Influence of Culture and Community Perceptions on Birth and Perinatal Care of Immigrant Women: Doulas' Perspective

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ABSTRACT

A qualitative study examined the perceptions of doulas practicing in Washington State regarding the influence of cultural and community beliefs on immigrant women's birth and perinatal care, as well as their own cultural beliefs and values that may affect their ability to work interculturally. The findings suggest that doulas can greatly aid immigrant mothers in gaining access to effective care by acting as advocates, cultural brokers, and emotional and social support. Also, doulas share a consistent set of professional values, including empowerment, informed choice, cultural relativism, and scientific/evidence-based practice, but do not always recognize these values as culturally based. More emphasis on cultural self-awareness in doula training, expanding community doula programs, and more integration of doula services in health-care settings are recommended.

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The aim of this study is to describe the influence of cultural and community perceptions on birth and perinatal care of immigrant women from the perspectives of doulas who practice in Washington State. Doulas are trained and experienced women who provide continuous physical, emotional, and informational support to mothers before, during, and after birth (Gentry, Nolte, Gonzalez, Pearson & Ivey, 2010). Researchers have found that doula support influenced positive birth outcomes, including decreased need for medical technological interventions or pain medications (Hodnett, Gates, Hofmey, & Sakala, 2013), lower rates of birth complications or having a low birth weight newborn (Gruber, Cupito, & Dobson, 2013), and less likelihood of lower newborn Apgar scores (Hodnett et al., 2013; Sauls, 2002). Doula support is also associated with decreased maternal stress (Wen, Korfmacher, Hans, & Henson, 2010), more breastfeeding, greater self-esteem, confidence in mothering, and a decreased likelihood of postpartum depression and anxiety (Abramson, Breedlove, & Isaacs, 2005).

Doula support may be particularly pertinent for perinatal immigrant women, especially those who are limited-English speakers or those with limited resources. As immigrant mothers account for 23% of all births in the United States (Livingston & Cohn, 2012), birth and perinatal care for these women are

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important issues. Although immigrant women are an extremely diverse population and research on their birth outcomes is highly equivocal (Ceballos & Palloni, 2010; Cervantes, Keith, & Wyshak, 1999; Cripe, O'Brien, Gelaye, & Williams, 2011; Janevic, Savitz, & Janevic, 2011; Johnson, Reed, Hitti, & Batra, 2005; Madan et al., 2006; Qin & Gould, 2010; Urquia et al., 2010), navigating an unfamiliar and complicated U.S. health-care system may nonetheless leave many immigrant mothers overwhelmed, vulnerable, and less able to access necessary resources during a particularly stressful time such as pregnancy and birth (Schoroeder & Bell, 2005). For example, in a study about the birthing and perinatal experiences of immigrant Filipina, Vietnamese, and Turkish women in Australia, Small, Yelland, Lumley, Brown, and Liamputtong (2002) found that these participants reported less satisfaction with the caregiver attitudes, provision of information and explanations, participation in decision making, and continuity of care they received than did non-immigrant Australian women. Olayemi, Morhason-Bello, Adedokun, and Ojengbede's (2009) study with African women of various ethnic backgrounds found that pregnant women who shared their caregivers' ethnicity experienced the labor as less painful and that having trained doulas who gave social and emotional support helped reduce the mother's experience of pain. In a U.S. study, Dundek (2006) reported that cesarean surgery rates were lower among Somali refugee/immigrant women who were attended by a doula at birth than among their counterparts who did not have a doula. Hazard, Callister, Birkhead, and Nichols (2009) reported positive outcomes from the Hispanic Labor Friends Initiative, a Utah project through which Hispanic women from local communities who were mothers and trained for labor support and translation provided perinatal support to pregnant Hispanic immigrant women across care settings. As these studies indicate, doulas who practice in a culturally sensitive manner may help improve the childbirth and perinatal care experience of immigrant women (Callister, Corbett, Reed, Tomao, & Thornton, 2010) by acting as cultural brokers and advocates throughout these processes as they help immigrant women navigate through the complex process of health-care decision making and by providing social and emotional support (Small et al., 2002).

