to allow the new mother to rest. Rest is considered paramount to the mother’s recovery and she is not expected to perform any household duties except feeding her newborn. Several participants commented about not being given an opportunity to rest in the hospital, which conflicted with their expectations. Since they perceived that their expectations about their need for rest were not met while in the hospital, they also viewed their nurses as less supportive of their needs because of the frequent interruptions in provision of care. They also perceived that nurses could have been less intrusive on their rest time and more supportive of their requests for assistance in caring for their newborns so that they could rest. This is a new finding as there is a gap in the literature concerning cultural expectations about rest and immigrant women’s childbirth experiences in the United States.

The participants also needed to be supported by nurses because they missed family members. Some talked about feeling lonely due to separation from family members, especially their mothers, who remained in their native countries. They shared that not having their mother present with them during childbirth, which is common in their native countries, left them feeling alone. They stated that they looked to their nurses to provide the emotional support that would normally have been provided by their
families in their native countries. Most of them said that they felt they were emotionally supported by their nurses, with stories shared about how the nurses’ support positively impacted their childbirth experiences, especially when the support of their family was not available. This finding supports the findings of the study conducted by Higginbottom et al. (2013). The study of how immigrant women experience care in Canada resulted in the identification of seven key concepts from the literature regarding maternity care experiences, including the importance of cultural adaptation and social support on high quality maternity health care. Separation from family and friends was cited by immigrant women as contributing to their need for more support from healthcare professionals in meeting their emotional and practical needs. Support from nurses was reported as most important to many women in helping them to cope with their needs during the maternity period.

Most of the participants felt that their nurses cared for them and were supportive of their needs. These positive feelings of support from their nurses influenced their overall satisfaction with their childbirth experience. One participant, however, did not feel cared for or supported, and shared that there were times during her experience that she felt ignored. She elaborated further that her nurses did not spend the time with her that she had expected. She also felt that she was not always treated with kindness and respect. This is similar to the findings from the qualitative study conducted in the United Kingdom by Jomeen and Redshaw (2013). The study aimed to explore Black and minority ethnic women’s experiences of maternity care in England. A random sample of 4800 women was selected through birth registration records and mailed a maternity
survey, designed to investigate core aspects of maternity care, three months after they had given birth. Two hundred and nineteen ethnic minority women responded to the survey. Three open-ended questions were asked, regarding the support received during their hospital stay. Three themes that emerged from the data analysis were (a) feeling cared for, (b) staff attitudes and communication, and (c) ethnicity and culture. “Feeling cared for” described the participants’ need for caregivers to convey sensitivity, reassurance and caring to them during childbirth. The participants’ expectations of care frequently reflected that they needed more time and attention from their midwives and nurses than they felt they had received. Their expectations for help and kindness were often unmet, with participants describing that they felt “ignored” or “a nuisance.” The most common issues regarding staff attitudes by the participants were related to poor communication, lack of information-giving, and a need for individualized care, respect, and sensitivity. They voiced the desire to be treated like a person and not just a part of a standard routine process.

Feeling vulnerable

The second theme that emerged from the data was feeling vulnerable. This theme encompassed the feelings of the participants when situations emerged, usually during childbirth, that left them feeling that they lacked control. Some of the situations in which participants felt that a lack of control was due to not being given choices or being persuaded into making choices that they would not have preferred. All of the participants reported that they received epidural anesthesia, despite many who stated that they preferred not to have it. Feeling vulnerable also describes participants’ feelings when
their stated wishes were not accommodated, such as feeling incapacitated by physical exhaustion or pain, or having their bodies exposed.

Some of the participants felt vulnerable when they were not able to utilize their preferred pain relief measures during labor, like taking a warm bath or using a birthing ball. Two participants felt vulnerable when they needed to have a male provider present in the delivery room, which conflicted with their religious beliefs. Another participant wanted to exclusively breastfeed and felt vulnerable when a pediatrician told her she must give the baby formula instead, against her husband’s wishes. While they expressed their understanding that emergent situations could alter their preferred choices for care, several of them voiced that they still felt vulnerable as a result of these situations. These findings are similar to those from the Jomeen and Redshaw (2013) study of Black and ethnic minority women’s experiences of maternity care. In the study, women blamed medical staff for denying their choices and not involving them in decision-making, which left them feeling vulnerable. They felt vulnerable because of their ethnicity or cultural needs, especially when Muslim women requested only female doctors during the delivery and were attended to by males. Women also reported that they felt vulnerable due to having been born in another country, recent migration, difficulties communicating because of lack of fluency in English, and different expectations from their healthcare providers.

