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Senior Capstone Final Report:

African-Born Women's Birth Experiences in Worcester, MA

By: Anneke Kat, Maya Baum, Bernadine Mavhungu

Introduction

This semester our group of IDSC student researchers worked closely with Professor Sarkis on her project which aimed to collect the birth stories of African-born immigrant women who are living and gave birth in the city of Worcester. This project is part of a larger effort to investigate the disproportionately high infant mortality rate in the Worcester African community by the Infant Mortality Reduction Task Force. The initial goal of the project was to collect 20-25 stories but both time and the limits of IRB approval limited our community research to observing a focus group of immigrant women discussing their perceptions of childbirth in the United States as well as interviewing key healthcare practitioners in Worcester who serve the African population. Our findings shed light onto both the differences in how healthcare providers and patients understand interactions with each other and the very important role that the community and the support of social networks plays in a woman's experience during pregnancy and birth. While we were able to uncover some valuable research and perspectives within the Worcester community, our research experience was characterized by several challenges that hindered us from collecting more data and directly interviewing women.

Background

Before our research within the Worcester community could begin, our group decided to familiarize ourselves with the bodies of research that existed and most closely pertained to both our topic of research as well as our research methods. Our literature

review explored the differing attitudes and approaches towards childbirth both in the United States and abroad in African nations. Additionally we obtained health information and statistics about women of color in Main South and Massachusetts as well as information that explores the advantages of conducting both storytelling and hospital ethnographies as research methods. Additionally the literature review helped make us aware of just how little information there is available about immigrants in the United States, especially when it concerns both women's experiences of birth.

Our group first sought to gain some basic understanding in the physical and psychological health status of women in Massachusetts, and especially in Worcester. The Massachusetts Department of Health states that as of 2009, women of color make up about 1/5th of the state's population yet they disproportionately suffer from poor health and poverty at a rate much higher than any other group. Professor Ross conducted a study in Main South that exposed that women of color are the highest at risk for multiple health conditions as well as stress caused by both their socio-economic situation and the built environment itself. What was lacking from our research was the visibility of immigrants and refugee women in these data.

Our research also explored American women's perceptions of the birthing and prenatal experience in comparison to that of African-born women and immigrants. Miller and Shriver conducted numerous in-depth interviews with a diverse group of American women and their research results showed that the prevailing practice is one that embraces and trusts a biomedical environment and views the guidance of health practitioners and the environment of hospitals as the least risk involved place for birth. The study identified a minority of women who operate outside of the biomedical

perspective of birth and view a hospital as a more risky environment for birth. The study conducted by Namey and Lyerly sampled a similar diverse population of American women and explored how American women understand and perceive control during their pregnancy and births. This perception of control was described by five core characteristics; self-determination, respect, personal security, attachment, and knowledge. These characteristics were placed within the framework of a woman's own psychological well being as well as her relationships and attitudes towards others. This gave us a basic knowledge of what kind of pregnancy culture African-born immigrants are finding themselves in within an American context.

Additionally we also looked into the experiences of African-born women with healthcare systems of western nations such as Sweden, Canada and the United States as well as within Ghana itself. In a focus group conducted by Professor Ross with Ghanaian women living in Worcester and through several other studies in the nations mentioned above, our group identified areas where African-born women had both praise and concern and criticism for the Western healthcare systems they found themselves in. Many of these women had a lot of praise for the American healthcare system and all its services but the cited many issues as well. This included issues with language barriers, including practitioners who could not understand thick accents and many women felt ignored or underrepresented in their experiences with practitioners or in hospitals. Additionally women said the felt judged or misunderstood by practitioners for their interpretations of prenatal care including the use of traditional vitamin supplements or concerns of witchcraft. These concerns would also become apparent in our further research within the African-born Worcester community.

Most importantly, what our literature review revealed was that in the United States, pregnancy and birth is understood as phenomenon and experience that requires biomedical treatment. Infant mortality and prenatal health is understood through this biomedical lens, less attention is paid to the socio-cultural and economic factors that influence women's, and especially African-born immigrant women's, experiences and perceptions of childbirth. This unexplored perspective is what our group decided to focus on and look for within our research. Additionally we were able to start to compare the perspectives and stories of African-born women to that of some healthcare providers and find the discrepancies between the two perspectives.