The role of culture is critical in terms of birth and perinatal care for immigrant mothers when considering the role of doulas as cultural brokers and advocates; however, it must be considered in a complex and contextual manner. Although many health-care providers recognize the importance of culture when working with immigrants, one common pitfall is essentialization (Takeuchi & Gage, 2003). When providers assign limited and generalized cultural understanding and meanings to an identified ethnic group, they gloss over the intricate within-group diversity as well as the complex social and historical contexts within which those cultural meanings may exist. Another pitfall is creating a dichotomy wherein the immigrant "culture" is studied and scrutinized, whereas the practitioners' cultural beliefs, values, and practices remain unexamined and normalized (Davis-Floyd & Sargent, 1997). In addition, cultural values and perceptions that caregivers/resource brokers hold are important to examine because they may serve as a lens through which clients' needs are interpreted; there are times when the caregiver thinks she or he understands but may have misinterpreted because of her/his own unexamined cultural filters. For example, Brookes, Summers, Thornburg, Ispa, and Lane (2006) found that Early Head Start program home visitors in their study negatively interpreted when mothers wanted to focus on their own needs instead of parenting or child development during home visits. Rather than interpreting such behavior as healthy self-care, which is a necessary part of effective parenting, some home visitors viewed it as selfishness.

Thus, it is important to understand how doulas think about culture, community perceptions, and childbirth and perinatal care because these perceptions influence their understanding of what the immigrant mother is trying to convey to them as well as whether or not they will advocate for immigrant women who seek help and support during such vulnerable times such as childbirth and perinatal periods. This study helps to illuminate not only the doulas' perceptions about childbirth and perinatal care and the impact of cultural and community beliefs on pregnant women's health-care decisions but also their own cultural beliefs and values that affect their ability to work in intercultural settings.

METHODS

This qualitative study used a key informant interview method to understand phenomena from the point of view of participants and their particular social and institutional contexts (Strauss & Corbin, 1990). The author obtained a human subjects review approval from her institution for the study and was aided by two major childbirth service organizations in the Pacific Northwest to recruit professional doulas who practiced in Washington State. The in-person interviews were audio taped and later transcribed. Data were analyzed using conventional content analysis (Hsieh & Shannon, 2005). Peer debriefing, negative case analysis and consultation with a knowledgeable insider (in lieu of member checks[1]) were used to foster trustworthiness of the interpretation of data (Lincoln & Guba, 1985).

Eleven participants, whose individual experiences as a professional doula ranged from 1 to 7.5 years, were interviewed for this study. Seven participants self-identified as White, European, or Caucasian; three as Black or African American; and one as mixed race. Eight participants were U.S. born, and three were immigrants from Peru, Somalia, and, Venezuela, respectively. In addition to English, six spoke Spanish, one Somali, two French, and one both Japanese and Chinese. All but one participant worked with clients who were immigrant women of color from Asia, Southeast Asia, Africa, South America, Middle East, and Mexico.[2] An average of 40% of their clients were immigrant women of color, and 45.5% were nonimmigrant White women. Most immigrant doulas spent most of their time working with women of their own ethnic and/or linguistic backgrounds.

RESULTS

The "Good" Childbirth and Perinatal Care

Three factors were identified by all of the participants as important in their consideration of "good" birth and perinatal care: mothers being able to make informed choices, mothers feeling supported and respected by care providers, and natural (nonmedicated/nonintervention) childbirth. These factors linked directly to what they saw as their work as doulas.

Participants emphasized that pregnant women's ability to make decisions about their birth and perinatal care depended heavily on having sufficient information about their options regarding health-care providers, types and places of birth, possible health-care procedures (and whether they are elective or not), and pre- and postpartum care plans. They also often linked mothers' ability to make informed choices to a sense of empowerment. Thus, participants regarded actively encouraging their clients to ask for information, discussing options with them, and advocating for access to information when needed as an essential part of their work as doulas.