In addition to situations that the participants felt unable to control, some also felt vulnerable when they were persuaded to make a decision that they were not comfortable with. Examples include agreeing to receive epidural anesthesia when they preferred
natural childbirth and agreeing to keep their baby with them when they preferred that the baby be in the nursery, so they could rest. They reported that they did not fully understand what their options were in these situations, were not informed of their other options, or were misunderstood by their healthcare providers when they stated their preferences. These findings support those of Wojnar (2015), who studied Somali couples’ perspectives on perinatal care and support in the United States using descriptive phenomenology. The sample included 48 Somalian immigrants who previously had at least one child in their native country and at least one child born in the United States. Open-ended interview questions were asked about the experiences of pregnancy, childbirth, and maternity care in the United States. Data was analyzed using Colaizzi’s (1978) method, with an overarching theme of “navigating through the conflicting values, beliefs, understandings and expectations” emerging from the data. The first of the three subthemes to emerge was “feeling vulnerable, uniformed, and misunderstood” (Wojnar, 2015, p. 362). Since many of the Somali participants spoke little or no English, they reported that they often felt uniformed about pregnancy and childbirth and did not ask questions because they didn’t know what to ask. They indicated that they wished caregivers had spent more time explaining things, verifying their understanding and their wishes. They often did not understand what was happening, which caused them to miss opportunities important to their religion and culture. Additionally, many participants described breakdowns in communication between healthcare professionals and themselves during childbirth, which caused confusion and fears for them due to lack of understanding. Because of these communication breakdowns, some participants felt
pressed to agree to treatments and that providers did not take the time to fully explain the informed consent for their understanding.

Although all the participants in the current study spoke English, several of them also talked about feeling misunderstood and vulnerable when they requested information or stated their preferences. For example, one participant and her husband requested more information about why their baby needed to be in the Neonatal Intensive Care Unit. They received conflicting information that they did not understand from the healthcare provider, who became angry and argued with them when they asked questions. Another participant stated that she requested that no medical students be present during her delivery, but a medical student was present, and she felt too exhausted to protest. Another participant was emotionally traumatized when a nurse did not believe the intensity of her pain. These experiences left them with a feeling of vulnerability. These findings were also found in the study by Jomeen and Redshaw (2013). Ethnic minority women in their qualitative study described issues with communication between their healthcare providers, difficulty with obtaining and understanding information from them, and not being listened to or believed by hospital staff. They felt vulnerable in these circumstances because of their limited English, lack of understanding about the health system, and feeling uncared for by their healthcare providers. These issues with their healthcare providers contributed to the women feeling disappointed in the care they received.

Similar findings were found in the systematic review conducted by Small et al. (2014). The systematic review included 34 studies conducted across five countries
(Australia, Canada, Sweden, United Kingdom, and United States) in order to determine what immigrant and non-immigrant women want from their maternity care, and to investigate what is known about immigrant women’s experiences of maternity care. From their findings specific to immigrant women, the researchers found that language difficulties interfere with effective communication and understanding between them and their caregivers when they are not fluent in the language of their receiving country. Almost all of the immigrant studies reviewed cited language difficulties as a major issue. Immigrant women also reported that they did not receive adequate information about their care options and were reluctant to make their wishes known.

Two of the participants were Muslim, a culture that forbids a woman to be unclothed in the presence of a man other than her husband. They talked about feeling vulnerable due to the presence of male providers in the delivery room. Both participants said that they understood the medical necessity of having the male providers present, but it still made them feel vulnerable. This finding has not been reported in the literature but has been anecdotally reported in literature guiding cultural practices and gender in healthcare. Padela and Rodriguez del Pozo (2011) discussed the bioethical perspective of cross-gender interactions between Muslim patients and their physicians. The Islamic religion dress code for women states that only a woman’s face and hands should be uncovered in the presence of men, other than her husband. The need for modesty makes women patients reticent to change their dress, expose parts of their body, or to be examined by or alone in the presence of male physicians. Islamic law does allow for deviation from same-sex healthcare providers in cases of emergency or need. The
authors’ recommendation is that physicians recognize the importance of culture to patients, try to understand and respect their values, and be willing to adapt their practice to accommodate patients’ values whenever possible.

Several of the participants talked about feeling vulnerable when they were served food and beverages that were not culturally acceptable to them, or well-tolerated by their bodies, and felt helpless trying to obtain something that they could eat. The Chinese participants all talked about the cold water and cold foods that they were served after giving birth, the “American” style foods that they could not eat, and the lack of availability of warm soups and beverages by the hospital food services. Some of the participants talked about how it was customary for family members to bring food to new mothers after they give birth. Separation from family in their native countries decreased their ability to obtain foods prepared according to their customs. The finding about the challenges of meeting immigrant mothers’ cultural dietary needs and preferences while they are hospitalized has not been reported in the literature. A similar finding about the importance of diet and traditional Chinese practices to Chinese mothers was found in a descriptive phenomenology conducted by Lee, et al. (2014). The 15 Chinese immigrant women in the sample were recruited and interviewed about their experience with receiving maternity care in Toronto, Canada. The Chinese immigrants practiced the traditional 30-day confinement period, avoiding cold temperatures during the postpartum period. The women in the sample reported that nurses demonstrated cultural insensitivity during their intrapartum and postpartum hospital stay, which included serving them cold beverages and exposing them to cold temperatures. Most of the participants in the study
stated that they still adhered to some of the traditional Chinese childbirth practices and expected that their nurses would accommodate their cultural preferences and be more culturally sensitive.

