Navigating the Unknown: Immigrant’s Maternal Health Experiences in Southeast Ohio

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ABSTRACT

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Navigating the Unknown: Immigrant’s Maternal Experiences in Southeast Ohio

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The purpose of this research is to explore the maternal health experiences of immigrant women in southeast Ohio, as well as the differences among those experiences. Common narratives often paint immigrant women as having homogenous maternal healthcare needs and outcomes, and they are viewed as vulnerable and unable to make their own healthcare decisions. Current research has focused on the negative maternal health experiences of immigrants in urban spaces and has, therefore, failed to include populations from rural environments. Athens, Ohio, the primary area where the maternal experiences in this research took place, is a rural environment that has limited maternal healthcare facilities. It does, however, have numerous community resources and is closely connected to Ohio University, which makes it a unique research location to examine immigrant experiences. Consequently, this thesis will examine the significance of spatial context coupled with the frameworks of intersectionality, Othering’, and authoritative knowledge to uncover the factors that contribute to the positive maternal healthcare experiences of immigrant women. Uncovered from semi-structured interviews were three factors participants used to describe their positive experiences. These are interactions with healthcare providers, community resources and support structures, and differences in maternal healthcare from their home countries. I conclude that although the rural spaces of Southeast Ohio provide limited maternal healthcare services, immigrant women have access to numerous community resources and connections to the international student population at Ohio University. This connection
contributes to the agency of immigrant women that allows them to defy common narratives in which immigrant women are often viewed under racialized assumptions.
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CHAPTER 1: INTRODUCTION

The goal of this thesis research is to explore and analyze the maternal health care narratives as told by immigrant women currently living in southeast Ohio. The ways in which women narrate their experiences and the differences among them and the connection to spatial context form the backbone of this research. Contributing to the foundation of this research are three frameworks, intersectionality, ‘Othering’, and authoritative knowledge, that provide insight into how immigrant women form perceptions on maternal care. Laid against the background of current immigrant health research, this thesis seeks to uncover how immigrant women navigate the healthcare system in a rural environment.

In current scholarship, immigrants are often constructed as a “vulnerable population” that is largely at risk for poor health outcomes. This definition of immigrants has been attributed to their political and social marginalization and lack of socioeconomic resources (Derose, Escarce, & Lurie, 2007). Stigmas surrounding immigration status also contribute to the vulnerability of immigrants in the United States and other Western countries. In recent years, the number of immigrants in the United States has rapidly grown, with over 42 million in 2014 (migrationpolicy.org). Current research has primarily focused on the larger immigrant groups such as Latin Americans and Somalis, leaving many groups out of focus.

Barriers associated with immigrants receiving inadequate maternal healthcare have been identified in several literatures such as: communication, stigmas and discrimination, negative perceptions that keep women from attending prenatal appointments, lack of cultural sensitivity from physicians, religious beliefs, resistance to technology, and lack of support. Exploring these barriers and the underlying structures
that construct them are essential to analyzing the perceptions immigrant women create regarding maternal healthcare.

Current literature paints a bleak reality for immigrant women regarding the maternal healthcare treatment they receive in Western countries such as the United States, Australia, and Canada (Reitmanova & Gustafson, 2007; Liamputtong & Watson, 2008; Borkan, 2010; Qureshi & Pacquiao, 2013). These women often experience discrimination from health professionals and their staff. This has been especially true for certain groups of immigrants such as Muslims, who experience discrimination founded on their religious beliefs (Reitmanova & Gustafson, 2007; Borkan, 2010; Qureshi & Pacquiao, 2013).

A main focus within immigrant maternal health research is the highly medicalized processes such as cesarean sections, that contribute to the American healthcare system (Borkan, 2010; Deyo, 2012). Immigrant women who are unfamiliar with the American healthcare system often navigate these maternal spaces without sufficient knowledge of how the system works and they are often expected to obey physician’s healthcare instructions, despite factors such as limited English proficiency. As a result, the maternal healthcare experiences narrated by immigrant women are overwhelmingly negative.

One way to explore how immigrant women perceive their maternal health experiences is through the theories of intersectionality, ‘Othering’, and authoritative knowledge. In current literatures regarding immigrant maternal healthcare, these theories have emerged through findings of discrimination and women’s aversion to medical technologies such as cesarean sections and epidurals (Liamputtong & Watson, 2008; Borkan, 2010; Deyo, 2012). Exploring the ways in which immigrant women are ‘Othered’ allows for further insight into how physicians use their authoritative knowledge against women.
Spatial context is an important factor that reflects how immigrant women perceive their maternal healthcare. Research that explores the maternal health experiences of immigrant women has largely focused on populations in urban areas (Small et al., 2002; Sword, Watt, & Krueger, 2006; Liamputtong & Watson, 2008; Reitmanova & Gustafon, 2008; Quershi & Pacquiao, 2013; Pavlish et al., 2010; Missal et al., 2015). Spatial context can be used as a way to analyze how immigrant women perceive their maternal healthcare such as: number of healthcare facilities in the area, community resources available to expecting women, and presence of an international community. The importance of spatial context has largely been left out of current immigrant maternal health literature. Thus, this research on immigrant’s maternal health experiences is set in the context of rural Southeast Ohio and is based on the following research questions:

1) **What factors contribute to immigrant women’s positive maternal healthcare experiences?**

This research question addresses how immigrant women currently living in southeast Ohio narrate their maternal health experiences with regards to the American healthcare system. It will explore what factors influence immigrant’s maternal care perceptions. This question will help provide insight on how spatial context contributes to the perceptions on maternal care as experienced by immigrant women in Southeast Ohio.

2) **How do these factors differ among women?**

This question will help uncover the differences between immigrant women’s narratives on the maternal care they received. The differences narrated by women make an important contribution to this research by demonstrating that immigrant women’s maternal care cannot be blanketed by cultural assumptions. Understanding the
differences among women’s experiences and the different factors used to contribute to their perceptions, illustrates the need for comprehensive maternal care that can reach women of all backgrounds.

Through qualitative methods, immigrant women’s narratives surrounding their maternal health experiences and the factors that contributed to how they perceived their care were collected. Close attention was paid to the differences discussed among women in order to highlight unique narratives. Narratives that discuss the factors that influenced immigrant’s maternal care perceptions and the differences between them can be found in chapter four under results and discussion.

The combination of intersectionality, ‘Othering’, and authoritative knowledge coupled with the exploration of spatial context provides a unique lens in which to explore the maternal healthcare experiences of immigrant women in a rural environment. This lens will help uncover individual experiences that will push against common narratives of immigrant women as having homogenous maternal health needs and outcomes. This theoretical contribution combined with the emergence of spatial context will contribute to the current gap in immigrant maternal health literatures. In addition, this research also works to fill the current void within geographic scholarship that neglects the maternal health experiences of immigrants in rural environments.

This thesis is divided into five chapters. Chapter two consists of the literature review, which forms the foundation of this research. In chapter two, the terms intersectionality, ‘Othering’, and authoritative knowledge that are briefly mentioned in this introduction, are thoroughly discussed. Additionally, the literature review will work to connect these theories to current immigrant maternal health literature and will highlight the perceived barriers related to immigrants accessing maternal healthcare. Chapter three will focus on the study area and the qualitative methods used to conduct this
research such as sampling and recruitment methods and individual interviews.

Chapter four explores the results and discussion of this study that highlights women’s personal narratives of their maternal health experiences. This chapter will also focus on the differences found among women’s narratives. Concluding this thesis is chapter five that summarizes key findings and offers recommendations for future research.
CHAPTER 2: LITERATURE REVIEW

Introduction

Situated in the sub-field of feminist geography, this research examines the maternal health experiences of immigrant women. The topics that emerge from exploring the health care experiences of immigrants can fall into various academic disciplines, including: sociology, nursing, health, and human and feminist geography, and various others. Important to this research, however, is the connection between “space” and “place” that helps shape the perceptions of immigrant’s health care experiences.

This chapter will first highlight current literature that references immigrant health care experiences, women, and reproductive health. Within this literature I will explore perceived barriers immigrant women face when receiving insufficient maternal health care and the consequences of this. Additionally, I will connect the current immigrant health literature to intersectionality, 'Othering', and authoritative knowledge, three theoretical concepts that emerge from feminist geographical scholarship in order to create the framework for this research. I will then argue that in addition to a consideration of these concepts in current research, geographic context also plays a major role in how immigrants perceive their maternal health care experiences. This spatial context contributes to and enriches this theoretical framework and also provide a unique perspective with which to analyze immigrant’s maternal health care experiences in South East Ohio.
Immigrant maternal health experiences

Research on immigrant maternal experiences can be found in academic journals dedicated to publishing research from fields such as public health and nursing. The following section will highlight current immigrant maternal health literature that will reveal barriers linked to insufficient care (see Figure 1). This research will then be connected to the feminist theoretical concepts of intersectionality, ‘othering’, and authoritative knowledge, which I will use to argue the importance of spatial context when examining experiences.

Although it ultimately depends on multiple circumstances, including socioeconomic background, immigration status, and English skills, immigrants are often considered vulnerable (Derose, Escarce, & Lurie, 2007). Other factors that can impact immigrant vulnerability as noted by Derose et al. (2007) are access to public healthcare facilities, stigmas, and marginalization (p.1258). This study, which examined vulnerabilities that exist in the overall health care of immigrants, found that stigmas contributed to lack of quality care. These stigmas were connected to factors that marginalized immigrants including skin tone, language barriers, speaking with an accent, and cultural and religious practices (Derose et al., 2007). Derose et al. (2007) concluded that immigrants who experience marginalization through stigmas were less likely to continue using health care services.

Access barriers to maternal healthcare and negative perceptions of immigrant women have also been widely documented. Most notably, a lack of cultural sensitivity regarding significant traditions and religious practices was regarded as impeding the quality of maternal care a Somali woman received (Upvall, Mohammed, & Dodge, 2009; Hill, Hunt & Hyrkä, 2011). The culturally significant practice of female circumcision was noted throughout the literature for affecting the communication between patients and
physicians (Deyo, 2012). Physicians who neglect to ask questions regarding circumcisions ultimately impact how Somali women perceive their maternal care (Borkan, 2010). Communication barriers were commonly present throughout all immigrant maternal health studies, contributing to the lack of quality care women receive (Gany & Bocangegra, 1996; Sword et al., 2006; Reitmanova & Gustafon, 2007; Liamputtong, & Watson, 2008).

Racism and discrimination connected to immigration can also negatively impact the maternal health of immigrant women. In their study, Reitmanova & Gustafon (2007) explore the maternal health care needs and barriers when accessing maternal services of immigrant Muslim women in Canada. They found women do not receive adequate information from maternal healthcare physicians and their staff regarding maternity issues, and as a result they become dependent on other sources. Immigrant women also require emotional and financial support to cope with loss of support networks after resettling (Reitmanova & Gustafon, 2007). Most troubling, women described feelings of disrespect from physicians and nurses because of religious beliefs. Women were often disregarded when attempting to adhere to Islamic rules such as preferring to work with female providers (Reitmanova & Gustafon, 2007). Women experienced blatant discrimination when they asked health professionals to recognize their religious and cultural beliefs. Factors contributing to inadequate maternal care for immigrant Muslim women were language barriers, uneducated physicians, and loss of support (Reitmanova & Gustafon, 2007).

Notions of difference that often create women as the ‘problem’ helps fuel discriminative actions that impede appointments and procedures (Gany & Bocangegra, 1996). Constructing immigrant women’s beliefs as problems ultimately keeps their unique perspectives from becoming integrated into western obstetric care (Gany &
Research on Vietnamese, Turkish, and Filipino women in Australia demonstrates how perceptions of difference between immigrant women, physicians, and staff create feelings of neglect (Small, Yelland, Lumley, Brown, & Liamputtong, 2002). When women were given proper attention and care, they welcomed physical touch from nurses to ease pains felt during birth (2002). However, women ultimately reported negative perceptions of their care, detailing staff as unhelpful or uncaring, and noting that they had adversely impacted their experiences.

Pregnancy and childbirth are highly medicalized processes in western society, often conflicting with immigrant women’s ideas of maternities (Liamputtong & Watson, 2008). In certain societies giving birth at home is culturally significant, and women prefer to give birth without technological intrusions (Liamputtong & Watson, 2008; Hill et al., 2012). Somali, Cambodian, Lao, and Vietnamese immigrants express strong aversions to cesarean sections versus a natural birth (Liamputtong & Watson, 2008; Borkan, 2010; Hill et al., 2012). Noted as a strong influence, a doctor’s knowledge can be regarded as “the only knowledge,” as described by Liamputtong & Watson (2008) in their study on immigrants in Australia. This left women feeling uncomfortable and disempowered in asking for maternal care that is culturally appropriate. Lack of communication ultimately created environments that were not conducive in producing maternal care that woman deem culturally and traditionally appropriate. The importance of recognizing diverse maternities can be felt by uncovering the personal ideologies that are formed by “norms, values, expectations, and other culturally derived sentiments and standards” (Liamputtong & Watson, 2008, p. 76).

Furthering the notion that immigrant women are often unable to carry out their culturally significant maternal beliefs, Quershi and Pacquiao (2013) illuminate western obstetric experiences of Pakistani women. Similar to the previously mentioned immigrant
experiences, Pakistani women were unable to carry out maternal traditions that they felt were important. Once again highlighting negative perceptions expressed from physicians, Quershi and Pacquiao (2013) cement the notion that immigrant women are subjects of discrimination and marginalization. Away from norms that they are accustomed to, they often find themselves segregated from their traditional support systems. Likewise to that of Reitmanova and Gustafson’s (2008) research on Muslim immigrants in Canada, Quershi and Pacquiao (2013) document loss of support from female relatives and friends as a factor that negatively impacts how Pakistani women perceived western maternal care.

It is notable how difficult it is to uncover research that documents purely positive maternal health experiences from immigrant women. Given that the majority of immigrant maternal health literature focuses on negative experiences, maternal health care practices such as cesarean sections, epidurals, and frequent prenatal appointments often associated with western obstetric care deserves close attention in order to analyze how immigrant women are ‘othered’ in maternal health arenas.

