

Pregnancy-Related Experiences of Bangladeshi Immigrant Women in the U.S.

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Abstract

This study explored the pregnancy-related experiences of 10 immigrant Bangladeshi American mothers living in New York City. This qualitative research done through interviews and participant observations has revealed that the women faced several problems, including financial instability, isolation, loss of social status, and loss of their identity as (Bangladeshi) Muslims. The study also found that initial settlement challenges adversely affected their psychosocial and physical well-being, which in turn affected their prenatal health.

Keywords

culture; ethnic minority; Bangladeshi immigrants; immigration; women; pregnancy

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Pregnancy can be a joyful time as well as a critical stage in every mother's life. However, research suggests that becoming a mother is a trying time filled with many challenges (Canuso, 2003; Liamputtong & Naksook, 2003; Liam, 1999). Little is known about the lives of immigrant women, in particular those living in the United States who go through pregnancy while trying to adapt to another culture. Much of the research on migration addresses this stressful process, outlining various stages of adjustment patterns for immigrants coping with cultural changes (Akhtar, 1999; Ibrahim, Ohnishi, & Sandhu, 1997; D. Sue & Sue, 1987; S. Sue, 1988).

According to Liamputtong and Naksook (2003), not only is the migration experience associated with stress, but it is also often accompanied with the loss of a support system of family relationships (Al-Issa & Tousignant, 1997; Rice, 1999). But immigrants' confrontation with significant changes in many areas of their lives, their interpretation of these changes, and their perceptions of societal perspectives about immigration impose severe pressures on them (Espino, 1991). For women, immigration-related stress could be more complex in nature. Living as an immigrant is a struggle by itself as "migrant women struggle to find a comfort zone between their cultural traditions and the culture of their new land" (Liamputtong & Naksook, 2003, p. 664).

Research examining the experiences of South and Southeast Asian immigrant pregnant women is scant and studies on Bangladeshi women's pregnancy experiences in the United States as new immigrants are nonexistent. This cultural group needs exploration because it is ill-adapted to an American setting. Bangladeshi immigrants inherit a culture influenced by conservative social mores and religion. Their value system, which is heavily influenced by their religion, discourages them from exposing themselves to the U.S. mainstream lifestyle (Nazroo, 1998). They tend to retain these values even after living in the United States for a considerable time. Yet little is known about how these cultural characteristics affect Bangladeshi immigrant women's ability to experience a successful pregnancy. To expand research on Southeast Asian women's pregnancy experience in the United States, this study will explore the pregnancy experiences of 10 Bangladeshi women living in a major U.S. metropolitan area. This study also focuses on their physical, mental, emotional, social, and environmental health.

Review of Literature

Hoeffel et al. (2012) found that according to U. S. Census (2010) an estimated 3.9 million South Asians live in the United States, the third largest group within the Asian American and Pacific Islander category. Between 2000 and 2010, the Asian population in the United States increased by 45.6%, and Bangladeshis alone were the fastest growing group, registering a 156.6% increase. Although Bangladeshis have migrated to different regions in the United

States, New York City has the highest population of Bangladeshis in the country (Gany, Shah, & Changrani, 2006). Yet their experiences remain largely unchronicled.

An understanding of immigrant women's cultural backgrounds can enhance their chance for a successful pregnancy in the context of the U.S. health care system. However, physicians and other health service providers are not always able or willing to adjust their practices to a culturally diverse population (Adeniran & Smith-Glasgow, 2010). Substantial disparities in health care coverage remain for certain ethnic minorities (U.S. Department of Health and Human Services, 2000).

A small body of research suggests that Bangladeshi women are in a weak position to empower themselves in matters related to pregnancy because of religious beliefs, practices, and family structure. According to Rozario (2007), a woman's only social status is a wife and a mother. She is responsible for raising children and for anything that pertains to household matters. In the South Asian culture, a woman is represented as "educated, demure, chaste, modest, submissive, self-sacrificing, kind, patient, and devoted to family—a symbol of her nation, culture, and religion" (Deepak, 2005). Naturally, pregnancy and childbirth are considered sacred activities for women (Jones, Hughes, & Bond, 1999).