Methods

Our researching process began with ensuring that all members of our research team were qualified to conduct data collection under the University of Massachusetts IRB requirements. Certification was obtained through the Biomedical Research Investigators and Key Personnel, Basic Course administered online by The University of Massachusetts Medical School Human Subjects Institutional Review Board at <http://www.umassmed.edu/research/irb/citi/>. Our study had already been submitted to and approved by Clark University's IRB, and was still awaiting approval from UMass IRB. The completion of certification by our group members allowed us to begin preliminary interview with health providers, not patients. Practitioners became the main source of data collection for this project in the time allotted and while we await approval from UMass.

Through professor Sarkis, we were able to attend a focus group comprised of immigrant women discussing their reproductive experiences in the Worcester medical

system. After receiving the consent of each participant, data was collected through audio recording. The recording was then transcribed and a script developed. From this script, background data on broad issues faced by immigrant women was obtained for our project.

Professor Sarkis also provided us with a list of practitioners and community leaders whose knowledge and experience would lend itself to our research. Through email correspondence, we reached out to these sources in attempts to schedule interviews. In preparation for these interviews, we created an interview instrument to be used for practitioners and providers. In the two week timeframe available for interviews, we were able to schedule interviews with two contacts. These interviews were conducted at Clark University and at Umass Memorial Hospital. Consent was obtained for both interviews, and audio recording were collected. Transcriptions for these interviews served as preliminary findings for our study.

We have received responses from other relevant contacts and interviews with these contacts have been scheduled for next semester, as two of the three research assistants intend to continue the study with professor Sarkis.

Preliminary Findings

Our first interview was with Grace, a Ghanaian registered nurse working in the Worcester medical system. Through her interview, we uncovered the ways in which kin relationships, social support groups, immigration, cultural beliefs, and language barriers affect African immigrant women's pregnancies and birthing experiences.

Kin relationships, especially maternal ones, are very important to African immigrant women when it comes to their pregnancies. Older women, especially older mothers, are well respected in the community, and are vital in the pregnancy of young women. In the delivery room, it is expected that the birthing woman's mother and/or other older female figures will be present. Mothers are looked to for knowledge, support, and guidance. The presence of a woman's mother or older maternal figure is integral to this population of women.

Other social support networks play a part in the experience of African immigrant women. In this community, the church is a very important social group. African immigrant women and their families place a lot of emphasis on church attendance and religious values. For a pregnant woman, the church serves as a support group. When women are pregnant the church shows its support for the woman and her child by presenting her with gifts for her newborn. For women who break the standards set by the church however, namely those women who become pregnant outside of marriage, there is a very different church experience. Often the church will visibly be less supportive of this woman, and she will receive less financial and material assistance. Women who become pregnant outside of marriage are also publically shamed, made to sit in the back of the church to symbolize their transgressions. For these women, the negative response from the church, a vital support network, can have negative effects in the way she bonds with her baby.

Immigration plays a role in the health of a woman's pregnancy by providing misleading information about the mother's age. In order to qualify for certain visas when travelling to the United States, many African immigrant women will lie about their age,

either claiming to be older or younger. When these women become pregnant in the United States, their legal age may not represent their true age. The safety and health of a pregnancy then becomes threatened as doctors may not administer the necessary tests for a woman who is high-risk by being pregnant in her forties because her paperwork claims she is much younger. On the other hand, a young pregnant woman may be asked to take extra precautionary tests because her legal age is much older. When this woman does not attend all her appointments, because she knows she does not need them, her lack of attendance will be recorded as non-compliance.

Cultural beliefs surrounding the causes and treatments for certain ailments also affect the ways in which women respond to diagnoses and medical advice given to them by practitioners. The belief in witchcraft and sorcery in this community plays out in women believing their own theories of what is responsible for a medical condition. Many Ghanaian women believe for example that diabetes is either from the devil or the result of a curse placed on them by someone who is jealous or does not like them, often a mother-in-law or step-mother. This belief means that practitioners need to be sensitive to these women, and also work within cultural parameters when administering treatment. Grace described a situation in which a woman was convinced her mother-in-law gave her diabetes, and so grace did not disagree with her, but rather focused on helping her understand the way to treat her condition, without dismissing or judging her patient's belief system.

Cultural ideals surrounding childbirth and what it means to a woman also affect the child birthing process. To African women, childbirth and being a mother are the most important roles a woman will play. Mothers command great respect, and the experience

and the pain of childbirth are viewed as a spiritual and physical process all women must go through. Epidurals and other forms of pain management during birth are culturally discouraged, and so most women elect to give birth free of medication. The aversion to medication however leaves many women uneducated about the various options they have when it comes to pain management during birth, and so if they become overwhelmed during delivery, they feel forced to stick to their birth plan. Some women do opt for epidurals, but it is still socially discouraged. C-sections are also not preferred, and so rates of elective C-sections are non-existent. Women who are unable to give birth naturally and require a C-section can be made to feel like failures among other women.