Figure 1. Recognized Barriers to Maternal Care
Theoretical Concepts

As was briefly presented in the previous section, immigrant women face multiple barriers when attempting to access culturally appropriate maternal care. These commonly discussed barriers can be identified as: communication, stigmas and discrimination, negative perceptions, cultural sensitivity, religious beliefs and resistance to technology and support. Existing within the feminist theoretical concepts of intersectionality, ‘Othering’, and authoritative knowledge, there is a connection pertinent to immigrant women, one that can be applied directly to these eight barriers. These concepts play an underlining role in how immigrant women ultimately perceive their maternal care. A direct connection can be seen between the eight barriers listed above and the three theoretical concepts that will further be discussed.

Intersectionality

Intersectionality uses discrimination as a starting point to focus on the many intersecting identities that define lived experiences (Martinez Martin, & Marlow, 2014, p. 447). Originally termed by Kimberlé Crenshaw, intersectionality has been defined by Kathy Davis as “the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements and cultural ideologies and the outcomes of these interactions in terms of power” (2008, p. 448). For immigrant women seeking maternal care, discrimination produced by difference can determine the type of treatment she will receive. In this theoretical framework, the multiple facets that intersect to create identity are brought center stage to uncover multidimensional identities that exist through human experience. When using intersectionality as a tool to analyze the social processes that oppress women, Crenshaw calls for “multiple grounds of identity when considering how the social world is constructed” (1991, p. 1245).
Established in black feminist theory, intersectionality sets out to uncover “how individuals negotiate intersecting oppressions within their experiences” (Martinez et al., 2014, p.460). Crenshaw highlights this in her earlier work that focused on the “multidimensionality of Black women’s experience” to detail how race and gender are treated as mutually exclusive within feminist theory and antiracist politics (Crenshaw, 1989, p. 139; Davis, 2008; McGibbon and McPherson, 2011). She argues that a “single-axis analysis” misrepresents black women’s experiences that ultimately keep them subordinated. To emphasize this, Crenshaw illuminates the importance of intersectionality by stating that “because intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated” (Crenshaw, 1989, p. 140). This theoretical concept aims to identify members of a group that have been “defined by race, sex, class, sexual orientation or other characteristics” while naming the “nature of the oppression experienced by members of that group” to better act as a “source of strength, community, and intellectual development” (Crenshaw, 1991, 1242).

An important aspect of intersectionality is the diverse ground on which it can be applied. Its universal nature can be “useful for understanding and analyzing any social practice, any individual or group experience, any structural arrangement, and any cultural configuration” (Davis, 2008, p.72). This applicability has proven useful in deconstructing oppressions held over black women in feminist scholarship, analyzing immigrant health, and processing inequalities in everyday activities (Crenshaw, 1991; Nightingale, 2010; Viruell-Fuentes, Miranda, & Abdulrahim 2012). Intersectionality is also an applicable tool to use when analyzing immigrant’s maternal health beliefs and preferences. It proves to be a useful concept when analyzing the social and cultural
underpinnings that women use to create their perceptions of pregnancy and childbirth. Liamputtong & Watson conclude in their study that the perceptions Cambodian, Lao and Vietnamese immigrants women held regarding childbirth “…may have been the reflection of their personal and cultural ideology of reproduction and motherhood” (2008, p. 75). The varying identities that form childbirth and motherhood perceptions among immigrant women make it difficult for women’s voices to be heard when physicians are not responsive to various cultural backgrounds.

Intersectionality can also be a useful tool for analyzing the negative perceptions immigrant women create when they experience discrimination and unequal treatment due to their immigration status, religious beliefs, and race. Examples of this were seen in literature where Muslim immigrants experienced health professionals who lacked the appropriate cultural knowledge needed to treat them (Reitmanova & Gustafon, 2007; Quershi & Pacquiao, 2013). Intersectionality helps to understand the negative perceptions immigrant women create due to its ability to analyze power relations and how power works to create health inequities among women.

Crucial to this theory is positionality. Positionality takes multiple identities found in intersectionality and analyzes them based on “social locations and processes that are context-, meaning-, and time-specific, explicitly located within social hierarchies, and tied to both material and cultural resource distribution” (Martinez et al., 2014, p. 448). Arguing for the significance of positionality, Martinez et al. suggest that positionality is an active process, one that not only analyzes the present, but also is capable of shifting with “changing social and individual circumstances” (2014, p. 448). Another important aspect of positionality is that it can be used to discuss how groups or individuals are oppressed through space and time. For example, in the maternal health care arena, positionality works to analyze who holds power within space such as physicians over
their patients. Positionality, coupled with intersectionality, can be used to explore everyday activities within social groups and individuals while focusing on the space that social processes emerge from to create difference (Martinez et al., 2014, p. 448).

Intersectionality draws from multiple identities to produce difference. This notion of difference is a critical concept within the theory of intersectionality (Davis, 2008; hooks, 1989; Martinez et al., 2014; Mohanty, 1988; Nightingale, 2010). Intersectionality focuses on the simultaneous interactions between gender, race, and class to create difference (Viruell-Fuentes et al., 2012). Analyzing difference that emerges through intersectionality is key to understanding how experiences are constructed through outside forces (Martinez et al., 2014, p. 454). Feminist scholar bell hooks emphasizes the importance of this concept by stating it is important to “confront difference to expand our awareness of sex, race, and class as interlocking systems of domination, of the ways we reinforce and perpetuate these structures” (hooks, 1989, p.468). She argues that confronting difference is crucial to be able to resolve dividing oppositions that hold women in oppression (hooks, 1989, p.469). Insisting that we “open ourselves to the unknown, the unfamiliar”, hooks offers a solution to understanding difference by realizing our “critical consciousness” (1989, p.468). By destroying our concrete perceptions, we are able to pick apart difference to deconstruct the realities of gender, sex, and race to also include other social determinants such as age, culture, immigrant status, and spirituality (hooks, 1989; McGibbon and McPherson, 2011).

The interwoven nature of intersectionality forces an examination that stretches across multiple identities without giving attention to one structural power over another (Tsouroufli, Rees, Monrouxe, & Sundaram 2011, p. 214). Mohanty describes the issue of labeling “an average third world woman,” by the notion that women as a group are bound by the same oppressions that ultimately place all women of color under the same
category (1988, p.374). The danger lies within the “the crucial assumption that all of us of the same gender, across classes and cultures, are somehow socially constituted as a homogenous group identified prior to the process of analysis” (Mohanty, 1988, p. 374). Examples of this were frequently seen in Somali maternal health literature when the focus was on circumcision. Health professionals perceived circumcised Somali women as having the same experience, ultimately categorizing them while ignoring their needs. Mohanty highlights the link to women and oppression by underlining the assumption that all women share a “sameness” that ultimately labels them as “powerless, and “exploited”; the multidimensionality of their identities is limited to gender (Mohanty, 1988, pp. 374&375). Categorizing identities can further marginalize women by defining universal experiences so that it “produces the image of an 'average third world woman' which enforces the feminine gender to paint her as 'ignorant, poor, uneducated, tradition-bound, domestic, family-oriented, and victimized' (Mohanty, 1988, p. 374).

Case studies regarding public health have fallen short when analyzing the interactions in societal systems that are produced from intersectionality (McGibbon and McPherson, 2011, p. 72). Analyzing the interactions in societal systems produced from intersectionality requires the analysis of systematic oppressions, such as racism and sexism. McGibbon and McPherson (2011) argue that the interconnectedness of these oppressions within health systems makes this analysis difficult. By using intersectionality as a guiding framework to unpack the landscape of disparities often seen in healthcare, a focus on the ‘Other’ can highlight the relationship between constructing identities and hegemonic structures that attempt to categorize women. Through categorizations that are created on intersections of gender, class, nationality, and race, spaces of social power can be seen operating in healthcare environments.
‘Othering’

Drawing from Jones and Manda (2006), Mauthner (2013, p. 26) describes ‘Othering’ as relying “on the construction of dichotomies between categories such as race, colour, religion, development and modernity”. Although intersectionality focuses on intersecting identities such as class, race, and sex, the universal categories often tagged to these identities work together to construct the “Other.” By building on Said’s (1979) work *Orientalism*, Mauthner underlines the definition of ‘Othering’ by describing its linkages with “hierarchy and racism”. Constructing the ‘Other’, as noted by Said (1979), is rooted in Western knowledge. This in turn is used to “characterize certain groups as inferior” (Mauthner, 2013, p. 26). For those cast as ‘Other’, inferiority is usually felt through “marginalization, disempowerment and social exclusion” (Grove and Zwi, 2006, p. 3) Johnson, Bottorff, & Browne (2004, p. 254). A common theme throughout the literature is that immigrant women feel disempowered to voice their concerns. This common form of ‘othering’ from health professionals led women to withdraw from future appointments (Small et al., 2002; Hill et al., 2012).

An important facet of ‘Othering’ is the construction of identities based on perceptions gained from analyzing differences between oneself and others (Johnson et al., 2004, p. 254; Mauthner, 2013). Focusing on societal norms, categorizing is often how society begins constructing the ‘Other’ (Canales, 2000, p. 21). Canales builds on this notion by describing stigmas that are created when one strays from norms created within societies. She details this with, “Persons are categorized or ‘labeled’ according to perceived differences from the societal norm. Once labeled, as different from this prevailing norm, they are stigmatized. It is this stigmatization that constructs their identity as ‘other’” (2000, p. 21). Skin tone, speaking with an accent, and cultural and religious practices are common factors physicians and nurses use to ‘Other’ immigrant women.
(Derose et al., 2007). In addition to the creation of stigmas that surface from disobeying societal norms, stereotypes offer justification for those who construct individuals as ‘Other’.

Cultural characterizations expressed through stereotypes perpetuate ‘Othering’ by cultivating discrimination among those perceived as different (Browne, 2007; Canales 2000; Johnson et al., 2004). By defining difference with cultural definitions, individuals are placed under an umbrella where uniqueness is masked with universalism (Johnson et al., 2004). In the health care arena, Johnson et al. note that “patients’ problems with access, communication, and compliance are seen as occurring because customs and traditions conflict with mainstream medical practices” (2004, p. 255). ‘Othering’ in this context, can be viewed as ignoring individual behaviors and beliefs to disregard diverse knowledges. The close relationship ‘Othering’ has with intersectionality can trace stereotypes to underlying issues of race and gender and class (Johnson et al., 2004).

Essential to analyzing how the ‘Other’ is constructed, discourses that surround marginalized groups paint individuals as nameless while using characterizations such as “white”, “brown”, “us”, and “them” (Johnson et al., 2004).

In health care, such discourses have signified underlying assumptions of an “idealized other” who “listens” to the “expert” (Johnson et al., 2004, p. 260). ‘Othered’ groups producing their own set of ‘Othered’ knowledge is a direct contradiction to authoritative knowledge, defined by Jordan (1997) as “the knowledge that is attached to persons in authority positions, as for example, the doctor in childbirth, the teacher in the classroom, the foreman in a plant” (p.3) Opposing sets of knowledge can further discriminate groups and can limit access to appropriate health care (Browne, 2007; Canales, 2000; Johnson et al. 2004). The two theoretical concepts that have been
mentioned above will be used to analyze how authoritative knowledge serves as a platform to shape ‘Othered’ experiences through the exploration of intersecting identities.

Authoritative Knowledge

In order to fully understand the maternal health experiences of immigrant women, an examination of authoritative knowledge is required. By assessing intersectionality and the ‘Other’ it is imperative to explore competing knowledge systems that exist through multiple power structures in order to analyze the inequalities created by authoritative knowledge (Borkan, 2010; Johnson et al., 2004). Authoritative knowledge indicates that “for any particular domain, several knowledge systems exist some which by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority) or both” (Jordan, 1997, p. 56). A consequence that can unfold from focusing on one knowledge system is detailed by Jordan as “the devaluation, often the dismissal of all other kinds of knowing” (1997, p. 56). Through analyzing health care experiences, authoritative knowledge becomes crucial to understanding why patients who have been discarded as ‘Other’ perceive feelings of discrimination (Browne, 2007; Johnson et al. 2004; Robinson and Cort, 2014). Examples of authoritative knowledge have been detailed by immigrant women who felt pushed to undergo cesarean sections, prefer homebirths, and who wish to perform maternal traditions (Liampputong & Watson, 2008; Borkan, 2010; Hill et al, 2012). Much like diverging from societal norms, “those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, and naïve, or worse, simply as trouble makers” (Jordan, 1997, p. 56).
Authoritative knowledge allows those who are in positions of power to assert knowledge in a “non-negotiable manner” over those who have little say in decision-making (Robinson and Cort, 2014, p. 51). Positioned as the ‘other’, immigrant women who lack adequate communication skills are often unable to be heard over the voice of a health professional (Gany & Bacangegra, 1996; Reitmanova & Gustafon, 2007; Borkan 2010). Those that allow authoritative knowledge to take precedence over other differing systems “come to see the current social order as a natural order, that is, the way things (obviously) are” (Jordan, 1997, p.56). Justified by “experts”, this system of knowledge is considered “persuasive because it seems natural, reasonable, and consensually constructed” (Jordan, 1997, p.56). As one Lao woman stated, “I think they are experts and know what they are going to do to help me. They just gave me a consent form to sign and I signed it” (Liamputtong & Watson, 2006, p.72)

Closely related to authoritative knowledge, the concept of biopolitics has been analyzed to uncover how power structures hold authority over subjugated bodies (Robinson and Cort, 2014). Surrounding pregnancy and birth, authoritative knowledge “delegitimizes other potentially relevant sources of knowledge such as the woman’s prior experience and the knowledge she has of the state of her body” (Jordan, 1997, p. 61). Contrasted against embodied knowledge, which can be defined as, “subjective knowledge derived from a woman’s perception of her body and its natural processes as these change throughout a pregnancy’s course” (Belenky, Clinchy, Goldberger, & Tarule, 1986, p. 113), authoritative knowledge successfully silences those who question, “particular actions by people engaged in accomplishing the tasks at hand” (Jordan, 1997, p.58). As an example, it is culturally appropriate for Somali women to move about freely in order to ease the pain of contractions. Physicians, however, instructed women to be “tied down” with monitors, and restricted the ability of Somali women to roam
during pain. This assertion of knowledge instilled fear and limited communication between physician and patient (Deyo, 2012).