Bangladeshis often live in extended families, and the presence of extended family members can constrain health choices by women. In some cases, the religious beliefs of family members can delay mothers in seeking care outside the home. For example, the sociocultural norm of wearing the veil, known as a hijab or purdah, is not meant to create a barrier. But in many cases, hijabs or purdahs can be construed as a barrier for a variety of religious or social implications. Reinforced by a patriarchal society, a woman who wears the purdah is generally not allowed to have contact with males, including male physicians (Rashid, Hadi, Afsana, & Begum, 2001). Adamu, Salihu, Sathiakumar, and Alexander (2003) reported that Muslim women must ask their husband's permission to use health services. Few Bangladeshi men are present at the delivery room and are generally unaware of the physical, mental, and emotional pain the women go through, yet they make critical decisions about pregnancy-related treatment and childbirth (Sapkota, Kobayashi, & Takase, 2011). On the contrary, research also suggests that American physicians and other health care providers tend to react negatively toward patients who wear the purdah (Stewart, Parker, Chakraborty, & Begum, 1993). Stewart et al. (1993) also noted that these purdah restrictions act as barriers to women's use of a hospital during the baby birthing process.

Theoretical Framework

The theoretical framework used in this study is the PEN-3 model developed by Airhihenbuwa (1995). This model is particularly relevant to this study because it is a culture-centered model. It builds on the cultural criticism of the existing models of health communication by viewing health beyond mere biological factors and emphasizes the sociocultural context in which to analyze how health behavior is shaped, enabled, and empowered (Dutta, 2007). With the sociocultural context in mind, this study is prompted by one overarching research question (RQ): What are the experiences of immigrant women from Bangladesh living in a large U.S. metropolitan area during pregnancy?

Method

Sample Selection and Recruitment

Prior to data collection, approval to conduct research was obtained from the Southern Illinois University Carbondale Human Subjects Committee. Initially, 30 Bangladeshi women were recruited to participate in the study using the snowball technique of the nonprobability sampling method (Gubrium & Holstein, 2003). However, the interviewing process ended after the 10th participant was interviewed because data had reached a point of saturation (Guest, Bunce, & Johnson, 2006). To participate in the study, the women had to have completed their first successful pregnancy in the United States between 1 month and 1 year prior to the date of the interview. All interviews were conducted in Bengali by the primary author. The first four participants were recruited through the primary researcher's personal network, and the remaining six were referred by participants. All lived in the New York metropolitan area.

Three of the 10 participants had been living in the United States for 2 years, six participants between 3 and 6 years, and one participant for 9 years. The participants ranged in age from 22 to 39. Half of the participants had a high school diploma, and the other half also had a college education. Only two women were working, and they along with their husbands had blue-collar jobs. Family income was between \$1,200 and \$2,400/month. Five participants shared apartments with their extended families.

Data Collection and Interview and Setting

Three data collection methods were used in this study for triangulation purposes: interviews, observations, and hospital documentation. Triangulation is the use of multiple data sources (Schwandt, 1997) to support themes or the theories that are being built or confirmed and also for validating the accuracy of the data gathered in the data collection process (Lincoln & Guba, 1985; Patton, 1990). The data collection for this qualitative study involved in-depth,

open-ended, semistructured interviews. Most of the interviews were held in the participants' homes while their husbands were away.

Observations

The primary author observed interviewees' home environment, their interaction with other family members, their neighborhood, and the hospital prenatal care units they went to. The primary author also accompanied one participant in her labor room. Participant observation was used as a method of data collection, to produce a rich and thick description of social interactions within their natural settings (Geertz, 1973). The primary author conducted two observation sessions in the prenatal care outpatient unit in one of the hospitals for approximately 6 hr. The scope of observation was narrowed to patients of Bangladeshi origin. During the observation, field notes were taken on how they came to the clinic, how they reported to the reception/information desk, who was accompanying them, how they were dressed, how they were communicating with the health care professionals including their verbal and non-verbal communication patterns, and what kind of treatment they received from the health care providers.