Beliefs around mental health also affect African immigrant women by preventing them from seeking mental help when they need it. African women are from a culture where they are expected to be strong, and seeking mental health is equal to admitting to being crazy. The stigma surrounding mental health leaves many women having to cope alone in the face of stress and depression. Grace highlighted the importance of practitioners to be vigilant in observing African women, especially post-partum, and to be proactive in suggesting the woman receive mental healthcare, as she will most likely not ask for it herself.

The lack of English proficiency creates a barrier between African immigrant women and American health care providers. In her place of employment, Grace has the majority of African patients under her care. Patients find it easier to not only understand a fellow African, but also find it easier to relate on a cultural level. Even with patients who are fluent in English, Grace finds herself playing the role of cultural mediator between

patients and practitioners. Even immigrants who can speak and understand English find that their accents make it difficult for doctors to understand them. This frustration leads them to prefer African nurses or doctors, who unfortunately are not numerous enough to satisfy the client base. Speaking with Grace was extremely insightful, she provided us with both the perspectives of a health practitioner serving this community as well as an African-born woman herself, she had an insider's understanding about how African-born women feel and act within the healthcare system as well as within their community during their pregnancy and birth. She acted as a gatekeeper to the Ghanaian community and will be an extremely helpful resource as the research for this project moves forward.

Additionally some of our preliminary data was obtained from a focus group conducted by Professor Sarkis and two interviews with medical providers who practice in Worcester. The focus group was investigating immigrant women's perceptions of pregnancy and childbirth in the United States versus their home countries. The group consisted of around 3 or 4 Ghanaian women, two Vietnamese women, and a woman from Nepal. While it was not focused on African born women, a lot of the data is relevant to this project.

Some important themes came up in the focus group that helped shape our interviews with the medical providers. One of the most salient themes that came up was the idea of "stress" surrounding their pregnancy. One of the Ghanaian women described her first pregnancy in the United States as very stressful because she felt that she was constantly being bombarded by phone calls from the hospital telling her to come in for more tests and that there were all these problems with her pregnancy and she didn't understand what was happening. From this idea of "stress" came another very interesting

concept. The idea that Ghanaian women “don’t want to know” when/if someone is wrong with their pregnancy. The Ghanaian women all agreed with each other that it is a cultural thing; in Ghana they explained, due to understaffed facilities, lack of resources, and general lack of caring on the part of medical providers, women don’t know if something is wrong with the pregnancy, it is simply not part of their pregnancy culture. That aspect has been brought over to Worcester. One of the Ghanaian women told the story of her pregnancy with her daughter when she was told her baby had a hole in her head. She explained her relief in not having listened to the doctors as her daughter came out perfectly healthy and if she had listened to the doctors, she would have terminated her pregnancy and lost her baby. The women credited part of their “not wanting to know” to the fact that the physicians and their tests are not God, and can be wrong, as seen with the example of the hole in the head. The women acknowledged that this “issue” is their problem and not the fault of physicians.

Other women cited stress as well; in most cultures the mother plays an extremely important role in a women’s pregnancy, birth, and postpartum, helping to raise the child. Most of the women at the focus group were away from their mothers and discussed the separation from their families and mothers as being stressful; not having someone to help with the tasks that traditionally a mother does.

Stress was also cited by one of the physicians we interviewed, Dr. Sara Shields. She cited that many of her Ghanaian patients (who constitute the majority of her African born patients) are dealing with stress issues brought on by acculturation issues and having to juggle multiple jobs, raising children, and for some going to school. An interesting positive piece that Dr. Shields provided was that the Family Health Center provides

group sessions ,where they discuss things related to pregnancy and childbirth, and that her Ghanaian patients seem to really enjoy these settings. We also found that during the focus group the Ghanaian women were very engaged and were working off of one another as opposed to the other Capstone research group working with Professor Sarkis experiences trying to interview Ghanaian women one-on-one.