**Respecting my Cultural Preferences**

*Respecting my cultural preferences* was the third theme to emerge from the data. The theme represents how the participants perceived whether or not their nurses respected their culturally acquired customs, preferences, and practices related to childbirth. Each culture celebrates the significant life event of childbirth in unique and meaningful ways. The participants eagerly shared some of their cultural customs with the researcher when they were asked to describe their experience of childbirth. It became evident that immigrant women hold onto the customs and practices of their culture even when they have been living in the United States for many years. Participants who immigrated from their native country to the United States as children or young adults shared that they continued to follow cultural traditions for childbirth that were passed along through family members or acquaintances.

Many of the participants perceived that the nurses did not seem to respect their preferences and customs. They shared that their requests were ignored or not honored, despite specifying their wishes to the nurses. Because of their cultural belief systems, the participants sometimes encountered situations that caused them to feel both vulnerable and not respected by their nurses when they did not respect their wishes.

The most commonly cited example of nurses not respecting participants wishes was discussed by all the Chinese participants. The participants described how in Chinese
culture, new mothers avoid the consumption of cold beverages and foods after giving birth. They talked about the traditional custom of a 30-day confinement period, or “sitting the month” in Chinese culture. For the first month after giving birth, new mothers are advised to drink only warm beverages and consume warm foods, such as special soups with high fat and protein content. The participants stated that it is believed that keeping the body in a warm state will renew the mother’s strength, restore health, and increase her milk supply. They all voiced their dismay that they were served only ice water to drink by their nurses. Despite their requests for warm water, tea, or soup, they stated that nurses continued to bring ice water. To the Chinese participants, not bringing warm water instead of cold meant disrespect for their cultural preferences. A participant in the current study noted that even though she grew up in the United States, she wanted to try the traditions of confinement to restore her health and increase her milk supply. She believed that following the practices made her feel stronger and she had fewer colds and viral infections the winter after giving birth than in previous years.

The preference for this cultural practice supports the findings of Leung (2017), who examined the postnatal dietary practices of Chinese immigrant women. The aim of this qualitative study was to explore how cultural beliefs influence postpartum dietary choices and infant feeding practices among Chinese women living in London. The sample included 10 self-identified Chinese mothers who had given birth in the past 12 months. Like the participants in the current study, all the Chinese women knew of the practice of zuo yuezi (ZYZ), or “sitting the month.” The majority practiced the dietary approaches of ZYZ for up to one month after childbirth, avoiding “cold” foods and
consuming “warm” ones. Like the participants in the current study, the Chinese mothers in the Leung (2017) study felt that their customs regarding their cultural dietary practices were not understood by their nurses. They reported that they sometimes received advice from their healthcare professionals that contradicted their cultural dietary practices. The importance of the dietary proscriptions of ZYZ to Chinese mothers was demonstrated in both studies, as was the expectation that nurses should be aware of and respect cultural preferences.

The findings of the current study about immigrant women having the expectation that nurses would be aware of and respect their cultural preferences was a finding in the meta-ethnography conducted by Higginbottom et al. (2013). Immigrant women in their study also had the expectation that healthcare staff would know and understand their cultural practices and customs related to childbirth. Immigrant women often adhere to diverse ethnocultural customs and practices associated with childbirth, which may not be congruent with the philosophy of the western healthcare system. When these customs and practices were not understood by their nurses, the participants in both studies did not feel respected.

Some of the participants felt that the use of medical interventions during their labor, including Pitocin for induction of labor and epidural anesthesia, disrespected their cultural preferences for natural childbirth. They talked about how the use of epidural anesthesia is not commonly practiced in many countries, yet it is the most common form of anesthesia during childbirth utilized in the United States. Every participant in the current study reported receiving epidural anesthesia. Although most of them were glad
that they received effective pain relief, some talked about nurses who persuaded, or even urged them to consent to an epidural. A few participants stated that agreeing to receive the anesthesia made them appear weak in the opinion of others in their culture. Others mentioned that they felt that they could have tolerated the pain of labor without anesthesia, had they been given the opportunity. According to one participant, in her culture, it is believed that epidural anesthesia may cause more complications for the mother and baby, and its use is to be avoided. Another participant talked about how she felt that her cultural preferences regarding induction of labor were not respected when she was immediately given intravenous Pitocin to induce labor. In her culture, it is customary to allow nature to dictate the timing of delivery.

The literature does not address the issue of natural (non-medicalized) childbirth preferences on a global nature. The finding about immigrant women preferring to allow “nature to take its course” during childbirth, however, was found in the study by Hill, et al. (2012). The qualitative study aimed to describe the health care experiences and beliefs of Somali immigrant women regarding pregnancy and birth in the United States. The convenience sample of 18 Somali immigrant women included women who were currently receiving prenatal health care or had experienced prenatal care and delivery in the United States within the previous 2 years. Focus groups were conducted with participants being asked open-ended questions regarding their cultural beliefs about pregnancy and experiences of prenatal care in their new country. Thematic content analysis of the data revealed six themes, including “pregnancy as a natural experience for women” (Hill, et al., 2012, p. 75). The participants discussed their cultural view of
pregnancy and childbirth as being natural states and allowing faith in God to guide the childbirth process rather than science. Because of their deep religious faith, the Somali women participants were reluctant to agree to medical care or advanced technology procedures for what they considered to be natural processes (Hill, et al., 2012).