Instrument Development and Data Analysis

For the purpose of this study, the PEN-3 model guided the design of the interview instrument to ensure that all questions covered the various aspects of the project. Interviews were audiotaped and transcribed verbatim in Bengali and then translated into English. Two independent bilingual researchers checked the translation for accuracy. Data were analyzed using thematic categories. The constant comparison method was employed to identify relevant themes and categories that emerged from the transcribed interviews, following the suggestions of Strauss and Corbin (1988). The study received ethical approval from the Southern Illinois University Carbondale Human Subjects Committee.

Findings

Transition

Most of the study participants perceived the process of transition from Bangladesh to American society to be a rocky experience featuring major challenges. Many of them saw physical relocation as an uprooting from the traditional families, coupled with changes in the societal value system, environment, and culture significantly affecting their life, livelihood, and well-being. A majority of the participants said pregnancy became an additional source of stress because they were struggling physically, mentally, emotionally, and above all financially at the initial stage of resettlement. After coming to America, most

participants could not relate to the American way of life and wondered where they belonged. One participant illustrated her frustration by saying, “Who am I? A Bangladeshi or an American? Where do I fit in?” Another reported, “I was no less excited when I got the news of our possibility of immigration to the U.S. But, believe me, I never ever think of calling America my home. So, I really don’t know where I belong.” Despite the hardships, some participants felt proud of settling in the United States. Coming to America with more opportunities for them and better education for their children was like a dream.

A couple of participants felt good about their pregnancy, but most women felt they had lost social status by leaving a comfortable lifestyle in Bangladesh, typical of the middle and upper class. With the loss of social status came a sense of shame and guilt. After the baby was born, they were still struggling for survival with their husbands working long hours in low-paying jobs and living in substandard housing environments. One respondent said,

Can you imagine, my father is an investment banker and here I am in this ghetto? During the first few days, I did not even call my parents in Bangladesh. How could I tell them that my husband is a construction worker?

For most participants, coming to America came not only with social costs, but also with financial ones. For them, “America was like a dream gone bad.” Almost all respondents complained about the high cost of living in New York City and how it made their life difficult. One respondent from the Bronx said, “My husband made about \$2,400 per month as a framer at an art gallery. We lived in a joint family of 13 people in a three-bedroom apartment.”

Culture

Participants in this study put high emphasis on living in close proximity to other Bangladeshis and adhering to their traditional practices. They described a number of issues that mattered to them: (a) re-creating Bangladesh in New York, (b) clustered living, (c) preference for family setup, (d) traditional practices, (e) value systems, (f) religious issues, and (g) food habits. The neighborhoods where the participants lived became a home away from home. Narrating her experience, one respondent expressed, “Here we talk in Bengali, eat Bangladeshi food, wear our traditional dresses, enjoy Bangladeshi TV channels and observe common religious and community festivals and national holidays of Bangladesh, and we raise our children in the Bangladeshi cultural environment.” Pregnant women especially preferred clustered living. It helped them develop a network of strong bonds with other new or would-be mothers. They also relied on the elderly women in the neighborhood as a substitute for their mothers in Bangladesh for guidance and advice. One study participant said, “After I had a baby, my extended family members, friends, and neighbors

visited me both in the hospital and home, brought me foods and clothes for the baby. Some of them became part of my family.” Most of the participants were generally happy about their cultural environment, and one participant from Brooklyn said that she wears the hijab and keeps her face covered when she goes out. It gives her pride and respect. But in other neighborhoods, people would take it as a strange way of dressing.

Participants who lived in joint family households were even happier. One of them said,

We share a three-bedroom apartment, the kitchen and household chores, and spend our leisure time together. If someone gets sick or otherwise busy some of us take her place and do the job. During my pregnancy it was really helpful.

A few participants expressed their frustration about the role and attitudes of their husbands toward their pregnancy. Those who did not get their husbands’ support during the pregnancy felt that in a new land the husband should be the most important individual for a woman to lean on, to confide in, and with whom to have intimate exchanges.

One of the most common concerns shared by the participants was whether they would get a female doctor for their prenatal checkups, delivery, and post-partum care. Some of the respondents said their religious outlook and cultural upbringing discouraged them from seeing a male doctor unless it was life threatening. One participant said, “I do not even feel comfortable talking to a man about what I am going through. Being checked by a male doctor is out of the question. That’s how I grew up as a Muslim girl.”