Participants believed that having care providers (such as doctors, midwives, nurses, and doulas) who demonstrate their support and respect for mothers' individual childbirth experiences was essential. This involved listening to mothers (or mothers and their partners when appropriate), communicating with them about their choices, and honoring their wishes and cultural practices. Support and respect were especially important when the birth did not go as the woman hoped (e.g., needing a cesarean surgery when the woman planned for a "natural" birth) or when women's cultural practices (e.g., having multiple family members in the birthing room) did not correspond with their care providers' expectations. Because doulas are involved throughout the prenatal period as well as the birth, they have an intimate knowledge of individual women's birthing plans and preferences; therefore, they are able to provide consistent care and support to women in a way that is different from other health-care providers. Participants emphasized that birth was the time when women were both highly vulnerable and courageous; many immigrant women chose to have a birth doula because they wanted someone to "be there for them," "support them when they are fearful," and "speak for them when they can't."

Participants indicated a strong preference for natural birth by which they often meant birth that did not involve medications (e.g., epidural) or medical technological interventions (e.g., cesarean surgery); for a subset of participants, natural birth meant nonhospital birth. Although some participants felt that natural birth was paramount to a good birth because of the possible adverse effects of medications and medical procedures, others felt that as long as the mother felt supported throughout her birthing process and both the mother and the baby were healthy, medical technological interventions, if necessary, did not take away from having a good birth experience. Despite this difference, participants generally advocated for natural birth whenever possible and often educated women about this option.

Culture and Community Perceptions

Participants identified a prominent source of community perceptions for immigrant women as other women in their families or social networks. Community narratives about childbirth and perinatal care, shared among these networks and reproduced across generations, not only constructed a community's perception of good birth and perinatal practice but also shaped the cultural meaning-making, that is, how a woman understood her childbirth experience and how she felt about herself as a mother. Also, cultural meanings about childbirth and perinatal care practices were not uniform, reflecting the internal diversity based on class status, generational differences, and other factors, within any given ethnicity- or national origin–based community. For example, within the same immigrant community, good birth could mean a natural birth or a cesarean birth, because in their country of origin, cesarean surgery was promoted to upper- and middle-class women as the "modern" and "medically superior" way to give birth, whereas lower income women who had little access to such expensive medical technological interventions equated "the traditional way" (giving birth without medications or technological interventions) with a strong womanhood. Women often interpreted their childbirth experience through the lens of their own social network's narratives, which sometimes meant that they doubted their childbirth choices or felt as if they let themselves and other women in their family down if their childbirth experience did not match the narrative. Similarly, immigrant women who were raised in the United States sometimes felt conflicted when the traditional perinatal care practices that their mothers or grandmothers insisted on were at odds with their health-care providers' recommendations.

The Confluence of Cultural and Language Differences and Economic Resources

The confluence of cultural and language differences and lack of economic resources greatly diminished low-income immigrant women's access to the best care and treatment. Participants who worked with such clients observed that they were often given significantly less information about their birth and perinatal care and that their care options seemed to be delimited by their health insurance (e.g., Medicaid) coverage rather than by their individual health needs. The fact that many immigrant women were not used to asking questions of or demanding explanations from health-care providers, which may be based on cultural beliefs about medical authority, further disadvantaged them. Another complicating issue was the fact that many health-care providers worked under pressure from a heavy patient load and a tight schedule, which barred them from taking sufficient time to assure that all the options were fully explained, interpreted, and understood. If doulas were not available to help them to sift through this complex and at times contradictory information, women would have been greatly disadvantaged.

Participants spoke about language barriers as a major factor that hindered immigrant women from getting the best services. Even though the state required interpreter services, it was often difficult to find reliable and culturally appropriate (such as female) interpreters. Language differences could become acutely problematic if women needed unexpected procedures or if the health-care provider needed to make an urgent decision during birth because sometimes they had to rely on phone-based interpretation services, which could be stressful and confusing for the mother and for the health-care team.

Participants expressed a strong concern over the lack of respect for low-income and/or limited English–speaking immigrant women's cultural preferences during birth at some hospitals. Although some health-care providers were respectful, other providers disregarded women's culturally based wishes (e.g., a woman having her body covered for cultural reasons) even though there was no apparent health-care reason not to honor them simply because doing so would necessitate providers altering their "standard" practices. Participants also found it deeply troubling when some health-care workers treated immigrant women and their families as if they were "charity cases" that did not deserve the best services based on racial/ethnic/class stereotypes or when health-care providers imposed their own cultural beliefs and values on women and their partners (e.g., pressuring and shaming male partners into being present in the birthing room when women did not want them there for religious and cultural reasons). Because of these reasons, participants felt that community doula programs, which offered no-cost doula services to low-income immigrant women, were essential in offsetting some of these disadvantages because they helped women gain much-needed information, access, and advocacy.