The examples of ways in which their cultural preferences were not respected shared by the participants in the current study reflect the importance of cultural sensitivity when providing maternity care to immigrant women. Cultural sensitivity involves acceptance of patients’ cultural beliefs and practices without imposing one’s own beliefs upon them. The participants expected their nurses to respect their preferences. Yet despite having stated their requests about food and beverage temperature and natural pain relief methods, some participants found that there were nurses who imposed their own beliefs upon them.

The finding about maternity nurses not respecting or understanding the cultural preferences of immigrant mothers supports one of the findings of the study conducted by Lee, et al. (2014). The Chinese immigrant women in the sample reported that nurses did not always respect their personal preferences regarding the avoidance of cold temperatures, and cold foods and beverages after childbirth. The practice of applying perineal cold packs to reduce discomfort from swelling was cited by the women as an example of not respecting their cultural preferences. Some of their nurses insisted on applying the cold packs, despite the women’s requests not to have them. The study pointed out that nurses could easily adapt certain care practices, such as not applying cold packs to the perineum postpartum and providing alternative comfort measures that are
more culturally appropriate. “Ethnic and cultural considerations are important when providing care to immigrant women because women’s satisfaction with maternity services is an important component of optimizing maternal health” (Lee et al., 2014, p. 7).

The importance of understanding and respecting immigrant mothers’ cultural preferences was also found in the descriptive interpretive ethnography by Wikberg et al. (2012). The study’s objective was to describe and interpret the perceptions and experiences of caring of immigrant new mothers on their maternity care in Finland from an intercultural perspective. Seventeen immigrant mothers from 12 countries were interviewed within a few days after giving birth in a Finnish hospital. The study found that although most of the participants were satisfied with their maternity caring experiences, some of their nurses demonstrated stereotypical and ethnocentric views toward patients from different cultural backgrounds, which negatively impacted their experiences. They reported that some nurses imposed their western views on them, not allowing them to practice their traditional customs, such as using herbs, eating certain foods, or using religious symbols. For example, nurses did not understand the Asian theory of hot and cold, removing extra blankets that a mother put on her infant because they were “not necessary.” The special hot meal after delivery was also missed by the Asian mothers, who did not have relatives nearby to provide traditional foods. The immigrant mothers perceived that nurses who did not respect their cultural preferences were uncaring, as did the participants in the current study.
Methodologic Issues

The recruitment of immigrant populations for the research study proved to be more difficult than anticipated. Recent changes in immigration policies in the United States have caused immigrant inhabitants to become fearful of arrest or deportation if they entered the country illegally. Many immigrants, especially women, have limited education and do not understand the research process. Fear of being discovered as an illegal immigrant may have contributed to the lack of response to recruitment materials placed in physician’s waiting rooms and offices, and the local Women, Infants and Children (WIC) office. Prior to the recruitment phase of the study, the current presidential administration was not yet elected into office and the immigration policies were not yet enacted. As harsh new policies were enacted regarding immigration, it became more difficult to recruit participants who did not want to risk being identified as illegal aliens.

The importance of having gatekeepers in ethnographic studies has been well established in previous research. It became apparent during the recruitment of participants for this study that gatekeepers would be necessary as well. The potential participants who did contact the researcher for eligibility screening all commented that they did so because a person held in authority recommended that they apply. The gatekeepers for this study included a priest and nursing faculty from two local universities. Local churches with large immigrant populations proved to be good sources for recruitment, if personal connections were made through gatekeepers to women who fit the inclusion criteria. It was the personal connection with the researcher, as an
acquaintance of the gatekeeper, that ultimately resulted in potential participants feeling safe in contacting the researcher.

**Theoretical Connection**

The findings from the current study are theoretically consistent with the Model for Intercultural Caring (Wikberg & Eriksson, 2008). The Model for Intercultural Caring (Wikberg & Eriksson, 2008) was developed from the assumptions of Eriksson’s Caritative Caring Theory (2002). Caritative caring incorporates compassion and love for other human beings, deep respect for human dignity, and genuine presence for those who are suffering (Wikberg & Eriksson, 2008). Wikberg et al. (2012) defined “intercultural caring” as “the genuine relationship that occurs between nurse and patient who belong to different cultures” (p. 639).

The Model for Intercultural Caring (Wikberg & Eriksson, 2008) holds that caring is a complex whole, consisting of inner caring, outer caring and the goal of caring. Inner caring takes place in the relationship between nurse and patient, where caring and culture are interwoven and inseparable. Caring is dependent upon cultural contexts and symbolic meanings. Outer caring is comprised of the external factors that influence caring, such as social, administrative, and educational structures. The goal of caring is to affect change towards health and well-being.