The natural persuasiveness of authoritative knowledge lies within its construction. Built on “power relationships within a community of practice”, experts (doctors, nurses, and medical staff) construct women as the ‘Other’ to justify dismissing competing knowledge systems. By using authoritative knowledge as a platform for constructing the ‘Other’ in the medical arena, maternal health experiences of immigrant women can be examined through a lens that has been neglected from geographic scholarship. Examination of the ways that ‘experts’ classify women can differ based on their spatial location and on what an immigrant’s situation has defined for her. Applying a geographic lens to deconstruct why an immigrant has been ‘othered’ by authoritative knowledge can uncover experiences that have been molded by their spatial context.

The Importance of Spatial Context

An intersectional approach to exploring the maternal health experiences of immigrant women will allow for the inclusion of spatial context to be examined alongside categories of race, nationality, and class, and will establish the platform from which authoritative knowledge and ‘othering’ take place. Geographic distribution of immigrants can play a large role in the outcomes of maternal health experiences. This means that the location in which immigrants settle matters. Locations that are accustomed to large numbers of immigrants can better accommodate their health needs (Viruell-Fuentes & Abdulrahim, 2012). Areas where immigrant populations are new are less likely to have culturally competent health professionals, language translators, and community based organizations (Derose, Escarce, & Lurie, 2007). This, however, does not mean that health facilities in these locations are free from ‘othered’ immigrants, and other factors
such as health status, social support, and education level also play a role in determining perceptions of maternal care (Sword et al., 2006; Derose, Escarce, & Lurie, 2007).

Geographic locations where immigrant populations are large provide ample social networks that women can turn to for support and information regarding health services (Derose, Escarce & Lurie, 2007). In places where immigrant populations are well established, support groups may establish themselves in clinical settings such as child birthing classes. Immigration has also been noted to shift gender roles in locations where men take on active roles during pregnancy, birth, and child rearing. This shift of expectations could be attributed to the locations where these norms are present (Qureshi & Pacquiao, 2013).

Within feminist geography, research on the social experiences that surround reproduction has been limited (Klimpel & Whitson, 2016). However, scholarship within the last decade has focused on the social and spatial processes of reproduction including the Internet as a space for mothers (Madge & O’Connor, 2005), lactation in public spaces (Boyer, 2012), and spatial discourses that aid in creating women’s birth experiences (Klimpel & Whitson, 2016). Additionally, feminist geographers such as Fannin and Longhurst have pioneered the sub-field with contributions to the growing geographic scholarship on reproduction by exploring home births, home-like birthing wards, and public spaces in urban areas (Fannin, 2003, Longhurst, 2005, 2008, Klimpel & Whitson, 2016).

Though Longhurst (2005,2008) and Fannin (2003), contribute to the geographic research of birth with discourses from inside hospitals, homes, and work places, feminist geographers Klimpel and Whitson (2016) argue for the inclusion of national narratives that often shape women’s perspectives on birth. Citing scholarship outside the field of
geography that highlights the notion that reproductive activities are given multiple meanings in different spatial contexts, Klimpel and Whitson (2016), connect “narratives of place to help frame and give meaning to women’s reproductive lives” to their research on urban Brazilian women’s experiences of cesarean sections (p.3).

Although Fannin (2003,2013) and Longhurst (2005,2008) have built the framework of reproductive geographies with a focus on the social and spatial practices of birth, those practices have not been a primary focus of geographic maternities research. While the theoretical concepts presented in this research are not easily identified in current geographic scholarship, they are being used to explore topics ranging from sexualities to migration. In geography, reproduction has been pushed to the side with little attention being paid to the maternal experiences of immigrants. My goal is to dissect and deconstruct the spaces used by immigrant women to analyze how spatial context combined with intersectionality, ‘Othering’ and authoritative knowledge work together to create maternal health experiences.
CHAPTER 3: RESEARCH METHODOLOGY

The purpose of this chapter is to outline the methodology and field methods used to conduct this research. I will begin by describing the study area and why this area is unique to immigrant maternal health research. I will then summarize the qualitative methodology I used as the guiding framework to design this research. Next, I will describe the qualitative methods and sampling techniques used in this research. Then, I will highlight the data coding and analyzing process used in this research. Finally, I will discuss the limitations of this research.

Study Area

Southeast Ohio consists of eight counties that lie within the Appalachian region. These eight counties include: Athens, Hocking, Meigs, Monroe, Morgan, Noble, Perry, and Washington. This research focuses on the Athens County region, as this was where the majority of participants gave birth. There was one exception to this where one participant underwent an emergency birth in Columbus. However, this participant still received maternal care from facilities in the Athens area.

Athens County has a total population of approximately 64,000 residents and is home to Ohio University that houses a student population of over 29,000 (athensohio.org, 2016). The university has drawn a large international student population, with numbers reaching nearly 2,000 residents from countries across the globe (ohio.edu, 2016). Currently there are 17 international student organizations on campus that provide students with support and foster a sense of community (ohio.edu, 2016).

Despite the large number of residents currently living in Athens, there are limited options in choosing a maternal healthcare facility, due in part to the rural nature of the
area. In the area, there are two primary locations for women to receive maternal health care: River Rose Obstetrics-Gynecology, which employs seven physicians, and Holzer Health Systems, which employs ten physicians (See Table 1). River Rose is located within walking distance from campus while Holzer Health must be reached by vehicle. The Hudson student health center located on campus is student’s first option to receive healthcare treatment. From here, students are then referred to facilities such as River Rose and Holzer for further prenatal treatment. In addition to these two maternal health facilities, there are numerous community resources that provide women with maternal health education, supplies such as diapers and bottles, and emotional support. The Athens Birth Circle holds monthly meetings along with numerous activities throughout the year that provides women and their families with support that ranges from informational discussions on pregnancy and birth topics to emotional support groups for topics such as infant loss. La Leche League is a community group that also meets once a month to foster proper breastfeeding skills and promote breastfeeding education to women and their families. The Pregnancy Resource Center is a non-profit organization that provides women with pregnancy related information such as abortion alternatives and provides women with supplies such as infant clothing and bottles. Additional resources are found from state based programs such as Ohio’s Help Me Grow program where a representative makes home visits to provide families with education and support for up to three years.

O’Bleness Hospital is the only facility for women to give birth and it is within walking distance from campus. The hospital is not equipped to deliver babies that will require NICU treatment and therefore women are referred to facilities at Nationwide Children’s Hospital in Columbus. Pregnant women who are also classified as high risk are also referred to facilities in the Columbus area (Ohiohealth.com, 2016).
Table 1

*Maternal Health Care Facilities*

<table>
<thead>
<tr>
<th>Facility</th>
<th>Location</th>
<th>Number of Providers</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>River Rose Obstetrics-Gynecology</td>
<td>Athens, Ohio</td>
<td>Rotated between seven physicians</td>
<td>Prenatal healthcare &amp; midwife services</td>
</tr>
<tr>
<td>Holzer Health Systems</td>
<td>Athens, Ohio</td>
<td>Rotated between ten physicians</td>
<td>Prenatal healthcare &amp; midwife services</td>
</tr>
<tr>
<td>O’Bleness Hospital</td>
<td>Athens, Ohio</td>
<td>Varies</td>
<td>Delivery and labor</td>
</tr>
</tbody>
</table>

Ohio University’s international influence on the rural community of Athens meshes together Appalachian culture with diverse cultures from around the world to make this research location unique. This unique place provides an opportunity to examine the importance of the spatial context in mediating immigrant women’s healthcare experiences. The area’s numerous community resources for expecting women and their families coupled with the support from the international community provides women with support structures that are not often found in rural environments. As a result, the area’s physicians and other health professionals have experience in working with individuals from multiple backgrounds, which have created unique maternal healthcare spaces in rural Appalachia.

**Qualitative Methodology**

This research was conducted using qualitative methods to focus on the maternal health experiences of immigrant women in Southeast Ohio. I chose a qualitative approach because of its ability to focus on social structures and individual experiences (Sayer, 1992). A focus on individual experiences through qualitative methodology allows for “…viewpoints to be heard that otherwise might be silenced or excluded” (Winchester
and Rofe, 2010). The foundation of this qualitative methodology is centered on a feminist post-structural approach for “…destabilizing notions in the realms of knowledge and truth claims” (Moss, 2002). A post-structuralist approach critiques notions of universalism while opening discussions that accepts differences (Moss, 2002).

Qualitative research that is grounded in feminist methodology challenges power relations commonly associated with positivist, scientific research. Its goal is to take everyday experiences to recognize how positionality “…shapes people’s experiences and attitudes based on the intersectionality of a variety of characteristics such as race, class, gender, nationality and sexuality” (Hesse-Biber, Leavy, Yaiser, 2004, p. 14). An additional reason for choosing a feminist qualitative methodology lies in its ability to hear diverse voices. Under the scope of a feminist lens, power relations that exist between the researcher and study population are also examined. Qualitative methodology calls for critical reflection in order for the researcher to examine the power relationships between the researcher and participant (Dowling, 2010). Self-reflexivity is necessary in order to make our positions with regards to the research known (Valentine, 2002). Finally, qualitative research is useful for studying voices that span cultures. Engaging study participants across cultures under qualitative methodology, researchers seek “to interact rather to remain distant” (Howitt and Stevens, 2010, p.48). By attempting to interact on an individual basis, rather than grouping women together on a cultural basis, I was able to use qualitative methodology to gather and understand the experiences of immigrant women in Southeast Ohio.
Postionality

As a qualitative researcher, the recognition of positionality is crucial to the research process. My positionality during this research assumed dual roles: insider and outsider (Dowling, 2010). These roles acted simultaneously together to form my dualistic positionality to my research participants. At times, my role as an insider was recognizable. An example of this is when my participant and I would discuss life as a graduate student, or life as a female, during interviews. Other times I was quickly placed into the outsider role as I am not an immigrant or mother. Because I did not previously know any of the research participants my role remained primarily as a researcher. Despite my prominent outsider role, I was able to gain rapport from research participants due to my position as a female graduate student. Additionally, my gender opened the discussion to include sensitive health topics that participants may have felt uncomfortable discussing with a male. Establishing good rapport with participants was an important step in the research process in which I was able to gain deeper insights despite my dual researcher role.

Research Methods

I chose the qualitative methods used in this research for their ability to promote an understanding of immigrant’s maternal health care experiences. To accomplish this, my methodological approach included in-depth semi-structured interviews that were aimed at gaining insights into the maternal care experiences of immigrants. Semi-structured interviews were chosen for their ability to “collect a diversity of meaning, opinion, and experiences” (Dunn, 2010, p.102). Women who have been pregnant or have given birth have formed their own perceptions and created their own experiences that differ from one another. In-depth semi-structured interviews emphasize that
knowledge is not universal and pushes for the participant to expose what is significant to them (Dunn, 2010).

Recruitment and Sampling

To recruit participants, I used social networks from Ohio University that were established prior to this research. Within these social networks, contacts were recruited to identify potential participants using the criterion sampling method. This technique requires that potential participants meet criteria: in this case, immigrant women who are eighteen years or older, and have given birth within the last three years in South East Ohio (Bradshaw and Stratford, 2010). This eliminated American born women, international women who gave birth outside of Southeast Ohio, and international women who gave birth outside of the required time span. This time span was designed to foster interview responses that reflect recent experiences.

The decision to seek participants that have given birth in Southeast Ohio allowed for this research to fill a current gap within immigrant maternal health research that has primarily been focused on urban areas (Small et al., 2002; Sword et al., 2006; Liamputtong & Watson, 2008; Reitmanova & Gustafon, 2008; Quershi & Pacquiao, 2013; Pavlish et al., 2010; Missal et al., 2015). In recent years, the number of immigrants resettling in new and rural areas has grown. These areas often lack the necessary health infrastructures for immigrants, contributing to the need for these areas to be included in immigrant health research (Viruell-Fuentes et al., 2012).

The second technique used to identify potential participants was the snowball method, which identifies interest from people who are involved in similar situations (Bradshaw & Stratford, 2010). Research participants that I had previously established contact with used their social networks to refer me to additional potential interviewees. In
this research, the snowball technique was useful due to the close-knit communities surrounding international populations. Initial contact with potential interviewees was established through email or by phone, as these were the preferred methods of communication.

Among those identified through criterion sampling, ten women were ultimately selected through the snowball method to identify and recruit potential participants. This selection covered all of the research requirements and consisted of immigrant women from various countries including: El Salvador, Ghana, Jamaica, Nigeria, Sri Lanka, Saudi Arabia, and Uganda. Time lived in the United States varied, with 10 years being the longest span and three being the shortest. The participants’ ages ranged from 28 to 40 and the majority of women were married and had one child. All of the women were either current graduate students or had recently completed their graduate degrees. The majority of participants were current graduate assistants in their departments of study. After recently completing their graduate degrees, two participants are now adjunct professors at Ohio University.

It was the first birth experience for eight women in this study. The remaining two participants each had two children. One participant had her first child in her country of origin and the other respondent gave birth to both children in Southeast Ohio. In this study, there were no home births and none of the participants discussed having this option or that it was their preference.

Pointing out the uniqueness of this study sample is important when comparing it to other immigrant maternal health studies. This study sample is unique in several ways. The immigrant women interviewed here are atypical to that of immigrants. First, all of the participants are current graduate students or had recently obtained a graduate degree. Several participants were working on their PhD’s and two women had recently become
professors at the university. Second, many of the participants come from backgrounds that allow them the financial means to travel and their families to visit after the birth of their children. Finally, the large international population from Ohio University gave participants the opportunity to connect with the international community to form social networks as a form of support. All of these factors greatly contributed to the results of this research and the study sample is unlike the majority of current immigrant health literatures. While this population is not representative of all immigrant communities, by focusing on such a unique population, this research is able to both highlight a different set of experiences and also further research which explores the mechanisms through which power functions in the context of immigrant maternal healthcare.

