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The Lived Experience of Childbirth among 21st Century Cuban Women In a Florida Hospital

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The Lived Experience of Childbirth among 21st Century Cuban Women In a Florida Hospital

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The most common reason for women of childbearing age to access healthcare is for assistance with childbirth. Cultural diversity is increasingly common in the U.S. and the group of people with Hispanic heritage is growing most rapidly. Cubans are the second largest group of Hispanic people and may have cultural beliefs that influence health that have not been uncovered. The purpose of the study was to examine and describe the lived experience of childbirth among a group of Cuban women. Descriptive phenomenological methods were utilized to interview 29 Cuban women who had recently given birth. Two open-ended research questions guided the study: What is the experience of childbirth among 21st Century Cuban women in a Florida hospital? What is the influence of Cuban beliefs and culture on the experience of childbirth among Cuban women in a Florida hospital? Demographic data and semi-structured interviews were transcribed using Colaizzi's method of analysis. The findings reflected three main clusters of themes: Preparing for birth that described anticipating the birth, working and experiencing emotions. Birthing that described labor, feeling pain and supporting the birth. Integrating that described going home and adhering to customs and traditions. The cluster of themes, Preparing, is demonstrated by a participant speaking about her husband when she stated, "He's got a scholarship over there, so, he's back there right now". The cluster of themes, Birthing, is demonstrated by participants who said, "Around 5 am I

start to have pain. Small, little pain like my period. Something like that. OK. I told that to the nurse. They let my husband cut the umbilical cord and that was beautiful! My husband would go like this (gesturing) you know, it gives you a tremendous impression". The cluster of themes, Integrating, is demonstrated by a participant who stated, "I am breastfeeding so I will keep him near me in my room. Well, my mother breastfed us that way and my mom and my sisters told me that it was better for the baby" Culturally competent interventions are necessary to reduce health care disparities and improve the quality of the birthing experience for modern families.

This dissertation by Jane Cox fulfills the dissertation requirement for the doctoral degree in Doctor of Philosophy Science approved by Dr. Patricia McMullen, Ph.D., as Director, and by Dr. Janice Agazio, Ph.D., and by Dr. Denise Heinemann, DRPH., R.N. as Readers.

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Chapter I

Life, from the instant that conception occurs until natural death, is a great mystery. A woman who has recently given birth may describe a sense of breathlessness while waiting to hear her baby's first cry and feelings of overwhelming joy upon seeing her new baby. While the childbirth experience should be a natural and normal phenomenon, many modern women report a variety of events and emotions during the experience of childbirth.

In a survey by DeClerq, Sakala, Corry and Applebaum (2006) new mothers were asked select from a list of randomly ordered positive and negative words that described how they felt while giving birth. The most common positive terms selected were alert (45%), capable (43%) and confident (42%). The most common negative terms selected were overwhelmed (44%), frightened (37%) and weak (30%). Interestingly, a majority of women had a large range and sometimes conflicting responses. They felt both "confident" and "overwhelmed" (14%), "groggy" and "alert" (8%), "agitated" and "calm" (5%) and "powerful" and "weak" (5%) (p.38).

As women go through childbirth, they imitate their own mothers and other women who have carried and given birth to a child. Callister, Knalaf, Semenic, Kartchner and Vehvilainen- Julkunen (2003) found cultural variations to childbirth pain. While a normal physiologic process, delivery is also a major psychosocial experience (p.145). Increase understanding women's of experiences and perceptions during childbirth may contribute to improvements in birth outcomes.

Infants born in the U.S. in the 21st Century are more culturally diverse than ever. More than one quarter of the U.S. population belongs to a minority ethnic group and

about one million additional immigrants each year become new members of communities. National statistics show that nearly one in 10 counties has a population that is more than 50% minority. These counties are now termed "majority-minority" communities. Two of the largest majority-minority counties are Denver County, Colorado and East Baton Rouge Parish, Louisiana. Los Angeles County, California is the largest minority populated county at 7 million or 71% of its total population. Harris County, Texas gained 121,400 minority residents between 2005 and 2006, which led the nation as the county with the highest rate of immigration (U.S. Census Bureau, 2007).

About 15% of the U.S. population is of Hispanic descent with the proportion rising rapidly in some areas of the country. Hispanics remain the largest minority group and by the year 2040, Hispanic individuals will comprise 22.3% of the total U.S. population. The highest proportion of Hispanic minority residents in states with 100,000 or more population are: New Mexico, Texas, California, Arizona, Nevada, Florida, Colorado, New Jersey and New York. Florida had the highest proportion of this minority population (82%), mostly Hispanic, in the most populated counties of the country (U.S. Census Bureau, 2007).