The researcher has adapted this theoretical model for the population in the current study (Fig. 1). Inner caring in the current study occurred through the relationship between nurses and patients from different cultural backgrounds. During childbirth, the participants indicated that they needed the support of their nurses to help them to manage
CULTURAL COMPETENCE
NURSES/ORGANIZATION

INNER CARING

Feeling Vulnerable

Respecting My Cultural Preferences

Perceptions of Support

ALLEVIATE FEAR, ANXIETY, PAIN
PROMOTE HEALTH & WELL-BEING OF
MOTHER/BABY

Figure 1. Application of Wikberg and Eriksson’s Intercultural Caring Model using the study findings. Adapted from “Intercultural Caring – An Abductive Model,” by A. Wikberg and K. Eriksson, 2008, Scandinavian Journal of Caring Sciences, 22, pp. 485-496. Copyright 2008 by John Wiley and Sons. Adapted with permission.
loneliness, fear, and pain. Being in a different culture and country for the birth of a child caused them to look to their nurses for caritative caring. In their perceptions of support, the participants reflected on both caring and uncaring relationships that they felt were formed with the nurses who provided their care. Most of the participants reported feeling the type of genuine relationship with their nurses found in intercultural caring. The participants spoke about how their nurses made them feel encouraged, assured, or less lonely during their childbirth experience. They also talked about how they felt that they could trust their nurses, the compassion that was conveyed, and the respectful attitudes displayed by their nurses. Trust, compassion, respect, and genuineness are elements of caritative caring and intercultural caring that are a part of nursing’s core (Lindström, Lindholm, & Zetterlund, 2006).

The participants in the current study also talked about circumstances that left them feeling vulnerable, such as feeling a lack of control, being in pain, physical exhaustion, and being unable to make culturally acceptable choices. Intertwined with these situations that resulted in feeling vulnerable were other situations that caused the participants to feel supported by their nurses, or that their cultural preferences were respected by them. For the participants in this study, feeling that their nurses were caring was at the core of relationships, affecting the women’s perceptions of being supported by the nurses, feeling less vulnerable and feeling respected. The overarching influence on patients’ and nurses’ perceptions of caring was culture (Wikberg & Eriksson, 2008). Culture shapes and defines the behaviors of both the patient and the nurse. When the patient and the
nurse are from different cultures, their perceptions of what constitutes caring may also differ. The outer core influences on caring for immigrant women were cultural competency and organizational factors. Cultural competency refers to the knowledge, skills and attitudes of nurses who cared for the participants. Organizational factors include those that affect the delivery of maternity care within the individual facilities where the participants gave birth. These varying levels of nurses’ cultural competence and organizational influences on culturally competent care resulted in some participants receiving more intercultural care from their nurses than others. The goal of intercultural caring is to alleviate suffering and to promote health and wellbeing. In the current study, the goal of intercultural caring was promotion of the health and well-being of the mother and child.

**Implications**

The findings related to the childbirth experiences of immigrant women in this study contribute to the body of knowledge about immigrant women’s perceptions about their childbirth experiences in the United States. There are implications from the study’s findings for nursing science and research, education, and practice.

**Nursing Science and Research**

Immigrant women’s perceptions about their first-time childbirth experiences in their new country have not been previously explored in the United States. This study’s findings add new knowledge to nursing science by qualitatively exploring this phenomenon. The findings also add to what is already known about caring for immigrant mothers by contributing the perspectives of the mothers themselves. The development of
culturally competent nursing care is needed due to the burgeoning patient population of immigrant mothers in the United States. The findings contribute to nursing knowledge about how to incorporate knowledge, attitudes and skills that reflect care for immigrant women’s unique cultural beliefs and needs.

Furthermore, the findings provide evidence that may be used in the development of an instrument for the measurement of nurses’ perceptions of the needs of immigrant women during childbirth. Such an instrument would assist in determining nurses’ cultural competency in providing care to a burgeoning patient population. Assessing nurses’ cultural awareness, sensitivity and understanding when caring for immigrant populations will facilitate the planning of continuing education programs to improve the delivery of more culturally competent care. The adapted Intercultural Caring Model (Wikberg & Eriksson, 2008) might also be tested on other populations whose cultural backgrounds differ from those of their nurses, to determine its usefulness in describing the intercultural caring between those populations and their nurses.

Gaps in the literature remain in the areas of maternity care for immigrant women and nurses’ attitudes about caring for immigrant mothers. The current study findings offer inspiration for future research into these areas by illuminating immigrant women’s experiences and how nurses’ attitudes contributed to them.

**Nursing Education**

The study findings hold relevance for nurse educators in the preparation of nurses to deliver culturally appropriate care to diverse populations, in accordance with the AACN (2008) *Essentials of Baccalaureate Education*. The information from the findings
may be added to existing nursing curricula to facilitate student nurses’ understanding of the needs of culturally diverse women during childbirth. Specific areas of information from the findings that may be utilized for nursing education include communication skills with patients who speak English as a second language, assessment of cultural beliefs and practices related to childbirth, and developing cultural competency in assessing, planning, and providing nursing care to the intrapartum and postpartum woman. The inclusion of immigrant patients into clinical assignments in the maternal-child care setting should be utilized by clinical nursing instructors whenever possible. Simulation scenarios with standardized patients could be developed to demonstrate effective and ineffective communication techniques. Additionally, simulation scenarios focusing on providing culturally sensitive care, that incorporates the beliefs of the immigrant patient, into maternal-newborn nursing courses may be developed based on the findings.