Interviews

In total, ten interviews were conducted between January 15th and February 29th 2016 in Southeast Ohio. Most interview participants selected where the meeting would take place and interviews generally lasted between 30 to 90 minutes. I encouraged interviewees to choose the location of the interview in order for them to be in a comfortable setting.

Many of the interviews were held on campus although a few were conducted in the participant’s home. The interviews held in the home produced an environment different from those on campus. A participant greeted me with her child and mother in one home, while in another home only the participant and her small toddler welcomed me inside. Because some of the interviews were held at the participant’s home, I was able to witness the various roles women take on and the support some women have, that allow them to focus on their studies. In this setting, it was not unusual for a small child to be crawling over me reaching for the audio recorder or for a grandmother to be
feeding lunch to a child while I interviewed her daughter. At the university, the interviews were completely private, one on one with only the participant and myself in the room. This setting allowed for great concentration without interruptions. However, I was still able to produce quality interviews in participant's homes.

A semi-structured interview protocol primarily of open-ended questions was designed for all ten interviews due to its content-focused approach (Dunn, 2010). This approach promoted a relaxed discussion and allowed for diverse perceptions about maternal health experiences (See appendix A for complete interview protocol). Probing questions that assisted in uncovering deeper meanings were easily fit into the protocol given the flexibility of a semi-structured approach (Dunn, 2010). Informed consent from participants was gathered prior to the interview, and I disclosed my position as a researcher. I also described why their insights would be useful to the research.

The interviews began with warm up conversation where the participant and I would discuss various topics, such as graduate school life, the weather, or their children. This approach to interviewing promotes relaxation and leads to a more open discussion (Dunn, 2010). The interview design ranged from basic demographic questions to more in-depth questions regarding doctor appointment experiences, what their support system consisted of, and their pregnancy and birthing opinions. I chose to omit topics that could be perceived as sensitive such as income and religion and left those open to the participant to discuss if they chose to do so. I recorded all interviews in English with a digital audio recorder and jotted brief notes when needed. This approach was useful for keeping the conversation flowing, as I was not preoccupied for the duration of the interview (Dunn, 2010). However, note taking was useful for recording probing questions that came to me during a conversation. With this method, I was able to continue the
conversation and ask the probe I had written down to engage the interviewee into deeper conversation.

Data Coding and Analysis

The experiences gathered from immigrant women were transcribed using InQscribe transcription software. A one step thematic coding approach was used to create codes based on major themes found in the data. Codes were created with NVivo 11 software to reflect topics such as: communication, community resources, interaction with healthcare professionals, support, actions and responses, and negative and positive experiences. In addition, general codes such as pregnancy and birth experience and similarities and differences to home country were also created. The purpose of thematic coding was to uncover important sentiments that reflected understandings and experiences of maternal health care. Thematic codes were important to this research for allowing me to discover patterns and emerging themes of immigrant’s maternal health experiences. Pseudonyms were given to all research participants referred to in this thesis.
CHAPTER 4: RESULTS AND DISCUSSION

This research on immigrant maternal health experiences in Southeast Ohio is based on the following questions:

1) **What factors contribute to immigrant women’s positive maternal healthcare experiences?**

2) **How do these factors differ among women?**

This chapter outlines how immigrant women narrate their maternal healthcare experiences in Southeast Ohio. The first part of this chapter will focus on research question one, detailing what immigrant women chose to discuss as impacting their maternal health experiences. Women narrate their experiences with various topics including: Interactions with healthcare providers, community resources available to them, and maternal healthcare in the United States compared to their home country. This chapter will also focus on how maternal health experiences differ between immigrant women, which will answer research question two. These narratives uncover the actions taken by immigrant women, and their responses to the maternal healthcare they have received in Southeast Ohio.

**Interaction with Healthcare Providers**

Conversations surrounding the topics of interacting and communicating with health providers were heavily discussed throughout interviews. The majority of women commented on the influence these interactions had on their perceptions of their maternal care. The maternal health care differences that women discussed ultimately uncovered distinctions that were shaped by the healthcare providers who worked with them during their pregnancy and labor. This was a common occurrence throughout interviews and
cemented the notion that interaction with healthcare providers is an important consideration when determining a positive or negative healthcare experience.

For many women, interacting with numerous healthcare providers was a facility requirement. When receiving services from River Rose or Holzer Health, women are rotated between several physicians for the length of the pregnancy. Some women expressed distaste for seeing a different physician at each appointment:

I don’t know, in my culture when you go to an OB GYN you go to the same doctor you know, that’s your doctor you go to the doctor and that’s the doctor you see all the time. Until you have the baby, uhm... so that was a little hard for me because I was expecting to work with one doctor but I didn’t. –Kady, Jamaica.

Other respondents were happy to have been exposed to numerous points of view. Lydia explains how her opinion of this policy changed after she experienced an emergency cesarean section:

I guess I appreciated the idea they had that you had to just get to know all the doctors because you wouldn’t know who you would end up with. But I kind of got to like some of the doctors a lot and I wish that maybe most of the time they were the ones I saw. Funny enough, I ended up getting someone that I hadn’t even had a lot of time with and she wouldn’t have been my first choice for the delivery but actually after the delivery I was happy she was the one that I got. And I had only seen her like twice so I guess before delivery I kind of felt like oh I would have really appreciated just one person. After the delivery I was kind of ok with the practice that they had. –Lydia, 32

Immigrant women who discussed positive maternal healthcare experiences, described interactions with healthcare providers as “encouraging” and “comforting”. Angela, a mother of one, positively describes her experience with physicians at River Rose and O’bleness:

I liked the way the doctor interacts with you, you’re the patient they explain everything to you. That was with River Rose and O’bleness too. Like with me I went into labor for a long time but they kept encouraging me oh you’re doing well, good job, so I liked the whole experience, yeah. They are at your beck and call for anything you need so it was a great experience. –Angela, Ghana

These sentiments do not fall in line with the literature that suggests immigrant women often perceive their physicians as insensitive and unconcerned with patients cultural
needs (Cristancho, Garces, Peters & Muller 2008; Reitmanova & Gustafon, 2008). Here, we see that some women perceived their interactions with health professionals positively, which supports the notion that the majority of immigrant women in this study area have experiences that contradict immigrant health literature. It is important to note here that physicians in the area are accustomed to working with patients of multiple nationalities, given the close proximity to Ohio University’s international population, adding to the notion that spatial context plays an important role in how immigrant’s perceive their maternal health experiences.

Through conversations with participants, it became clear that some women felt that they had worked with physicians who helped them through a particularly difficult time in their pregnancies. Women that spoke of health professionals who supported them during these times describe their feelings as appreciative. During her first pregnancy, Reena experienced a sickness that caused her discomfort. She details an interaction with a physician that calmed her worries:

I was very sick the first few weeks. I could not keep anything in, I would just throw up. I couldn’t even turn my head. So I ended up going earlier than my first appointment because I called in and told them I am really sick. I may be dehydrated. So they asked me to come in, checked me out, this doctor asked me about my you know how im feeling and I told him oh im sick, I don’t know what to do. I was kind of depressed because I couldn’t keep anything in so he then said ok it will be fine. He made me go through an ultrasound and they gave me pictures of the baby. I think that really stood out to me because I think he did it on purpose. Maybe it was part of the medical process but I felt like he did it so I’d see the baby and kind of my mind would change and I would be like oh it’s a baby. So he asked me questions did the baby say hi? You know things like that, kind of showing me you’re going through a hard time but it’s worth it kind of thing. So I really appreciated that. –Reena, Sir Lanka

Implied in Reena’s account is the emotional assurance she received from her physician. This type of positive interaction, in which participants gained emotional reassurance from physicians, was common throughout the interviews.
Also uncovered during interviews were narratives including positive interactions with midwives. In this study, three women chose to work with a midwife. The women that narrated interactions with midwives spoke of them with importance. For some women, interacting with their midwife included divulging their personal lives. By speaking of their personal lives, women were able to form personal connections with their midwife. While several studies link immigrant women to occurrences of physicians using race, class, nationality, and immigrant status to ‘Other’ women, notions of bonding with health professionals were not commonly seen throughout immigrant health literature (Small, Yelland, Lumley, Brown, & Liamputtong, 2002; Herrel et al., 2004; Reitmanova & Gustafson, 2008). In this research, two participants shared instances in which they discussed important connections with health professionals. Here, Shari details her experience with her midwife:

Because my midwife was so professional but yet again comforting because she knew I was here all by myself, I was a foreigner and my husband was not here and I didn’t have a car. That was so hard. -Shari, Uganda

In Shari’s case, there is evidence that her midwife understood what kind of comfort was needed. This interaction contributed to a positive experience during what she considered a difficult time. This finding is similar to that of a study from Small et al. (2002) where they found that immigrant women perceived their overall care more positively when they had worked with a midwife. Akin to Shari’s connection with her midwife, Reena’s experience with a doula helped her overcome a difficult birth experience. Reena conveyed that she and her husband decided to hire a doula so that they could interact easily with physicians. Although Reena and her husband are both fluent in English, they both felt uncomfortable with the idea of navigating maternal spaces alone due to their unfamiliarity of the system. Though immigrant health studies have focused on barriers to receiving quality care such as limited English proficiency (Flores, 2006; Derose et al.,
2007; Cristancho et al., 2008), little has been noted regarding immigrants who are fluent in English but unfamiliar with navigating the American health system. Reena is the only participant in this study to have used a doula during her pregnancy and labor. Here, Reena describes how the doula acted as a liaison between her and the medical team:

We’ve heard many good things and many people have told us we need to get someone to communicate so we thankfully had a doula. She was my yoga instructor and she was doula too. The good thing was doulas are kind of expensive I think but both Simone and I were graduate students at that time so we got a doula for free. –Reena, Sri Lanka

She continues to say:

We depended on the doula to communicate between the doctor’s and us because there was a lot of jargon. Jargon that we didn’t understand so she did a perfectly good job- Reena, Sri Lanka

The connection between Reena and her doula contributed to better communication with her physicians. Communication plays a prominent role in how participants interact with healthcare providers and how they perceive their experiences. The relationship between immigrants, positive healthcare experiences, and communication has been explored in numerous literatures, which suggest that communication is key for immigrants to perceive positive outcomes to their healthcare experiences (Liampuntong & Watson, 2006; Sword et al., 2006; Deyo, 2012). Although these literatures often suggest that immigrant women experience poor communication with physicians, the majority of women in this study discussed that communication was not an issue. This can largely be attributed to English fluency and the educational status of participants.

In this same light, most women noted that they were listened to, and that providers explained information thoroughly to them. During Reena’s interview, she told the stories of her first and second pregnancies. She detailed using services at River Rose for her first pregnancy and why she was fond of one particular physician:
I really liked Dr. Tony. Philip Tony at River Rose. Very nice, very... I really liked the way he explains what happens. And if im concerned he’ll go through the whole process and tell me about why I need to be concerned or not and I really liked the way he explains things and cares about his patients. –Reena, Sri Lanka

Several participants described physicians and their staff as “supportive”. Many were said to have taken the time to explain things to participants who were first time mothers. For Lydia, who spent a week in the hospital with her child after giving birth by an emergency cesarean, this meant all the difference:

Yeah they were really supportive. They were really nice. They took their time to explain everything, were doing this, were doing that and especially for her because we spent almost a week. They were pretty like helpful in giving us information. This will be no big issue, she’ll get over it, it’s quite common... giving us all the facts we needed to keep our minds kind of settled. –Lydia, Ghana

Throughout interviews, respondents continually recalled discussing their pregnancy, delivery, and child rearing beliefs with their physicians. Women discussed speaking to physicians about their preferences on pain medications, such as epidurals during deliveries. A few respondents were determined to have an all-natural birth without the use of pain medication and discuss communicating this preference with health professionals. During Lydia’s interview, she detailed her labor experience and communicating her preferences to a nurse:

I was so hell bent on doing like the natural birth. We felt like that was the best option for us and even if we needed a C-section, I didn’t want to do an epidural or anything. I just wanted to labor until I couldn’t anymore. Yeah, so C-section was not in the cards for us. And I remember when I went in and the nurse was trying to see if I was dilated, she was like uhm do you plan on having any epidural or anything like that? I was like no all natural. She was like ok, but by that point she had started signaling other people to tell them something was off. And she was just like ok so we are going to go all natural? And im like yeah. So right now I laugh because she obviously realized it wasn’t going to be possible. –Lydia, Ghana

In this instance, the nurse who asked Lydia if she planned to have an epidural chose not to communicate the severity of the situation. Despite carrying on as if everything was going according to plan, Lydia could sense something was not right when the nurse
began signaling for physicians to come check her out. Although this could be perceived as a lack of communication, Lydia believes the nurse was trying to keep her thinking positively during an emergency situation.

Other participants described going into labor with the mindset that they were going to deliver their babies without pain medication but ultimately changed their minds after communicating with their physicians. Shari details her experience of communicating with her OBGYN before and during labor:

This was talked about way before the baby was even due. My OBGYN had said ok you can go all natural; all the way, scream all the way, no medication or we can wait and if you need medication that’s when we will give it to you. Or we can give you medication from the beginning and you’ll feel no pain at all. –Shari, Uganda

In this quote, there is evidence that Shari and her physician communicated throughout her pregnancy and labor. The physician communicated with Shari in a way that let her know it was her decision if she wanted to take any medication during her delivery. This type of interaction strengthened the relationship between Shari and her physician while encouraging open communication where the patient’s preferences were heard. This contradicts the literature that suggests immigrant women are often unable to successfully communicate maternal beliefs and desires that are regularly overlooked by physicians (Borkan, 2010; Hill et al., 2011; Deyo, 2012).