Doulas' Own Culture and Community Perceptions

Most of the White participants had difficulty articulating their own cultural beliefs or values regarding birth and perinatal practice and did not believe that they influenced their perceptions. A subset of White participants identified their culture as "Western" and reflected that they usually did not think about their own culture unless they encountered clients whose cultural practices were very different from their own. This is consistent with the phenomenon where people in the mainstream often do not see the need to examine their own perceptions because such perceptions are reinforced constantly by society and thus seem "normal" and beyond interrogation (Miller & Garran, 2008). Participants of color (of which three of whom were also immigrants) more readily identified what they considered their ethnicity-based cultural beliefs and values and how they influenced their perceptions. It is likely that their lived experiences sensitized them to cultural differences and their consequences. However, all participants explicitly stated that they did not impose their own cultural values or beliefs on their clients and that they supported their clients' cultural values and beliefs "without judgment."

Most participants identified the "birth community," including doulas and midwives, as the community whose perceptions influenced them the most. Although they identified a remarkably similar set of community values (informed choice, empowerment, nonjudgmental support for women's cultural practices, scientific/evidence-based practice, and "natural birth"), some did not see these as culturally based, whereas others thought they could be considered a cultural influence (a "birth culture").

What complicates this picture is that some of the doulas' professional values may be in conflict with one another in certain situations. For example, the value of nonjudgmental support for women's cultural practices can be in conflict with the value of scientific/evidence-based practice when working with women whose cultural practices may be at odds with what doulas consider to be evidence-based practice. Similarly, most nonimmigrant doulas consistently conceptualized birth and perinatal care decisions as individual women's choices and often linked such decision making to a sense of empowerment. This may be at odds with some women's cultural practice wherein informed birth and perinatal care decisions include her family's opinions (S. Capestany, personal communication, March 9, 2009). It was not clear from the interviews how doulas might deal with such situations because, by and large, they have not interrogated these professional values as culturally specific values.

The cultural and community perceptions of the birth community were often contrasted with those of the "medical culture," with which doulas expressed a complex relationship. On the one hand, doulas shared with health-care providers many professional values, such as scientific and evidence-based practice, and had good working relationships based on mutual respect and care for pregnant women. On the other hand, doulas were often viewed as "outsiders" by some health-care providers, especially those who were skeptical of non-Western health-care practices. This outsider status was highly frustrating to doulas because it undermined their ability to advocate for their clients.

DISCUSSION AND IMPLICATIONS

The aim of this article is not to broadly generalize the findings but rather to describe the influence of cultural and community perceptions on birth and perinatal care of immigrant women from the perspectives of doulas in one state. In addition, as the author, I am mindful of the influence of my own sociocultural locations (a bilingual immigrant woman of color who is a health-care outsider but has worked extensively with immigrant women as a social worker) on my interpretation of the data. For example, on the one hand, as a social worker, I hold similar professional values as those identified by doulas in this study (such as client self-determination and respect for cultural diversity); on the other hand, my exposure to poststructural theories and social justice education sensitized me to the possible perils of grand narratives and normative discourses. Holding these potentially conflicting ideas may influence the ways in which I interpret the participants' values and beliefs. Similarly, as a bilingual immigrant woman of color, I may over-identify with the experiences of immigrant mothers of color who are navigating a complex U.S. health-care system, which can result in a paradoxical danger of erasing important within-group differences. Being aware of these and many other threats to interpretation, I have used several methods to foster trustworthiness of my analysis, such as peer debriefing, negative case analysis, and consultation with a knowledgeable insider (Lincoln & Guba, 1985). Thus, following discussion and implications are offered within such

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contexts as a reflection on and a synthesis of the lessons from this study.