The findings regarding immigrant mothers’ needs for increased emotional support and respecting cultural childbirth beliefs could also be incorporated into case studies within nursing curricula. Case study scenarios may be developed by nurse educators that incorporate the feelings shared by the study participants regarding loneliness, fear, vulnerability, and not having their cultural beliefs understood. The development of case study scenarios that incorporate the cultural preferences of immigrant women during the perinatal, intrapartum, and postpartum periods is also suggested.

Advanced practice nurse educators, especially those involved in preparing nurse midwifery students, may utilize the information from the findings to emphasize cultural competency and communication skills in the curricula. These skills could be developed
through the incorporation of case studies, role playing, and simulations with standardized patients pertaining to the needs of culturally diverse women during childbirth into educational programs.

Continuing education modules designed to increase nurses’ cultural competency with immigrant mothers may also include case studies, live panel discussions with immigrant mothers, and guest speakers with experience in caring for culturally diverse populations. Interactive learning opportunities with culturally diverse immigrant women would be especially beneficial in strengthening interpersonal relationship skills necessary for culturally competent caregivers.

**Nursing Practice**

In this study, immigrant women’s childbirth experiences were impacted by the nurses who took care of them. There are several recommendations for nursing practice based on these experiences. One of the themes that emerged from the data was related to the increased need for emotional support from their nurses, and how nurses were able to provide the expected level of support. Practicing maternal-child nurses need to be cognizant of immigrant women’s fears and loneliness to provide the level of emotional support expected by the women during childbirth. Relationships with their nurses that were built on trust, respect, and caring attitudes were reported by the participants who discussed having very positive childbirth experiences. Nurses who practice in maternal-child healthcare settings would benefit from in-service and continuing education programs geared toward developing awareness, knowledge, and skills for improving their
ability to support immigrant women’s needs, and to improve nurse-patient relationships with culturally diverse populations.

The current study also found that immigrant women often feel vulnerable during childbirth due to a lack of control over circumstances, being physically exhausted or in pain, or being unclothed in the presence of men. Practicing maternal-child nurses need to be especially aware of respecting immigrant women’s privacy, since it is unacceptable in some cultures for a woman to be seen unclothed by men other than their husbands. Allowing immigrant patients to make choices, when possible, and being aware of cultural expressions of pain and fatigue might also decrease feelings of vulnerability. Nurses need to advocate for the physical needs of women during and after childbirth. Patient advocacy includes ensuring that patients are served meals that meet their cultural needs, receive adequate pain relief, and are given enough opportunities for rest.

Nurses in maternal-child practice should receive continuing education programs regarding the provision of culturally sensitive care to women from diverse cultures. The findings from this study reflect the findings from the literature that immigrant women feel that their cultural beliefs are not always respected or understood by their nurses. The development of cultural competency may occur through continuing education programs about the cultural practices of populations commonly encountered in the maternity care setting. Incorporating case studies and in-services involving culturally diverse speakers centered around specific cultural beliefs or practices is suggested to assist nurses with developing cultural competency.
**Future Research**

The findings that emerged from this study lead to several recommendations for future research. Recommended areas for future research include exploration into the unique challenges for immigrant women in receiving maternity care in the United States, providing culturally competent nursing care to immigrant women during pregnancy and childbirth, assessment of immigrant women’s satisfaction with their nursing care during childbirth, and the development of tools to measure the cultural competence level of maternity nurses.

- Qualitative studies with larger, more heterogeneous samples to explore and describe immigrant women’s perceptions of first-time childbirth experiences in their new country.
- Explore nurses’ feelings about providing maternity care to immigrant patients from cultural backgrounds that differ from their own backgrounds.
- Examine immigrant women’s perceptions of support during childbirth.
- Explore interventions to reduce vulnerability during childbirth for immigrant women.
- The development of assessment tools to assess satisfaction with childbirth nursing care of immigrant women.
- Examine the effectiveness of interventions to increase cultural knowledge and attitudes of maternity nurses who care for immigrant women.
- The development of an instrument to assess cultural competence in maternity nurses.
• Explore nurses’ attitudes about the emotional needs of immigrant women during childbirth.

• Describe nursing interventions to facilitate emotional support by nurses to immigrant women during childbirth.