One participant discussed a different opinion of using pain medication with her physician from the beginning of her pregnancy. Kady’s experience was unlike the rest of the participants. Her doctor communicated to her early on in her pregnancy that she would either have to undergo a cesarean or deliver her child early. Here she describes the interaction that took place with her physician:

So we knew she was going to be born early and then... I still kept seeing my doctors here. Uhm... After we did the scan in Columbus because they we just had to monitor it and uhm they would probably plan to have a C-section at some point or an early delivery. Not necessarily a C-section but an early delivery.
Uhm... so I went through all the options, talked to everybody. Talked to my doctor from day one about making sure I got an epidural. Because I do not do pain very well. –Kady, Jamaica

Open communication with physicians was commonly mentioned among participants. Similar to Shari and Kady’s comments above, participants often expressed being able to communicate their maternal beliefs with physicians without negative consequences. An example of this was seen when women shared their opinions on breastfeeding. Many participants discussed the importance of breastfeeding and one participant took action and responded to her doctor who instructed her to switch back and forth from bottle to breast. Kady’s response shows the interaction she had with her physician who despite initially disagreeing with Kady’s choice, ultimately agreed with her decision to exclusively breastfeed:

…and then when I came home with her they wanted me to breastfeed and bottle feed so that I could ensure that she was getting a certain amount but it was not working because she had nipple confusion. So I was like you know what, I’m going to breastfeed her she will get enough milk... Forget you and your bottles. So yeah, I stopped doing the bottles and just breastfed her until she was over 2. –Kady, Jamaica

After this response, I asked Kady if her physician had any concerns when she decided to exclusively breastfeed. This is her response:

No, because my pediatrician was Dr. Miles. She was like if that’s what you gotta do then that’s what you gotta do. As long as she is eating enough and I was like yeah she’s eating... so I worked with the lactation consultants at O’Bleness... so that’s what we did and that reassured me that she was getting enough milk so after that I was like... no bottle, breast milk all the way. –Kady, Jamaica

In few cases, women described instances where open communication was poor. These instances, although uncommon in this study, do coincide with the literature that suggests immigrant women often experience poor communication with health professionals. For Dena, poor communication built a negative experience. Here she describes her initial appointment at the campus health center:
So I went to Hudson and the first time I went there the person, the nurse practitioner I saw said well maybe it’s just stress, classes and everything. So she just told me to get enough rest and to eat well and I’ll be fine. So I went back two weeks later and was like no there’s something, something is not right. For me, I didn’t have any morning sickness or anything so it wasn’t apparent that there’s something, that I was pregnant or anything. Two weeks after I went back, I requested for a pregnancy test. So they did that and it came back positive. They just said stress and it was not stress it was actually something going on in the body. So if it was something that could have killed me, I would be dead. –Deena, Ghana

This quote further illustrates previous research that has shown that communication between providers and patients is essential in creating positive healthcare experiences. Because Dena experienced poor communication with her physician, she expressed feelings of anger towards the student health center because she felt her symptoms had been overlooked. One participant commented that poor communication resulted in a lack of information from a physician that referred her to prenatal appointments at Holzer Health. Here, Shari explains how this referral was an issue:

I didn’t have a car and Holzer is allllll the way at the end of east state. That was not a good idea. I should have probably gone to O’bleness or somewhere else. See that was lack of information that I had when going through. Because if I knew the area really well if someone referred me to Holzer right now I don’t have a car, I would say no way. I can’t... I can walk to O’Bleness if I want to. But I didn’t know the area, I didn’t know much, let me just say that. –Shari, Uganda

Shari’s experience in receiving little information on where she could begin prenatal treatment at a facility that did not require her to own a vehicle highlights how lack of communication between physicians and patients works to define a woman’s perception. She also commented on receiving conflicting information from two physicians after the birth of her child. In this instance, Shari’s OBGYN and her child’s pediatrician had two contradictory opinions regarding the practice of co-sleeping. Here, she shares her opinion on the practice and her experience of receiving inconsistent information:

After our daughter was born there was conflicting information from my OBGYN and my pediatrician because back home when a child is born there’s no special room or a crib or anything. The child is with the mother constantly. You go to bed with the child, you hold your child, you nurse your child and so I asked the
OBGYN and this was even before the child was born I asked is it okay if I sleep with the baby in the bed? She said yeah that’s okay as long as you are aware that they are there then you don’t roll over them. And it’s good that they are close to you, they get to know you and they have that sense of safety. But then again I didn’t even bring it up with the pediatrician, they said ok so the child should be in her own bed and you shouldn’t sleep with the baby at all because it will squash them and that was so confusing because culturally we don’t do that. – Shari, Uganda

When I asked Shari if she disclosed to the pediatrician her decision to co-sleep she responded with: “Nope. She would not be happy with that.” Here, it is evident that Shari’s decision to co-sleep with her child is important to her despite the pediatrician’s converse instruction. Although she went against her pediatrician’s directive that she should not co-sleep, Shari explains that she was always given a choice throughout her pregnancy and labor:

It was never a do this and it was that... it was always this is the option this is the middle ground what do you want? But the pediatrician was like do not sleep with the baby and we said ok and we went back home and said nope! –Shari, Uganda

This piece of information is important when examining whose knowledge actually counts in the medical arena. Implicit in Shari’s response is that despite being given a choice, she was not comfortable conveying to her child’s pediatrician that she would practice co-sleeping. Shari’s account of disobeying her pedestrian’s order to not co-sleep, demonstrates that authoritative knowledge does not always influence patients. This finding contrasts against studies that found immigrant women often obey medical professionals advice, believing that ‘experts’ only do whats best for them (Liamputtong & Watson, 2008)

Although positive experiences illustrating strong communication between physicians and patients was present throughout the interviews, stories like the ones Dena and Shari shared provide useful insight into how women perceive maternal health experiences. Fortunately for many of the participants, negative experiences were few and far between, and did not impact much of their pregnancy and labor.
One participant, however, Rena, described poor interactions with healthcare providers that left her feeling so unsatisfied and disappointed that she changed healthcare facilities for her second pregnancy. I asked Reena to discuss what made her first child’s birth so different from her second. She begins by describing the interactions with providers that left her feeling pressured to undergo a cesarean section.

She states:

Because they were obviously trying to break my water. They were not giving me enough time, when I was sure... they told me the baby was perfectly fine, the heart rate was fine, if I could endure the pain as the mother and if I’m not complaining, and if I’m confident that I could work and change the position, walk and change the position of the baby, I’m like why don’t you let me do that you know? But they were not letting me do that, they were totally against it. And I did not like that. I did not appreciate that because I think they were trying to push me for a C-section. –Reena, Sri Lanka

From this quote it is evident Rena felt that she was not being listened to and physicians were not communicating well with her. This finding coincides with literature that is based on the concept of authoritative knowledge (Jordan, 1997). While it was uncommon for the concept of authoritative knowledge to be mentioned by participants, Reena’s account is similar to several findings that suggest biomedical technologies, such as cesarean sections, often take precedence in the maternal healthcare arena (Liamputtong & Watson, 2008; Borkan, 2010). This finding was also similar to literature that suggests immigrant women often feel pressured by physicians to give birth quickly (Small et al., 2002; Borkan, 2010; Brown, Carroll, Fogarty, & Holt, 2010). When I asked Reena how she felt about the way her doula communicated for her during this time, she responded with:

I think she was very powerful because me and my husband we are not very good about being straightforward at least at the time we were very worried about what to say and how to say it in a polite way kind of, but our doula was very strong and always helped us. So my doula was very respectful about my ideas too. She always asked me what do I think so the doula did the communication perfectly well and we were very lucky. –Reena, Sri Lanka
Although Reena was unable to communicate her wishes successfully to her physicians, her doula helped set a stage where she could advocate for Reena’s desire of a natural birth. Feeling pushed to undergo a cesarean section is only one of the negative interactions with health professionals that Rena discusses. Here, she details her account of asking physicians if she could try walking to speed the birthing process:

I asked them can I walk because I’ve heard that gravity helps move things down there so I asked them can I walk so they were like yes you could walk you could try that but they were not very encouraging. —Reena, Sri Lanka

Reena’s desire to walk in order to naturally speed up labor is similar to the findings from Deyo’s (2012) research on Somali immigrants that found it was traditionally significant for Somali women to get up and move during their labors. However, Rena’s account differs from the Somali study due to the fact that physicians granted her wish to move about freely. Although the two findings differ, they are similar in regard to health professionals projecting their authoritative stance over women.

When walking failed to speed up her labor, one member of the healthcare staff made Rena feel uncomfortable. She details this interaction between herself and a nurse:

I’ll give you another hour to walk but if you don’t... if the baby doesn’t move then we will have a different type of conversation. And throughout that period I was thinking throughout my head what type of conversation? I was in a lot of pain and I had think about those things too, which was very hard for me. —Reena, Sri Lanka

This interaction illustrates the importance of thorough explanations between providers and their patients in order to make them feel comfortable. Reena spent a large portion of our conversation discussing this labor experience and how it negatively affected her and her husband. As Reena discussed her experience, she focused on one particular person and how she made her feel uncomfortable. Here she explains an encounter with the same nurse that she clashed with during labor:

…At one point, I think they were sewing me up after the delivery, she made a nasty face like she made a bad face at me. She was looking at what they were
doing and kind of made a bad face. I saw it and it was kind of a disappointment. – Reena, Sri Lanka

She continues to explain how this interaction made her feel:

That made me feel really uncomfortable. I was really kind of feeling insulted you know? – Reena, Sri Lanka

Encounters such as the one Reena describes above, although uncommon to this research, highlight literature that portrays immigrant women as the “Other” in healthcare spaces (Derose et al., 2007). This was seen in Rena’s recount of the nurse making a ‘nasty face’ at her after labor, which ultimately painted her as different and disempowered. She further discusses these negative interactions that led her to question what she had done to deserve the treatment she received. Reena explains that she and her husband have never received ill treatment in the United States before, here she explains this in depth:

I don’t know. Maybe it’s her personality. I don’t know, I don’t want to think this because we’ve never been, we’ve always been treated very well in this setting and in this country people have never looked at us differently because we were of different race… we’ve been really treated well by all the people we’ve met. – Reena, Sri Lanka

In this quote, Rena implies that prior to her first labor, she has never felt ‘Othered’ while living in the United States. This find is interesting because numerous studies that suggest immigrant women are “Othered” based on identities such as race, gender, nationality, immigrant status, and religious beliefs to produce difference (Herrel et al., 2004; Reitmanova & Gustafson, 2007; Viruell-Fuentes et al., 2012).

Throughout this interview, Reena describes how despite the many positive interactions she had with physicians, these few people during her labor had a large impact on how she perceived the experience overall. During this interview, I asked how the labor experiences she had with her first child made her feel. This is her response:

It was kind of disappointing. Because when we went into the appointments everybody I met was so friendly and nice and I’m not saying they weren’t nice
during the birth but then I felt like I don’t know... I felt like I was being kind of deceived because I felt like they were not... my interest was not their priority so it felt really bad and disheartening and yeah... very disappointing. –Reena, Sri Lanka

Although poor communication with several health professionals greatly impacted Reena’s experience, she comments that other members of her healthcare team facilitated open communication. She affectionately spoke of several nurses who helped her through her difficult time. Acting as a positive force for Reena, she describes one nurse as the reason she delivered her daughter:

There was this nurse Julie, I remember from my first daughter she was the one who trained me to push. She was the one who said ok now wait for the breath and now push. So I delivered because of that woman. I mean I was so grateful. –Reena, Sri Lanka

This finding is similar to literature that found immigrant women valued nurses’ encouragement and frequent interactions (Missal, Clark, & Kovaleva, 2015). The positive experience Reena describes here, cements the notion that communication is important between every member of the healthcare team to produce positive interactions between patients and health care professionals. Reena explains how she took action after the negative experiences during her first labor and decided to switch facilities and physicians for the pregnancy and birth of her second child. She describes, Beth, the physician that delivered her second child as “amazing”:

...She was respectful about our choices, which we made. She always asked us ok what do you want, from me, what do you want me to do? And the guiding process was wonderful, she told me how to push, she told me like no, don’t push now. She told me when to do what. She was amazing, she told me different positions to sit in I mean all of that was done in the first birth too but...she is amazing; I think she must have delivered like 5,000 babies. She is a very smart person. –Reena, Sri Lanka

Although Reena largely narrates her first labor experience with negative stories, it is important to mention that her story is also filled with positive experiences like the examples given above. Her negative stories were unique to this research as most
participants spoke highly of their pregnancies and labor experiences. Most participants also spoke highly of the support structures they had during their pregnancies that were said to have helped during times of poor communication with physicians. This important influence on women came from community resources and from families and friends. Stories of support were mentioned throughout interviews making this topic a strong point of accord among participants.

Community Resources and Family Support Structures

Numerous community resources exist in southeastern Ohio for expectant mothers and their families. Almost all participants in this research discussed at least one of these community resources during interviews. Some participants discussed these resources in depth, declaring that these community organizations acted as a major source of support. Others briefly mentioned them, explaining if they played a role in their pregnancies or if they only knew of the resources that were available to them. The latter suggests that although some participants did not use community resources, they at least knew what was available to them. During interviews one of the initial community resources several women mentioned were classes offered from O’Bleness Hospital. Many women commented that they could attend these classes because they were free. They also commented that the classes provided a lot of information. Adella, describes some of the classes offered at O’bleness:

And they have for pregnant women, they have several support groups. For example, they have a childbirth class where you could go and learn about the hospital itself and how they practice and what to expect and they explain to you pretty much everything that could happen. And uhm what happen if you don’t naturally enter into delivery. Like which situations are more likely to produce a C-section. And they also show you the birth center. You pretty much know what you are going to find. –Adella, El Salvador
A few women commented on how helpful it was that the birthing classes offered at O’bleness were free. It was said that these types of classes are usually fairly costly and the only way they could attend them on a graduate student salary was because O’bleness offers them for free. Lydia shares a conversation she had with her sister-in-law regarding these classes:

They showed us the birthing chamber; we went all the way up there. So basically we understood what was involved and it was really good because it was free. Because I remember when I told my sister in law she lives in Maine and I said hey I’m going for a birthing class and she was like how in the heck... how much are you paying for that? And I was like it’s free and she was like wow. –Lydia, Ghana

She continues on to say:

Other places the minimum is like 250 bucks for just a birthing class. So the one they run here is free...even people came from Columbus, they are not very restrictive on that. –Lydia, Ghana

An important finding here was that most participants even knew about the existence of the prenatal classes; it was a bonus that they decided to actually attend. This finding does not follow the literatures that found many immigrant women were not aware of prenatal classes. That research also found that women were not clear on the purpose of these classes (Sword et al., 2006; Reitmanova & Gustafson 2008). A major difference between this study and the aforementioned research is the study populations. In this research, participants were graduate students who prior to becoming pregnant were aware of birthing classes and knew what their purpose was. This fact impacted the findings of this study because participants had the knowledge to seek out resources.