This study highlights the compounding impact of economic resources and cultural differences on immigrant women's birth and perinatal care. While language and cultural differences hindered immigrant women's full access to care, limited economic resources exacerbated the problem because their options were delimited by the confines of the public insurance coverage. Similarly, inadequate resources at the hospitals and clinics made it difficult for health-care providers to offer effective interpreters or sufficient time during perinatal appointments. A possible implication for perinatal care is that providing culturally appropriate and supportive services requires resource advocacy both on the client level (including families as well as individuals) and on the systemic level. Perinatal educators may consider including systems advocacy as part of the training for doulas and other perinatal care providers.

Another consideration for perinatal education is the need for increasing the number of trained bicultural and bilingual doulas from immigrant communities and for expanding community doula services for immigrant women. Lack of resources, information, or cultural resonance may prevent many immigrant women from accessing doula service and its many advantages. This study echoed prior research (Hazard et al., 2009) findings that having doulas who not only shared the primary language of the women and had understanding of their cultural beliefs and practices but also were skilled at navigating the U.S. health-care system was highly effective in aiding immigrant women to feel supported and to gain access to information and resources. Given the high birth rates among immigrant women, the number of community doulas and the availability of their services should grow accordingly to meet the needs of this potentially vulnerable population.

The participants' narratives about good birth and perinatal care demonstrate that there is a consistent set of beliefs and values that doulas hold, which reflect their professional orientation. However, these values and beliefs were so naturalized within the doula community (or the birth community) that it seemed difficult for some doulas to recognize them as culturally specific beliefs and values. This phenomenon elucidates how difficult it is to recognize the specificity of values and beliefs that one inhabits unless they are contrasted with another set of values and beliefs, which is particularly challenging for those whose values are echoed by mainstream culture (Miller & Garran, 2008).

Cultural self-awareness is paramount to intercultural practice because being keenly aware of the influence of one's cultural values and beliefs can help practitioners avoid privileging them over other values and beliefs and become more conscious of the dynamics of power in intercultural practice (Hays, 2008). Without cultural self-awareness, doulas can inadvertently become gatekeepers, advocating for the practices that are consistent with their values and beliefs and trying to influence women to change their beliefs or practices when they are not. An important implication for doulas and other perinatal care providers is that the cultural competence training should start with reflecting on their own professional and personal beliefs and values and how these values influence their perceptions and practices, which is consistent with Small et al.'s (2002) findings. Without this grounding, learning about other people's cultural beliefs and practices, as important as they are, still will be interpreted through a very specific, unrecognized, and unexamined lens (Davis-Floyd & Sargent, 1997), which can lead to essentialization and "othering" of diverse realities (Takeuchi & Gage, 2003).

Despite these challenges, doulas fill an important role with pregnant immigrant women; their advocacy can greatly aid women in gaining access to information and effective care, and their emotional and social support can significantly improve women's emotional experience during childbirth and perinatal periods. For example, Hodnett et al.'s (2013) international review of 23 trials indicated that women who had continuous labor support (such as doula support) were more likely to give birth without medical technological interventions and less likely to need pain medications or have babies with lower Apgar scores. In addition, these researchers found that mothers who had continuous support also expressed more satisfaction with their childbirth experience.

Given that doulas, as a profession, are at times considered health-care outsiders, it is more likely

that they are more sensitive to such status and its negative consequences than other health-care providers (such as doctors) who are more socialized and centralized into the health-care system. This experience and sensitivity may help doulas be more effective mediators and brokers for pregnant immigrant women. Furthermore, such services can be highly beneficial to health-care providers when working with immigrant women whose cultural practices and languages are unfamiliar to them. Therefore, more integration of doula services in health-care settings and an expansion of culturally relevant community doula programs are recommended.

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NOTES

1. Although Lincoln and Guba (1985) recommend member checks as an avenue for ensuring trustworthiness of the analysis of data, respect for the participants' time commitment and busy schedules barred the author from asking for more time from them for member checks. In lieu of member checks, the author consulted with a knowledgeable insider, who was a doula with extensive intercultural clinical experience and was very familiar with the local perinatal care practices and politics, during the data analysis phase. The consultant's feedback was incorporated into the analysis of data.
2. The national backgrounds of immigrant clients included Ethiopia, China, Mexico, Somalia, Honduras, Peru, Colombia, Algeria, Gambia, Vietnam, Chad, Iraq, Jamaica, Fiji, India, El Salvador, Nicaragua, Venezuela, Laos, Burma, and Eritrea.

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