Food habits surrounding pregnancy were an important issue among the participants and were also a cause of concern for the health care professionals. Bangladeshi women insisted on their particular way of food preparation and consumption and generally did not follow the dietary guidelines recommended by their doctors and nutritionists. Some participants and their newborn babies suffered from malnutrition and other medical conditions. Two of the participants said that their babies were born with severe dehydration and cracked skin. The food guide provided by the health care professionals did not carry any useful message to many of the Bangladeshi women, and as one participant put it, “I could not understand anything nor could I relate the guide to the food we are used to. I threw the food guide into the trash can. It was written in English with hard-to-understand Bengali subtitles.” Beyond malnutrition issues, other physical health issues included hypertension, physical weakness, and dehydration.

Some of the study participants were at a high risk for gestational diabetes and were advised by their physicians and nutritionists to take six meals a day spread equally over the course of the day. However, none of the high-risk par-

ticipants followed these instructions. Instead, they waited until their husbands returned from work to have a meal, which often meant eating dinner late at night. The participants and their husbands opposed the changes advocated by the physicians because they considered their dieting style an integral part of their life, which they were unwilling to change.

Experiences With Health Care Services

Participants had to deal with health care services issues such as (a) the lack of health care professionals' cultural sensitivity, (b) unequal health care treatment, (c) quality of services, (d) help (level of care) from professionals, (e) communication issues, and (f) language barriers. All the participants experienced the American health care system for the first time during their pregnancy and were critical of the overall health care delivery system.

Cultural sensitivity. Participants had mixed feelings about the attitudes of the health care professionals. They reported that physicians and nurses were not attentive enough to their pregnancy issues and were not culturally sensitive and cooperative. One participant described the problem as "American physicians and nurses expected me to behave as any other American woman. Hey, I am not an American, I am a Bangladeshi. Try to understand me. Ask me what I want to eat. Ask me how I feel." Another respondent provided similar feedback: "There were so many issues I could not express properly to my physicians or nurses. I was sure that any Bangladeshi physician could easily understand my problem. It's a cultural thing."

Unequal treatment. Several participants perceived unfair treatment by physicians and hospital personnel during their pregnancy due to their traditional attire. A participant believed that she was a victim of discriminatory treatment, stating,

I was not treated with respect and care. Their faces changed as soon as they saw me in long dress and "hijab." I did not fully understand their conversation but I could figure it out what they were talking about. They used to ask me why I wear such a dress. They made fun of it.

Quality of health services. Some of the participants were dissatisfied with health care services in the hospitals. The issues included a long waiting time, rude treatment from health care professionals, inefficient recordkeeping, lack of facilities, lack of physicians, lack of support staff, lack of coordination in scheduling, and a crowded and unhygienic environment. One participant described her hospital visit experience for a prenatal checkup as a nightmare, when she had to wait for hours and had to come back on many occasions without even having seen the doctor.

Help from professionals. Six of the study participants illustrated their positive experience with their physicians' attitudes as loving, caring, and help-

ful. To some participants, the service provided by American physicians was much better than that of physicians in Bangladesh. One respondent recalled that her primary care physician was kind to her and her gynecologist congratulated her and her husband on their first baby and gave them a red rose. She also added that the ultrasound technician showed her baby's movement in her womb and then the tech started dancing in joy.

Communication issues. All participants talked about the difficulty of communicating with physicians, nurses, or hospital personnel during their pregnancy. For some of the participants, the patient-physician gap was more a cultural issue than a lack of English language proficiency. Most of the time, patients' feelings and concerns did not make any sense to their American physicians and hospital staff members.

When the primary researcher talked to some of the hospital staff members regarding their impressions about Bangladeshi clients, their views varied. The dietitian of one of the hospitals was critical of the Bangladeshi patient population. She angrily said, "Bangladeshi patients are the toughest ones. They are very rigid about their behavior and have attitudes." In contrast, the director of the Department of Obstetrics & Gynecology of a hospital in New York was positive about Bangladeshi patients. He said, "Health care is a complex system. The Bangladeshi population is very nice. They know how to appreciate. Bangladeshis have very good family support. I wish I knew their culture to serve them better."