Dr. Shields also believed that the issue of premature births that accounts for the high rate of infant mortality in the Ghanaian population is not due to a medical reason but a socio-cultural one. However, it is clear by comparing the testimony of Dr. Shields and Grace and the other women from the focus group that there is a disconnect between what non-Ghanaian medical providers are perceiving as issues affecting the Ghanaian community and the problems/challenges Ghanaian women are citing. Based off of our preliminary findings from the focus group and comparing the two medical provider interviews, it is clear that there needs to be some type of communication bridge between medical providers and the Ghanaian women. Additionally, it seems that it would be beneficial to utilize the group setting when treating Ghanaian women, as they seem to feel more comfortable in that type of setting as opposed to one-on-one settings.

Next Steps

Now that we have some preliminary data we are going to continue trying to interview a few more medical providers, ensuring to reach out to both Ghanaian and non-Ghanaian providers. As this research continues next semester, our next steps will be to start making more connections within the Ghanaian community and within the medical community at UMass hospital. We learned a lot from listening to the other African immigrant group present. It is clear from their experiences that it would be beneficial to

be familiar presences in the community before attempting to interview them. As their experiences, combined with the knowledge we have from the focus group and Dr. Shield observations, inform us, Ghanaian women seem to feel more comfortable in group settings. Unfortunately, the nature of this research requires one-on-one interviews. We hope that we will be more successful if the women are already slightly familiar with us and perhaps even familiar with the nature of the questions (not necessarily what the exact questions will be but with the overall theme of the questions). Hence the importance of making connections within the Ghanaian community. Our ultimate goal is to interview 20-25 Ghanaian women postpartum in the hospital and that will be our final step before data analysis.

Challenges

While we were able to collect data and start thinking about some beginning theories, this project experienced some challenges along the way. The first major challenge was time. All three of us are full time students and finding time outside of our class and class-work time provided to be difficult. Additionally, trying to schedule interviews with the providers was quite challenging. We were working within a fairly short time frame and all the providers we contacted are very busy so it took time to get in contact with them and then to find a time that worked for both parties to schedule an interview. When we started this project, the goal was to interview women before the end of the semester. However, UMass' IRB form is incredibly complex and long and we are still in the process of receiving IRB approval.

Another challenge we encountered was in researching the existing literature. Our research question is so specific yet also slightly vague. We found it very difficult to find

literature that discussed African immigrants pregnancy and childbirth experiences. We encountered another problem when trying to research statistics on the African population. In all the census data it doesn't distinguish between African born persons and African-American persons. They are all clumped together into the category of "black". While those statistics were able to give us part of the picture, it was still incredibly difficult to understand exactly what is happening with this population.

Conclusion

This past semester provided our group to help Professor Sarkis bring this project to life and help get it moving. Although we encountered several challenges which hindered how much data we were able to collect from the Worcester community itself, our preliminary findings give this project direction and several ideas with which future students next semester can investigate further. We were able to expose how infant mortality rates within the African immigrant population in Worcester is much more of a cultural and socio-economic issue than it just being a biomedical one. Additionally our interviews with healthcare providers sheds light on what discrepancies exist between how the health care providers understand how this population experiences birth opposed to how these women experience birth and pregnancy. These differing perspectives not only provide valuable insight but will provide future researchers with the right tools and direction with which they can better collect the in-depth interviews and stories of African immigrant women right after their birthing experience.

Instruments

Health Care Practitioner Research Questions

1. Have you faced any challenges when treating women who consider themselves to be African Immigrants? What have these challenges looked like? How have they affected your work as a medical practitioner? What positive experiences have you had with this specific group of patients?
2. Have you noticed any cultural or behavioral differences in how these women act during their birthing experience as compared to American women?
3. What kinds of representatives from their social/familial networks are involved in the birthing process?
4. Through your experiences treating women who are African immigrants, have you gained any insight into how these women may evaluate risk to both themselves and the baby before, during, and after the birthing process?
5. To the best of your knowledge what prenatal services, if any, have this particular group of patients utilized during their pregnancies? Do African immigrant women attend prenatal exams at different rates than other groups of women? If so, do you know why this is?
6. Have you spent a lot of time treating African immigrants? Could you estimate what percentage of your patients would identify with this category?
7. Have you observed any specific medical issues pertaining specifically to pregnant African women immigrants or women of this category who have just given birth?
8. Have you encountered many problems with language barriers in your treatment of African immigrants? If so, who do you address this barrier? Are translators easy to access?
9. Have you encountered any cultural practices around maternity and childbirth that have been different from your standard practices? Herbal treatments, etc. If so, how did you navigate these cultural differences? Was there a clash/tension?

10. Describe the ideal childbirth process? How do African immigrant women play into this process? Have they helped or hindered it?

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