Although Southeast Ohio is located in a rural area with limited maternal healthcare options, the women in this study were surrounded with many community resources that they learned about from physicians, by word of mouth from the international community, and from health professionals such as midwives or doulas. Also important to this finding is the fact that the participants in this research were all current
graduate students or had recently obtained their graduate degrees. This detail plays an important role in how women seek out community resources such as birthing classes and fully understand their usefulness.

Through conversations with participants it became clear that community resources were an important part of women’s maternal experiences. Some respondents described the community organizations they took part in were their major sources of support. This was said to be especially important by women who immigrated here alone as students. A major source of support as described by several women was the Pregnancy Resource Center (PRC) in Athens. This organization was described by many to be a source of social, financial, and educational support during their pregnancies. One participant described the PRC as the place where she knows all expecting immigrant women to go:

Yeah... virtually all of the foreign women that I know have gone to the pregnancy resource center. And it's almost sometimes a referral like when I got pregnant I went there and whoever wants to go through there. —Shari, Uganda

In the above quote, Shari references women being referred to the PRC. The referral she describes is word of mouth from women in the international community on campus. For example, Dena who also used the Pregnancy Resource Center gave a similar response to how she heard about this community resource: “Friends, who had already used it mostly international friends who had already used the services. They told me about the pregnancy resource center.”

Some women who had not been in the community long enough to establish relationships within the international community, discovered the PRC through different means. Shari explains how she discovered the PRC and describes some of the services they offer:

Since I was a foreigner I googled for help. Oh If I was back home it would have been so easy, nothing would have been a problem but it was a challenge
because I was in the country just a few days like I could have counted the
days I was here…I didn’t know anybody, nobody. That was my very first stop to
interact with somebody else apart from me with this pregnancy. And they did a
pregnancy test and I came out positive and they told me what they do which was
really… Educating expectant mothers and uhm they call it earn while you learn
like they have you to learn about pregnancy, raising a child, labor and all that
stuff and while they do that you do quizzes then you earn like coupons to get
diapers to get clothes for babies and so I was all for it because I knew nothing
about being pregnant and I wanted diapers because those are expensive. –
Shari, Uganda

Several participants discussed the “baby bucks program” provided by the Pregnancy
Resource Center. This program provides clothes, diapers, and other baby necessities
when participants watch videos provided by the center. Women claimed that these
videos were educational and helped them prepare for the labor process. Reena
describes her time at the PRC:

We went to the pregnancy resource center from the beginning. Very helpful. Oh
the videos, those are the videos that helped me train. It’s all about education.
And the good thing is when you watch a video, they give you baby bucks. And
then we could do shopping in their little store, which was great because I got a lot
of supplies. Like blankets and bottles and what not. Everything was very nice. –
Reena, Sri Lanka

All statements from participants regarding the Pregnancy Resource Center were
similar in expressing how they gained educational and financial support from the baby
bucks program. One participant largely narrated her maternal experience by the support
she received at the Pregnancy Resource Center. She describes the relationships that
were created through the PRC:

I still have a strong link to the pregnancy resource center because of what they
did for me and for me at that very moment being so scared and not knowing what
to do. And currently I volunteer with them and I’m doing what they did for me
when I was unexpectedly pregnant. So that’s the relationship I have with them
and it’s ongoing and it was a very strong first contact. Because the friends I’ve
made in Athens I’ve made them through the pregnancy resource center. –Shari,
Uganda

Shari’s response indicates that the support she received during her pregnancy mainly
came from the Pregnancy Resource Center. It is evident that she feels invested in this
organization because she now gives her time to volunteer for them. She describes the pregnancy resource center as “warm” and “comforting”, suggesting that the interactions she has had there contribute to a positive maternal experience.

Other participants that spoke fondly of the baby bucks program were brief in describing their involvement with the PRC. Although Rena participated in the educational programs the PRC offers, she mainly narrates Ohio’s Help Me Grow Program as the community resource she received the most support from. In this research, she is the only participant to talk in depth about this program and how she and her family benefit from it. Through this program she learned how to acquire free doula services and received home visits during her pregnancy and after the birth of her children. Here she describes the program and her experience with its services:

So we enrolled in the Help Me Grow program and they are wonderful. They still come in and help us a lot. So through that, the person through Help Me Grow gave me a list, which gave me all the doulas who were willing to work free. I think we were under the poverty line or something which was great because we got lots of you know, information and a doula for free was wonderful and then we got WIC also. We get food items and coupons, which was all very good because it was really helpful for us at that time definitely. – Reena, Sri Lanka

Through the Help Me Grow Program Reena and her husband were able to obtain the information they needed as first time parents. This state funded program is designed to guarantee that children have a safe and healthy birth and provide parents with the resources needed to provide a healthy life for their children (www.helpmegrow.ohio.gov). Reena and her husband participated in the Help Me Grow home visit program. A representative visits the home to educate Reena and her husband and works with her children. Here, she briefly describes the home visits:

We have a representative coming in who is really smart. She knows a lot of things and is really helpful. So she basically gives us information so with Leyna she has been telling us how to be firm with her in certain things and how to you know manage her skills and you know behavior and things like that. With Ari she is... well yeah she’s just taking... well the good thing is they always do
questionnaires like social skills, motor skills, so that is good to know what they are doing. –Reena, Sri Lanka

Currently, Reena is employed at Ohio University. Before this, she explained that she and her husband qualified for WIC because they were under the poverty line. During her interview, Reena expressed how helpful Help Me Grow and WIC was to her family during their time of need. She says the information they received during her first pregnancy helped prepare her for motherhood. In this quote Reena describes the support she received through WIC

Yeah so with WIC I said there was food, there was a lot of support. We didn’t have to buy much because the coupons were given to us. And then when the baby was born they also gave us a little diaper box and they also gave me nursing bras and breast pads and things like that, which was really helpful. Because first time mothers you don’t know anything, I didn’t know anything. All of my clothes were getting wet and soaked and I was like what’s going on? What am I supposed to do? –Reena, Sri Lanka

These comments from Reena are unique to this research. Reena is the only participant to openly discuss the support she received from the Help Me Grow program and WIC. One participant briefly spoke about seeing information for Help Me Grow at the WIC office:

I actually don’t know about the Help Me Grow program. I know they have it at the WIC office. I just haven’t asked about it. –Lydia, Ghana

Lydia did not go into details on why she did not choose to ask questions about the Help Me Grow program. Conversely, she did discuss that despite knowing about another program, Head Start, she did not have the resources needed to join such as time and a vehicle. Here she further explains this:

I know about the early head start… I was going to do it but I don’t have time. And you have to be here for each visit and you have to attend some weekly meetings or something like that… I don’t have a car so ultimately I just couldn’t do that program. Because I feel like it would have been a good program for her to play with other kids and get to know other kids but I’m not mobile. My husband is not here most of the time, he moved to another school in New Jersey. I feel like she would have used it and it would have been helpful but it’s a commitment I just couldn’t commit to so I just had to do without. –Lydia, Ghana
It is evident in this quote that despite having several community resources in the area, participants still need time, and in most cases a vehicle and familial support before they choose to participate. A few respondents commented on their tight schedules and trying to juggle being a wife, mother, and student, which did not allow free time to participate in local community services.

In cases where women were unable to use community resources, their accounts of their support structures included family members. Despite Lydia’s husband living in another state, she says that he was there for the pregnancy and birth of their child. She describes her support system as “pretty good” and details who that includes:

> It was good. We had church, we had family, friends, the hospital was always there. They used to tell you hey were on call and the PRC was really helpful, especially for us, to new mothers. Especially with my husband and I, we didn’t really have family close to us. My mom came a week before I gave birth so that kind of put us in the frame of mind where we felt like hey we are prepared for this. So it was a pretty good support system. – Lydia, Ghana

Throughout interviews, women continually noted the importance of having family and friends to support them. Some participants spoke of the support they received from the international community. Lydia, one of three Ghanaians I interviewed, succinctly describes this notion:

> The support was obviously my husband was around and then going for the classes learning about stuff. Luckily for us we have some Ghanaians around who are quite grown (large) to help with her. So the Ghanaian community was good. – Lydia, Ghana

The conversations with participants about the international community suggest that their support systems were fairly large. It indicates that, despite living away from family, some women felt they had many people to rely on during and after their pregnancies. The large social networks that many participants discussed contradict numerous studies that imply immigrant women have few connections to the community and weak social support (Sword et al., 2006; Reitmanova & Gustafson, 2008; Hill et al.,
2012; Missal et al., 2015). Uncommon in the aforementioned studies, participants in this research had strong ties to Ohio University, which gave them many opportunities to become involved in the international community.

One participant discussed her large support circle with friends who she took trips with and who also threw her a baby shower. Sophia includes friends from the international community who helped provide her with the necessary things she needed before giving birth when she narrates her maternal experiences:

So my friends surprised me and I didn’t know anything about a baby shower so there were a lot of African friends around that came for the baby shower. Then towards the preparation for my delivery I had friends around who were coming to check on me to see how I was doing and everything so I was prepared. –Sophia, Nigeria

Other participants discussed smaller support structures that included husbands and mothers. A handful of participants gave accounts of their mothers and mother in laws who flew in to be with women during and after childbirth. During an interview with Alli, she explained that before her mother came to help after the birth of her second child, she experienced hardships while being alone:

The very first time... I think the very first time my husband was with me because he left at the end of my pregnancy... he went back home so... Yeah I delivered my baby alone. Yeah... but I mean like two months before I delivered he was gone and it was hard to be here alone. I brought my mom. I told my mom to come. It was good because she could sit with my 5 year old and I would go to study or to visit the doctor or something. –Alli, Saudi Arabia

Participants also discussed their mother in laws as being apart of their support circle. Lending to the care of the baby, women explained that their mother in laws came to help with the baby so they could go back to classes. During Sophia’s interview, she began by expressing that initially she did not want her mother or mother-in-law there for the birth of her child; she wanted to take care of the baby by herself. Here, she expresses this:
I guess my husband was my support system because I told my mom not to come. I told my mother in law not to come. I took care of my baby by myself. And everybody was like are you sure you can do it? Are you sure you can take her yourself? And I said I can do it. –Sophia, Nigeria

Despite this, she goes on to say that her mother-in-law did eventually travel from Nigeria to help take care of her grandchild: “Yeah my husband’s mom is around right now…She is at home with her to take care of her while im back in school.”

These quotes suggest that Sophia wanted to prove she was capable of raising her baby on her own, despite the support systems surrounding her. Although she was able to take a semester off from school to care for her child, she ultimately chose to utilize someone from her support circle. The relationship between immigrant women and the importance of kin support has been discussed in various literatures, which suggests immigrant women often rely on their relatives, more specifically female relatives, for support during and after childbirth (Deyo, 2012; Qureshi & Pacquiao, 2013).

It was very common for women to mention their husbands during interviews. Whether present or absent, participants commented on their partners, indicating the level of impact it had on their maternal experiences. As Sophia above narrates her story of wanting to take care of her child without the help of her mother or mother in law, she does include her husband as someone who supported her during that time:

So my husband was my support system then. He was there for me. He has been a very good man. He tried his best to make sure everything was fine. He is a very good man. –Sophia, Nigeria

Some participants commented on the level of involvement their husbands had during pregnancies. Attending birth classes and doctors appointments were a few of the instances mentioned during interviews. Here, Angela describes her husband and the actions he took during her pregnancy:

I wasn’t demanding for stuff. But my husband, anything they say he ask them to print out the explanation so he reads through it. He goes onto the Internet. When
they give any medications to either of us, he reads about it before he gives the go ahead. So I was like yeah whatever. -Angela, Ghana

Although some women such as Reena relied heavily on community resources such as the Help Me Grow program and WIC as a means of support, she also speaks of the support she received from her husband:

He was very supportive. He was always very proud of me after he saw that. He said in his eyes I was a different person, which made me feel very good. I really appreciate the support I got. My husband, every inch of the way without his support, his strength, I wouldn’t have done any of this. –Reena, Sri Lanka

These findings are similar to various studies that suggest spouses are often used to narrate various forms of support in immigrant women’s maternal experiences (Sword et al., 2006; Qureshi & Pacquiao, 2013; Missal et al., 2015). Additionally, these studies found that immigrant women’s accounts of their husbands often focused on men taking on new roles such as caretakers after the birth of their child. This finding was not present in this research, as participants largely spoke of husbands with regards to their support circles.

Unlike several participants, one woman commented that she did not need support as much during her pregnancy as she did after the birth of her child. Kady narrates her maternal experience with the story of her emergency birth in Columbus, and how her support circle came together after her child was born:

I didn’t really require support so much so during my pregnancy as much after. So after I had the baby that’s when I needed a lot of support and that was more in Columbus with Nationwide Children Hospital and Ronald McDonald house. Support groups that were there but during the pregnancy. I was pretty cool. – Kady, Jamaica

She describes support groups for parents of children in the NICU, and visits from family and friends that came to Columbus after the baby was born. Kady’s account does not reference support during her pregnancy, as she mainly discusses her experience of having an emergency birth. It was uncommon in this research for women to discuss
support as not playing a large role in how they perceived their maternal health experiences. Most women spoke highly of the support systems surrounding them, while others expressed the desire for a larger support circle.