Language barriers. The participants and health care providers agreed that language was a major problem for the Bangladeshi population. Some of them used body language to communicate with their health care providers, losing important information in the process. One participant said, "My physician was very caring, but I did not understand her words, because she spoke too fast." Sometimes, participants brought their neighbors or distant relatives to the hospital, who helped them fill out the paperwork and doubled as interpreters. However, three of the 10 participants expressed their satisfaction about the free professional interpreter services offered by the major hospitals in New York City.

During the informal interview with the hospital officials, the primary author was given copies of "Patient Guide," "Nutrition Guide for Pregnant Women," "Guide to Breastfeeding," and "Diabetes Booklet." The "Patient Guide" was written in English, Spanish, and Chinese, and the other books were written in English only. She was also given a Bengali version of the "Patient's Bill of Rights." The version was poorly drafted, had many typographic errors, and seemed difficult to understand for the average Bangladeshi mother.

Discussion

This study investigated Bangladeshi women's pregnancy experiences in the United States, including their physical, mental, emotional, social, and environmental health. Interview responses in relation to field observations and health documentation revealed three important findings about their pregnancy experiences in relation to their immigration experiences.

The first finding supports earlier findings exploring the traumatic experience of settling in a new culture (Liem, 1999; Rice, 1999). This trauma was caused by a major gap between Bangladeshi women's expectations about American culture and their experiential reality. Some of the hard realities encountered by the participants included financial hardship due to unemployment or underemployment, loss of social status, lack of social support, substandard living, and conceiving amid the fear of an uncertain financial future.

The second finding revealed the interaction between culture, religion, and pregnancy. Religion and culture are so embedded in Bangladeshi life that it is hard to separate one from the other. Participants' cultural practices and religious beliefs significantly influenced their health behaviors, including the decision-making process in accessing quality health care. Because of their religious and cultural upbringing and their gendered approach to health care, they could not take full advantage of pregnancy-related health services.

Participants who were brought up in a patriarchal and conservative society showed a significant lack of power over their own health and health care decisions. In a single family setup, the husband was the decision maker, whereas in a joint family setup, the in-laws were more likely to make decisions. These latter findings support Bloom, Tsui, Plotkin, and Bassett's (2000) and Singh, Bloom, and Tsui's (1998) work in India, which revealed that although men knew little about pregnancy and complications associated with childbearing, they made the critical decisions about the mother to be. This lack of agency, combined with physical, mental, and emotional weakness, low self-esteem, and feelings of depression and isolation, rendered the participants vulnerable to physical/mental breakdown during pregnancy.

The third finding was the lack of English language proficiency, which hampered efficient interactions between the participants and their physicians. Most of the participants spoke little to no English. Few health care providers had interpreter services. For this reason, the participants could not express their problems properly and did not understand what their physicians meant. Hyman (2001) observed that women's difficult immigration experiences were often aggravated by weak English language skills and limited social opportunities to improve them.

Conversely, many of the health care professionals lacked the knowledge, skills, and motivation to address the cultural differences of their clients. In support of existing research on the disrespectful treatment of ethnic minorities

because of their race or lack of English speaking skills (Blendon et al., 2007), this study also reports a lack of satisfaction with the health care experience during pregnancy (David & Rhee, 1998). Shaffer (2002) reminds that health care providers' understanding of another culture is an important factor that influences access to prenatal care.

Recommendation and Conclusion

Immigration and issues of pregnant women will continue to be a major concern for American health care services. The complexity of the issue will grow further with the changing demographic mosaic of the American population. This issue needs to be addressed from multifarious perspectives. Steps should be taken to deliver health care services in a culturally appropriate manner. Course curriculum and/or training materials should be developed for health educators, physicians, and other professionals to ensure access to quality care for ethnic minorities. In the development of further research initiatives focusing on immigrant pregnant women, much can be done in the areas of cultural sensitivity, health programs, policy development, and health education.

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