**Chapter Summary**

This chapter provided a discussion of the findings that emerged from the study, including new knowledge regarding immigrant women’s perceptions about their childbirth experiences. The findings were linked with related findings from previous empiric literature. There were significant connections of the predominant themes found in the current study with some of the findings from the literature. Specifically, the findings related to emotional support, feeling vulnerable, and nurses’ respect for cultural preferences mirrored findings from previous studies. The findings were linked to the Intercultural Caring Model, a conceptual model for Eriksson’s Caritative Caring Theory (Wikberg & Eriksson, 2008; Eriksson, 2002). A caring nurse-patient relationship was found to be especially important to the immigrant mothers in meeting their needs for support, decreasing vulnerability, and respecting cultural beliefs. Implications for nursing research, nursing education, and nursing practice were discussed. Recommendations for future research related to the nursing care of immigrant women were provided.
References


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Appendix A

Screening Tool for Sample Selection

1. Are you 18 years old or older?

2. Are you able to speak and understand English?

3. Are you able to read English?

4. Were you born outside of the U.S.?

5. Is your youngest child under the age of 5 years?

6. Was your youngest child born in a hospital?

Was this the first time that you had a baby in a U.S. hospital?
Appendix B

Demographic Information

This information will be used solely for the purpose of describing you in this study.

1. Age: _______

2. What country were you born in?

________________________________________

3. How do you identify yourself ethnically?

<table>
<thead>
<tr>
<th>Asian Indian</th>
<th>Korean</th>
<th>Other Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or African</td>
<td>Latino</td>
<td>Other Hispanic</td>
</tr>
<tr>
<td>Chinese</td>
<td>Mexican</td>
<td>Other Race</td>
</tr>
<tr>
<td>Cuban</td>
<td>Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>Filipino</td>
<td>Puerto Rican</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>Vietnamese</td>
<td></td>
</tr>
<tr>
<td>Japanese</td>
<td>White</td>
<td></td>
</tr>
</tbody>
</table>

4. Marital status which best describes your relationship:

Single ____
Married ____
Involved with a significant other or partner ____
Widowed ____
Divorced ____
Other (please describe) __________________________________________
5. Have you gone to school?  _____ Yes  _____ No

   If yes, what was the highest level you completed?

   _________________________________________________________________

6. What is your level of employment?

   Unemployed _____

   Work part time _____

   Work full time _____

   Currently on maternity leave _____

7. How long have you lived in the U.S.? ________________________________

8. Children

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Sex</th>
<th>Place of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

9. Did you receive any prenatal care in the U.S. with your last pregnancy? ________
If yes, how many weeks pregnant were you when you went for your first visit?
____________________

10. Was your youngest child born in the hospital? ________________

   Did you have a vaginal delivery, induced vaginal delivery, or C-section?
   _________________________________________________________________

11. Was the baby pre-term (less than 38 weeks) or full-term?
   _________________________________________________________________

   Was the baby discharged at the same time as you? ________________

12. How long did you stay in the hospital during the birth of your youngest child?
   __________________________________________________________________

13. Did you have any complications from the birth? What were they?
   __________________________________________________________________

14. Did you receive anesthesia (epidural or spinal, general) during the birth?
   __________________________________________________________________

15. Did you breastfeed your baby, or bottle feed?
   __________________________________________________________________

   How long did you breastfeed for? ________________________________
Appendix C

Semi-structured Interview Guide

The interview will open with the request:

“Please tell me about what is was like having your baby in the hospital.”

A series of probing questions will be asked during the interview to elicit further explanations, and to encourage richer descriptions of the experience from participants.

- “Describe the birth of your baby.”
  “How did you feel about the birth? What were your thoughts about the birth?”

- “Tell me about your time in the hospital.”
  “How did you feel about having the baby in the hospital?”
  “Describe your feelings about the care you received.”

- If the participant has given birth previously in her native country:
  “Tell me about having a baby in your native country.”
  “Tell me about what was the same and what was different about having a baby in the United States hospital?”

- “Please share any further thoughts you have about the birth of your baby in the hospital.”

- “Looking back over the birth of your baby, what are your feelings about the overall experience?”

- “Do you have any other thoughts you would like to add about having your baby?”
Appendix D

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Widener University IRB Protocol Number

INVESTIGATOR(S) NAME: Carole Lorup, PhD (candidate), RN

STUDY TITLE: The Meaning of Immigrant Women’s Experience of Childbirth for the First Time in a U.S. Hospital

PURPOSE OF THE STUDY
The purpose of this research study is to describe what it is like for women who were born in other countries to have a baby in the hospital in the U.S. for the first time.
I am being asked to be a participant in the study because I have recently had a baby in a local hospital, I was born in another country, and I have lived in the U.S. for less than 5 years.

DESCRIPTION OF THE STUDY
As a participant in the study, I will be required to take part in a live talk with the researcher. I will be asked to tell what it was like to have a baby in the hospital in this country. My story will be recorded on a voice recorder.
The amount of time required to participate in the study is about 60 to 90 minutes.
There will be no cost to me related to study participation.

RISKS AND DISCOMFORTS
As a participant in this study, I may become sad or upset while talking about my story. The risk that I might experience will be minimized by being able to skip any question that makes me feel uncomfortable. I am free to ask to go on with the talk, or to end it at any time.
If I experience any of the risks identified, I should ask to either skip the question or end the talk.