Maternal Care Differences From Home Country

Immigrant women that participated in this research originate from multiple countries that are unique to the Appalachia region. During interviews many women noted the differences of maternal healthcare in the United States compared to their home country. As previously discussed, women noted that they saw multiple physicians during their pregnancies, an unusual practice in their home countries. One participant named Adella who is from El Salvador and mother of one describes this:

Something that probably is different than from my country or what I’ve heard because you know I didn’t have any experience down there is that you have a doctor that is your doctor through the whole pregnancy and is the one that delivers your baby. Here doesn’t... at least in River Rose it doesn't work like that.

–Adella, El Salvador

The most common accounts of maternal care differences focused on the quality of the care received. Lydia discusses her experience at O’Bleness in depth and how it compares to Ghana:

…But some of the differences would be that here you get like two doctors, two nurses assigned to you, that’s a lot of medical help and the baby also has people assigned to her. But back home it’s like the same doctor does the delivery is basically the person that is assigned to the kid and I remember when I was in the hospital, I always had two nurses assigned to me and two nurses assigned to her. That’s good. You don’t have that much at home. Basically you might have a couple of nurses assigned to you, a couple of docs and to get like a private room like what we had. That would be paying a lot...it might be like private hospitals or something but you pay quite a bit to have that. So it was good to know that is the standard. And everything we took to the hospital we never used it until we left. Things like diapers and stuff like that. We don’t have that back at home, basically you take everything. –Lydia, Ghana

Similar to Lydia’s sentiments, Angela also describes health care in Ghana:
I know back home, if you have the money you get the best. But here even with your student health insurance you still get the best. Yeah. Best in terms of how I define best. Its good for me, with my student healthcare. I know back home the number of times you go for antenatal, is lesser for how I go here. And I think...they are way behind is what I'll say. If you have money, it will get you the best healthcare. - Angela, Ghana

Although Angela discusses the high financial cost of superior maternal care in Ghana, other respondents discuss financial constraints they experienced while receiving maternal care in the United States. Some participants commented on specific costly maternal services they must consider before using, such as working with a midwife:

There’s not many options in Athens. I really liked my midwife. And I really, really liked her and I would like her to still deliver my second child... but you have to pay more so there’s like do I really have to pay more or will I get another one who the health insurance network? - Shari, Uganda

Here it can be seen that some women consider financial constraints before choosing what maternal services to use. For some, the cost of giving birth in the United States came as a surprise. I asked Shari if she had been counseled on the financial costs and if she was prepared before the birth of her child and this is her response:

Nope. It was a big shock. Somebody... I would tell everybody getting a child is expensive. Yeah it’s very expensive. –Shari, Uganda

I didn’t know it was so expensive to have a child yet still having insurance I didn’t like it at all. You get surprised. So why do I even have insurance in the first place? I had a GA ship but you know with that it’s not enough. Really it’s not enough with a child and rent and food and diapers and all that then hospital bills. I think it’s a billing part that was so scary and I don’t want to do that again. – Shari, Uganda

Shari’s account of the financial burden she experienced even while insured raises an interesting finding that differs from that of Derose et al. (2007) where they state, “Immigrants have consistently lower rates of health insurance coverage than U.S.-born populations” (p.1260). This difference can be contributed to the specific participant sample of this research where all participants commented that they had health insurance that mostly came from the University, although a few women were insured privately. This
can be contributed to the University’s policy that all students must be enrolled under an active health insurance plan before they are eligible to enroll in classes (www.Ohio.edu). If students are not enrolled in an insurance plan, they are required to enroll in a health insurance plan that is chosen by the University; not being insured is not an option. While students are insured under the University’s chosen health insurance plan, there are still significant out of pocket costs that came as a surprise to some participants.

Shari did not go into detail if she knew how the cost of her pregnancy would have compared if she had given birth in Uganda. However, other participants did discuss the financial constraints they know to be associated with receiving quality maternal care in their home countries. Women often noted the differences between public and private hospitals in their countries and the level of care you would receive depending on which facility you chose. In many countries discussed by the participants, the best maternal care is received only in costly private facilities. Sophia, a 30-year-old master’s student and mother of one describes how quality care in Nigeria requires not only financial capital but also social capital:

Because I'll see O’Bleness as a public hospital. The public hospital in my country before you can get treatment like that you have to know people. So if you do not know top people at that hospital they will neglect you and some other things. - Sophia, Nigeria

While O’Bleness is not a public hospital, the fact that Sophia’s statement is untrue is not significant. The fact that this sentiment shaped her perceptions of the care she received is important. The above response also uncovers the unfortunate reality for many women in Nigeria and other developing countries, who often lose their children before the age of five (Forae, Uchendu, & Igbe, 2014). Women also mentioned the maternal mortality rate in their countries, and attributed it to low doctor to patient ratios, and the resulting lack of
promptness on physicians parts. During Dena’s interview, she touched on these differences:

…We (Ghana) have a lot of maternal mortalities compared to here because doctors are not prompt and patient to doctor ratio is very high. So the treatment, they are not as nice as they are here... people will sleep on the floor; they don’t even have beds to sleep on in the hospitals. Those are some of the differences.
–Dena, Ghana

These discussions raised by women often uncovered the belief that change is needed in regard to maternal health in their countries. Angela, who previously described how money can get you the best health care in Ghana, also expressed the need for growth within Ghana’s maternal health services:

I’m not the type of person who really goes to the hospital back home but from what I’ve heard, obviously this healthcare is way better. Like you have here a room to yourself, you have the doctors at your beck and call. Ghana... it’s developing we have a long way to go. And I know some people who they went until their full term and they lost the baby during that childbirth. Ghana has a long way to go, yeah. -Angela, Ghana

Maternal services used by women during pregnancy and labor were also discussed. After labor, it was often noted that a lactation specialist met with women to ensure they had appropriate breastfeeding knowledge. Some women commented that these services were something they would not have received in their home country. It was not discussed if someone else in their countries of origin played this role. However, it is important to note that in some countries physicians and nurses are active in multiple roles during the pregnancy and labor process. Alli describes her experience with maternal services at O’bleness hospital:

There was always a specialist... lactation... something and that was really good. I met her once also after first day I had my baby they told me they let her immediately come to me... In Saudi Arabia they didn’t do that. –Alli, Saudi Arabia

Some women also mentioned that they were rarely left alone during their labors at O’bleness. This was in contrast to Alli’s experience of giving birth to her first child in
Saudi Arabia. Here, she details her first labor experience and how it compares to the birth of second child:

In Saudi Arabia the nurse came and the midwife came and then she left and it was my first baby but she wasn’t with me all the time in the room. And then she would check she would come and go but in here... in Athens there was always someone with me. Even though it was my second baby. The doctor in Saudi Arabia just came at the end to I think I don’t remember if she... yeah she just came to take the baby out and to do the stitches. Here there wasn’t a doctor but there was the midwife which was with me all the time... almost all the time. —Alli, Saudi Arabia

When asked if she enjoyed the company during her labor she replied: “Yeah of course.”

Alli’s opinion of a health professional in the room for the duration of her labor is similar to the majority of participants. This corresponds with research that found immigrant women welcomed health professionals’ continuous presence and were unhappy when they were left alone in the delivery room (Small et al., 2002).

Women also commented that they were happy family and friends were allowed in the room during and after labor. Dena described having the presence of many people in the delivery room as her best maternal experience. She states:

The best experience was the birthing process because they... I don’t know of any experience back home where the people, friends and family were allowed in the birthing room. But here, in my experience and what I’ve heard so far people, friends, relatives, people that want to be in there with you are allowed. —Dena, Ghana

Dena’s account of her best maternal health experience includes the presence of family and friends in the delivery room. This finding is similar to numerous literatures that suggest it is often culturally significant for immigrant women to welcome in family and friends for support; however, an important finding in some studies was that only female kin and friends are welcomed during labor (Quershi & Pacquiao, 2013; Missal et al., 2015)

Similar examples of guests in the labor room were commonly mentioned in women’s accounts of the perceived differences in the maternal care they received.
Though many women shared common sentiments with regards to their maternal care and how they overall perceived the treatment they received, numerous differences between immigrants were highlighted throughout interviews.

Differences Among Immigrant’s Experiences

With the exception of one emergency birth that took place outside of Athens, the majority of women gave birth at O’bleness Hospital. Kady’s experiences with maternal facilities in Athens and Columbus, give her a unique perception on maternal health that differs from other participants. Kady’s account details going into an early labor:

Every thing seemed to be going fine and we were planning to take me to maybe 30 something weeks uhm... maybe 35-36 weeks hopefully before she was born. So we were already planning for me to go stay in Columbus and have her at Riverside so that she could be transferred to nationwide children’s hospital and then... at 30 weeks I went into labor. So... my husband drove me to the emergency room and we got there and one of the doctors from River Rose met us and they confirmed that yep I was in labor and they gave me what’s that thing that stops your labor, they gave me two shots. One to help the baby’s lungs develop and then another one to stop the labor which it did for a little bit and they discussed if they were going to put me in an ambulance or they were going to put me in a flight. They decided to put me in a regular ambulance since the medication was working to stop the labor. They drove me to Columbus. –Kady, Jamaica

The narrative of Kady’s emergency labor experience is largely filled with the interactions and support systems she had while in Columbus. Although she kept up with prenatal appointments in Athens, Kady’s experiences differ from the rest of this study’s respondents based on the notion that her maternal health perceptions were primarily formed in another area. Following the labor, Kady’s daughter needed surgery and was then placed in the NICU. In this study, she was the only participant whose child had any surgical procedure directly following birth and also the only participant whose child stayed in the NICU. Following the surgery, Kady’s daughter spent over a month in the hospital; the longest stay in any facility out of all the participant’s children.
Another major difference in how Kady narrates her maternal health experiences lie in the support structures she formed. She discusses the Ronald McDonald House as her primary source of support. Kady’s experience with the Ronald McDonald House was described as a major help and her account highlights the differences in the support she received. While other respondents spoke fondly of community services that they declared a part of their support structure, Kady largely narrates practicalities such as a kitchen to use and a room that was provided by the Ronald McDonald House for the duration of her daughters’ hospitalization. Here, she details the kind of support it offered her while her daughter was in the NICU:

> You have a room and then with the room that I had, it had like two beds in it so my friends could come and visit and help out uhm... and just be there. And then you could cook. Which was important for me because I did not eat a lot of the stuff that they made. –Kady, Jamaica

Kady describes how she interacts with health professionals in a way that was different than most other participants. While discussing her 10 week early delivery and the healthcare choices she made during that time, she began to discuss her stance on taking orders in the healthcare arena. When I asked Kady if any doctors had disagreed with any choices she made or went against her decisions during that time she replied:

> I’m a take charge kind of person and I make clear what I want from the get go. So... and if a doctor had that would be the last time that doctor would with me anyway. So... I’m just a no nonsense kind of person. And I had read enough about like healthcare because I guess... because part of my emphasis in college was health. And health communication so I was already aware how some doctors behave and how sometimes patients like I don’t know the patients wishes are not necessarily aligned with the doctors and so no... I knew from the get go going in that I had to stand up for myself. –Kady, Jamaica

The assertiveness that Kady describes in the above quote differs from studies that suggest immigrant women often uncritically trust medical authority believing that physicians only have their patients’ best interest at heart (McLaren, 2006; Liamputtong & Watson, 2008). Once again, a major factor contributing to the difference from the
findings of other studies is the participant sample used in this research. Women in this study were graduate students who are arguably taught to think critically and seek out information on their own. The above quote is also in contrast to another respondent whose response coincides with the aforementioned literature. When asked what she thought a good maternal health experience could be defined as, Angela described learning all you can and following the doctors to produce the best experience you can. She states:

I think the first one is like you have the resource center... you go ahead of time and you learn. They help you through the process, so how your body changes and what you should expect. You read around the pregnancy, you go for your antenatal classes, you go for the check ups and I think that is the best you can ask for. Then the birth... just go along with the doctors. – Angela, Ghana

Similarly, Liamputtong and Watson (2008) write the account of a Lao immigrant who states, “I just leave it with the doctor to decide for me” (p.72). Although not as explicit as Angela’s statement, narratives surrounding medical authority were present. Dialogue that focused on whether physicians would allow a woman’s choice, such as not preferring a cesarean section and other medical preferences, often came up in discussion.

When I asked Angela if she could give me an example of this, she spoke about her initial aversion to getting an epidural, but that she ultimately received one after she spoke with a physician. She describes how physicians’ expressed that an epidural was the best option for her even after she conveyed concerns about having the procedure. Her account of this experience highlights how a physician’s authoritative influence ultimately convinced her to receive an epidural:

I didn’t want the epidural. Mainly because a cousin in London had one and then since then she’s been complaining of back pain, yeah. And then he explained to me obviously that in London their procedure, the needle they use is way bigger than the needle they use here. So he explained and I just went for it. Because I seriously didn’t want it. – Angela, Ghana
Participant's different opinions regarding medical interventions were also present when they discussed cesarean sections. Although opinions differed amongst respondents, many women expressed distaste for the procedure and several women voiced their opinion on having a natural birth. This finding coincides with numerous literatures that state immigrant women overwhelmingly are opposed to cesarean sections (Liampittong & Watson, 2008; Borkan, 2010; Deyo, 2012; Missal et al., 2015).