**BENEFITS**
There is no benefit to me by being in the study, but my story may help nurses to give better care to other women from different countries when they have their babies. I will be given a small gift after sharing my story to thank me for my help.

**ALTERNATIVE PROCEDURES**
I may decide not to participate in this study.

**CONFIDENTIALITY**
All documents and information pertaining to this research study will be kept confidential in accordance with all applicable federal, state, and local laws and regulations. I understand that data generated by the study may be reviewed by Widener University's Institutional Review Board, which is the committee responsible for ensuring my welfare and rights as a research participant, to assure proper conduct of the study and compliance with university regulations. If any presentations or publication result from this research, I will not be identified by name.

The information collected during my participation in this study will be kept for 5 years after the study has been published. Data from the study will be stored in a locked filing cabinet in the researcher’s home office, and in a password protected personal computer.

My privacy and confidentiality will be protected by the researcher being the only person who can access my information.

My confidentiality will be also protected by the assignment of a false name on all paper records, and no mention of my real name in recordings.
TERMINATION OF PARTICIPATION
I may choose to withdraw from this study at any time and for any reason. If I choose to drop out of the study, I will contact the investigator and my research records will be destroyed.

COMPENSATION
As a study participant, I will receive the following compensation for being in this study: a small gift card to Babies R Us. To receive the compensation, I must complete the live interview. Compensation will be provided when the interview is finished.

INJURY COMPENSATION
Neither Widener University nor any government or other agency funding this research project will provide special services, free care, or compensation for any injuries resulting from this research. I understand that treatment for such injuries will be at my expense and/or paid through my medical plan.

QUESTIONS
All of my questions have been answered to my satisfaction and if I have further questions about this study, I may contact Carole Lorup, at (phone number and email address provided). If I have any questions about the rights of research participants, I may call the Chairperson of the Widener University’s Institutional Review Board at 610-499-4110.

VOLUNTARY PARTICIPATION
I understand that my participation in this study is entirely voluntary, and that refusal to participate will involve no penalty or loss of benefits to me. I am free to withdraw or refuse consent, or to discontinue my participation in this study at any time without penalty or consequence.
I voluntarily give my consent to participate / for my child to participate in this research study. I understand that I will be given a copy of this consent form.
I, the undersigned, certify that to the best of my knowledge, the subject signing this consent form has had the study fully and carefully explained by me and have been given an opportunity to ask any questions regarding the nature, risks, and benefits of participation in this research study.

Carole Lorup

Investigator’s Name (Print)

[Signature]

Investigator’s Signature

Date

Widener University’s IRB has approved the solicitation of participants for the study until 8/29/2018
Appendix E

Provider Letter

Carole Lorup, PhD (candidate), RN

Date ______________________

Dear ______________________ (obstetric care provider),

Thank you for your interest in participating in the participant recruitment phase of my doctoral dissertation research study, “The Meaning of Immigrant Women’s Experience of Childbirth for the First Time in a U.S. Hospital.” The purpose of this research is to describe and find meaning in immigrant women’s maternity care experiences during the birth of a child for the first time in a U.S. hospital. This study has been approved by the Widener University Institutional Review Board, approval number ____________. Your role in this study will be to distribute informational brochures to women who:

- have given birth to a live baby in a U.S. hospital within the past 12 months;
- are 18 yrs. of age or older;
- were born outside of the United States (other than Canada, the United Kingdom, or Australia);
- have lived in the United States for 5 yrs. or less;
- are able to speak, read, and understand English.

Enclosed are 25 copies of the brochure, describing the research study, for your distribution to patients who may meet the eligibility criteria. The brochure contains the researcher’s contact information. Interested parties will contact the researcher directly
for eligibility screening and study participation. Additional copies of the brochure are available upon request. Please feel free to contact me with any questions. Your assistance with my research is deeply appreciated.

Sincerely,

Carole Lorup, PhD (candidate), RN (xxx) xxx-xxxx
Nursing
Wideener Unit, School of
Imigrant Women's
Meaning Of

Carole Lorup, PhD (c), RN

Address
(researcher's email)

xxx-xxx

Thank you for
Your Interest.

Why?

U.S. hospital
You are having a baby for the first time. It is a new and exciting
experience. The nurse who will be doing your care will
need to know where you are from and some other
information about you.

English
Do you speak/read and understand:

the English language?

have been a baby in the hospital within

your country of origin?

are 15 or older?

Are looking for woman's voice.

Childbirth in A U.S.

Hospital: A Research Study

Women's Experience Of

The Meaning Of Immigrant
Email: [email]
Phone: (xxx) xxx-xxxx

Weber State University School of Nursing
Contact: Carole Long, RN, Doctoral Student

You are entitled to help with the study.

You will be asked questions about the study and address below to learn more about the study.

Call or email the researcher at the number below.

Contact the researcher for more information.

The interview will be given to you after the interview.

Please send the interview by email or phone at (xxx) xxx-xxxx.

The interview will be about 90 minutes. For the interview, your baby in your new country.

Researcher about what it was like to have

Volunteer to talk privately with the researcher.

How can I help?