Like many participants, Reena was adamant on having a natural birth. She states:

So my first concern was I really wanted to have a natural birth. I wanted the process to be as natural as possible. –Reena, Sri Lanka

Similar to Angela’s opinion on following physicians instructions, women who did not feel strongly against a cesarean stated that they would be fine with undergoing the procedure if that was the doctor’s orders. Often, participants commented that having a cesarean would be permissible if it was a life or death situation. Although several participants’ shared this opinion, having a natural birth was their first choice. During an interview with Alli, she spoke about her preference on natural birth and following the physician’s instructions:

I had no problem having a C-section if my situation required that I have it. But otherwise I preferred normal delivery since it is better from all perspectives during and after birth. So I guess my answer is that if the doctor told me I needed a C-section I would have it, and if not I was going to pick the normal delivery for sure, if we are allowed to pick. –Alli, Saudi Arabia

Alli’s suggestion that she may be unable to choose a natural birth is unique to this study. It was clear that many participants understood they had choices in their maternal care. Alli’s perception of her lack of choice could be contributed to her perceived lack of power within medical spaces. This form of control has been explored in numerous literatures that suggest “Othering” is used to exercise power over immigrant women (Browne, 2007; Borkan, 2010; Hill et al., 2012).
An important point to mention is the connection between having a natural birth and the participant’s country of origin. For some women, having a natural birth is significant in their communities. This sentiment was not something expressed by all participants, highlighting another difference between respondents. One participant however, spoke on having a natural birth with regards to becoming a woman after a natural birth, and some complications that she believes can arise after a cesarean:

My sister had a C-section and not that she had any complications, but I know from Ghanaians or Africans they say you are a woman when you give birth. And I know when you have a C-section, it limits the number of kids you can have. Yeah... and also I just wanted to have a natural birth. –Angela, Ghana

Angela’s sentiments are consistent with findings from the literature that suggest many immigrant women worry that having a cesarean section will ultimately limit the number of children they will have (Borkan, 2010; Deyo, 2012; Hill et al., 2012) The connection found between pregnancy, birth, and the participant’s home countries sparked discussions on differences in maternal care. As discussed earlier in this chapter, women in this study attended prenatal appointments at either River Rose Obstetrics or Holzer Health and were rotated between several physicians for their treatment. During these discussions, one participant who is from Saudi Arabia raised an interesting point. Her account of rotating between several physicians highlights a major difference that is not common among all participants:

I was always concerned if I would have a female or male doctor... but yeah there is always a female doctor for me since I asked for that... I have met more than one doctor like during the almost 9 months. So I think even there were three different but I mean I was, I was like really concerned about changing from one doctor to another–Ava, Saudi Arabia

In Ava’s statement, she raises an important concern some immigrant women claim that they must consider before receiving maternal care. For those who are originally from Saudi Arabia and other Muslim countries, seeing a female physician is often nonnegotiable. This statement coincides with literature that has focused on the
experiences of immigrant Muslim women (Reitmanova & Gustafson, 2008; Quershi et al., 2013; Missal et al., 2015).

In the above statement, Ava conveys she was always able to see a female physician despite having to rotate between several doctors. In this study I interviewed two women originally from Saudi Arabia, but both women did not share the same physician requirement. In Alli’s account, she describes the health facility that asked her preference and how she responded:

Yeah like the beginning when I went the first time to Holzer… they asked me if I would prefer a woman or a man to see me so that was nice. But I said whatever it doesn’t matter to me if im sick but even in Saudi Arabia men see us so… there’s not really anything different here. But some people prefer woman. —Alli, Saudi Arabia

This quote illustrates the differences among immigrant women’s maternal health care preferences. It highlights that immigrant women should not be blanketed with the same assumptions on the maternal healthcare they wish to receive, even if the women are of similar backgrounds.

In this study, participants narrate their experiences in ways that go against current immigrant health literature. As previously mentioned in this chapter, only one participant narrates a less than positive maternal health experience, pointing to the notion that, despite immigrant status, women in this study narrate their maternal health experiences optimistically. The experiences detailed by participants in this study are in contrast to many current literatures that draw narratives of ‘Othering’ by health professionals who often use their authoritative knowledge against immigrant women. A clear difference between participants of this study to that of other literatures can be seen through narratives that dissect the maternal spaces used by immigrants to uncover their maternal health experiences.
CHAPTER 5: CONCLUSION

This thesis research sought to examine the maternal health experiences of immigrant women in southeast Ohio. A main focus of this research was exploring what factors contributed to immigrants' positive maternal healthcare experiences. For women interviewed for this research, positive healthcare experiences resulted from four main factors. First, interactions with healthcare providers, second community resources and support structures, and lastly, maternal healthcare in their home countries compared to maternal healthcare in the United States. The interactions immigrant women had with their healthcare providers were a major influence on how they perceived their maternal health experiences. Women described their physicians as “supportive” by listening to their wishes and concerns, which resulted in positive healthcare interactions.

Also playing a major role in how women perceived their maternal healthcare experiences were community resources. Coupled with the support from family, friends, and the international community, women used community resources as a major source of support during their pregnancies. Many also commented on the importance of these support structures after the birth of their children. Finally, many participants used comparisons to the maternal healthcare in their countries when creating their perceptions of the maternal healthcare they received in Southeast Ohio. While women often cited negative aspects to receiving maternal healthcare in their home countries, there were discussions of similarities with maternal healthcare in the United States.

The differences in maternal health narratives given by women were also of particular interest to this research. Through interviews with immigrant women currently living in southeast Ohio, I was able to uncover their maternal health experiences, and expose gaps currently existing within immigrant maternal health literature. Additionally, I
was able to highlight the perceived strengths and weaknesses of maternal healthcare narrated by immigrant graduate students.

The many findings of this research were analyzed using feminist theories of intersectionality, ‘Othering’, and authoritative knowledge. The role of intersectionality in this study is significant to the findings of this research. The unique study population of this thesis that consists of current graduate students or recent graduates contributes to the uncommon narrative of what an immigrant is perceived as. In this research, the participants come from a place of power, which can be argued as atypical of immigrant populations where they are often a racialized powerless group. The women in this study however, have power in the form of education. They are highly educated individuals that are trained to think critically and to seek out information. Other factors such as English proficiency also positions them in a more privileged place with regard to the power structures immigrant women navigate through. These factors play a major role in how physicians and other health professionals view and interact with immigrant women. Immigrant women that come from a place of power are less likely to be ‘Othered’ in a way which results in racialized ‘Othering’, and they are more likely to have agency to resist and challenge discourses representing authoritative knowledge. Women who have agency are not positioned in the same place or feel the same disadvantages as those who do not have agency that they might otherwise as a result of these power structures. The findings in this research largely complement current maternal health literature that suggests immigrant women often face discrimination and neglect from physicians. This complementary finding offers a set of unique experiences from immigrant women, to offer fresh perspectives on the maternal health care of perceived ‘Others’ in the United States.
This research was conducted using a feminist methodology, which had important implications on both the process and the product of the research. One aspect of this was the awareness of my positionality throughout the research process. My dual role as an insider and outsider allowed me to gain insight I may not have had if I did not share life experiences such as being a graduate student with participants. My role as an outsider was felt at times when I did not share experiences of being a mother with participants. However, this did not impact the findings of this research, as participants were eager to share their maternal health experiences. This could be contributed to my role as a female investigator, where participants felt comfortable sharing their intimate maternal health experiences. The consideration of positionality was important to this research to recognize and confront any power structures that became present to keep equal ground between the participant and myself. Additionally, the use of feminist methodology allowed for the exploration of everyday maternal experiences. This contributed to this research by allowing for analysis to extend to routine maternal experiences that are often taken for granted such as prenatal appointments and breastfeeding. Feminist methodology also allowed for the analysis of how power impacts these everyday experiences.

While the overwhelming message of this study was that the majority of immigrant women in southeast Ohio narrate positive maternal health experiences, this was not the case for all participants. Therefore, this thesis best demonstrates that in any study regarding the maternal health experiences of immigrants, various factors that contribute to how women perceive their experiences such as: spatial context, time lived in the United States, English proficiency, educational status, and knowledge of the American health care system should be explored.
In this research, the aforementioned factors were examined and taken into consideration when analyzing participant’s responses. Previous studies regarding immigrant maternal health experiences are primarily set in urban areas with preference to those living in cities. This study takes a focus on immigrant women who navigate maternal health care spaces in a rural environment. While it can be said that this rural study area of Southeast Ohio is largely influenced by the presence of Ohio University, the area itself is still secluded, which leaves maternal healthcare choices limited and thus make this area a unique location to study immigrant experiences. However, because of Ohio University’s major presence in the community, and due to the fact that every participant in this research was tied to the University in some fashion, it can be concluded that immigrant’s maternal health experiences in this study was largely shaped by the University and the surrounding area. This finding is largely contributed to the mandated health insurance policy from Ohio University. Because of this, the majority of participants had health insurance coverage, although some women still commented on the burden of receiving hospital bills as a graduate student.

A major finding from this study was the impact that interactions with health professionals had on the perceptions of women’s experiences. Women heavily referenced interactions with physicians and nurses that influenced the perceptions of the care they received. The majority of participants concluded that the interactions they had with physicians were supportive and encouraging. However, the few respondents that discussed negative interactions, detailed poor communication that resulted in adverse perceptions. The presence of authoritative knowledge was seen throughout this research when women discussed negative interactions with health professionals. For example, one participant discussed feelings pressured to undergo a cesarean section and that her desire for a natural birth went unnoticed. This is a consistent finding within
immigrant maternal health literature that reinforces the notion that physicians hold a perceived position of power that is often misused.

Throughout this research it became clear that the majority of immigrant women relied heavily on their support systems through their pregnancies and labors. These support systems consisted of community resources, family, and friends. Many women commented on community resources such as hospital birthing classes and a local organization that provided participants with prenatal education and supplies such as diapers and clothing. The support of family and friends was heavily referenced throughout conversations with participants. While the majority of women were married and lived with their husbands, it was common for women to discuss the importance of having additional family members such as their mother in laws to support them. This was especially important to women after the birth of their children so that they could resume graduate classes.

The international community was also commonly discussed as having a positive impact on women’s pregnancies and labors through their support systems. Participants discussed the international community as being a strong influence on the way they perceived their maternal experiences. Women detailed instances where friends from the community would take women to prenatal appointments, friends who kept women company in the labor room, baby showers hosted by friends from the community, and through emotional support. These conversations were especially prevalent when women immigrated here without their families and heavily relied on the international community.

Another common topic of discussion was the maternal care differences women perceived in the United States versus their home countries. Although only one participant had given birth in her country of origin and in the United States, women were
quick to discuss the differences in maternal care that they gathered from relatives or friends. Women often spoke of healthcare as a whole rather than maternal care on its own, which included first hand accounts of the healthcare they received in their home countries. Many respondents commented on the quality of care in the United States compared to their home countries, which contributed to their maternal care perceptions of the treatment they received in Southeast Ohio. The overwhelming response from participants that discussed healthcare in their home countries was that they were happy to have received maternal care in the United States.

Another interesting finding on the difference between participant’s home countries and maternal care in the Southeast Ohio was the practice of rotating between several physicians for their prenatal care. Several participants commented that they were not familiar with the practice of being rotated among many physicians and that in their countries this was not a common occurrence. Some participants expressed their desire to have only seen one physician for their prenatal appointments, while others were happy to have had several opinions.

The differences among women’s maternal experiences varied greatly. This finding furthers the notion that immigrant women’s maternal health experiences should not be assumed by way of cultural blanketing. Participant’s responses highlighted differences in maternal care including: One respondent’s narrative on her emergency birth, women’s maternal beliefs and preferences regarding cesarean sections and epidurals, following a physician’s medical advice, a woman’s negative experience interacting with physicians, and preferences on seeing a male or female physician.

Finally, the combination of intersectionality, ‘Othering’, and authoritative knowledge used as the guiding framework of this study, was useful to this research exploring how immigrant women narrate their maternal health experiences based on
their spatial context, which largely contributed to the findings of this research. The relationship between these three theories and immigrant’s spatial context should be further explored with regards to educational status and knowledge of American healthcare system. Furthermore, additional studies should also reflect the narratives of health professionals who work with immigrant women, analyzed under the framework used in this study. In order to fully understand the maternal healthcare experiences of immigrant women, it is important to explore the narratives of those who work with them such as physicians, nurses, and midwives. This step is necessary in building supportive and understanding relationships between immigrant women and health professionals.
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APPENDIX: INTERVIEW PROTOCOL

• Where do immigrant women who live in this area go to receive health care while they are pregnant?
  -What makes these places different?
  -What makes you more likely to receive health care from one place over another?

• Can you talk about your experiences at these places?
  -What would a good health care experience look like to you?

• Tell me about your experience with pregnancy and birth here in Southeast, Ohio.
  -Tell me about your health care experience in Southeast, Ohio

• Can you describe a time when you felt you were listened to during any of your pregnancies/births from any health care staff?
  -Can you describe a time you and your needs were ignored?

• How do you feel your experience with the health care system in Southeast, Ohio could be improved?

• Is this what you had expected it to be? If not, tell me what you had expected it to be. Why had you expected it to be that way? (What gave you these ideas?)

• Have you had multiple pregnancies while living in Southeast, Ohio?
  -If so, how have your pregnancies differed? Did you keep the same doctor for all of your pregnancies? If not, can you explain why you decided to switch? If you did not switch doctors, tell me why.

• What did your first doctor’s appointment during your pregnancy look like here in Southeast, Ohio?

• Can you talk about what stood out to you? Did anything surprise you about this first visit?

• Can you describe your best pregnancy/birth experience while living in Southeast, Ohio? Where did it take place?

• Can you describe your worst? Where did it take place?
• What do you think of the healthcare you have received during your pregnancy and/or birth in Southeast, Ohio?

• How do you feel about the health care providers who have/are treating you?

• Describe to me what you feel are your maternal needs

• Can you describe a time when you felt your maternal health care needs were being met during a doctor’s visit?

• Can you describe a time when you felt your maternal health care needs were not being met during a doctor’s visit?

• What do you think a good pregnancy and birthing experience is?
  - How did you come to know what a good pregnancy and birthing experience is?

• Can you tell me about a time when you were frightened or worried with regards to your pregnancy/birth?
  - What did health care staff do to help you during this time?
  - Can you tell me about a time you felt safe and secure during your pregnancy and birth?

• What types of support have you received during your pregnancies/births?
  Support from family/friends/health care staff

• Tell me about a time when doctors or other health care staff has disagreed with your pregnancy, birthing beliefs, or opinions.
  - How did this happen?
  - How did you respond to this situation?
  - Can you give me an example of a time when doctors or other health care staff agreed with your pregnancy, birthing beliefs, or opinions?