Florida's Hispanic population ranks first among minority groups in the state with 3.75 million people. This represents 21% of the state's 18.5 million residents (U.S. Census Bureau, 2009). Between 1950 and 1990, there was phenomenal growth in the State of Florida. Much of the increase was due to a large influx of people, including retirees, workers in industry and many refugees from Cuba. The states with the largest proportion of Hispanic people are listed below (Table 1).

Table 1

% of Population by Hispanic origin for States of >100,000 Population

Geographic area	Total population	Percent Hispanic of any race
California	33,871,648	32.4
Texas	20,851,820	32
Arizona	5,130,632	25.3
Nevada	1,998,257	19.7
Colorado	4,301,261	17.1
Florida	15,982,378	16.8
New York	18,978,457	15.1
New Jersey	8,414,350	13.3
Illinois	12,419,293	12.3

Note. From (U.S. Census Bureau, 2007).

Though Hispanics share many aspects of common heritage such as language, traditions, religion and focus on the family, Hispanic cultures are heterogeneous and vary according to the country of national origin. Mexicans make up the largest number of U.S. Hispanics and research on healthcare has been conducted. Cubans are the second largest group of Hispanics, but little is known about women's health. Cuban families of childbearing age who immigrate to the United States bring their ethnic culture, traditions and expectations with them to their new communities (Hawke, 2004).

Ricci (2007) described how culture helps its people make sense of how life fits into the "big picture". Culture is the way people experience, perceive and interpret values, worldview, time orientation, personal space orientation, language, touch, and family organization. As nurses struggle to provide care to immigrant women and their families, cultural considerations become increasingly important.

Families, group members and other cultural groups demonstrate beliefs through rituals and traditions. Younger group members engage in behaviors that are learned by watching and modeling older members in the family and community. Cultural characteristics tend to endure over long periods of time and are frequently associated with ethnicity, national origin, religion or race (Becker, Gates and Newsom, 2004).

Acculturation is emerging as a factor in Hispanic women's values and lifestyle. Acculturation, or cultural assimilation, is the acquisition of at least some of the beliefs and values of the dominant culture in society. Acculturation is measured by nation of origin, number of generations that the family has been in the U.S., length of residence in the U.S., and use of the English language. These factors are useful in describing acculturation, but do not capture the nuances in family life (Abraido-Lanza, 2006).

Cultural norms, beliefs and values are factors in Cuban acculturation. Individual variations in acculturation within an ethnic group may assimilate into the dominant culture. While there are increased risks of low birth weight and infant mortality in certain cultures, the rates for infants born to first generation and less acculturated Hispanic immigrant women are the same as for non-Hispanic women and half that of African Americans. Consequently, being less acculturated may have protective effects on health

(Albraido-Lanza, 2006). Higher levels of acculturation to U.S. traditions and ways of life in childbirth have been correlated with poorer perinatal outcomes (Callister, 2002).

More research is needed to understand the effects of national origin and cultural practices on health indicators. Jones and Bond (1999) used an acculturation scale to assess the relationship between the acculturation of pregnant women and their infant's birth outcomes. In a convenience sample of 382 Hispanic women in a large, metropolitan population in the southwest U.S., a 30 item Likert scale yielded scores that demonstrated five levels of acculturation: (a) Very Mexican-oriented; (b) Mexican-oriented; (c) Slightly Anglo-oriented; (d) Strongly Anglo-oriented; (e) Very assimilated. Data were analyzed using descriptive statistics as well as Pearson Product Moment Correlation and multiple regression analysis. Based on the acculturation scale, 79% were very Mexican-oriented. Five variables were significantly associated with birth weight including gestational age, gravid status, and number of prenatal visits ($p<.05$). Acculturation level and marital status were only weakly associated with birth weight. These findings suggest traditional Mexican culture and practices serve a protective function in childbearing women (Jones & Bond, 1999).

Among the U.S. Hispanic population, approximately 63% is of Mexican descent; 11% are from Puerto Rico; 4% are from Cuba; and the remaining 22% are from Central America, South America, Dominica and Spain (U.S. Census Bureau, 2000). The subgroups of Hispanics vary in their geographical distribution in the U.S. People of Mexican decent live primarily in the southwest U.S., Cubans live primarily in Florida, and Puerto Ricans reside in large number in the northeast. Florida has many geographical

areas that resemble native lands. Florida has regions of low, rolling hills, vast swamps, marshes, numerous lakes and extensive forests (CDC, 2007).

In Florida, Cubans make up 29% of the Hispanic population, Mexicans make up 19%, and Puerto Ricans account for 15% of the Hispanic population (U.S. Census Bureau, 2008). The quality of healthcare for Hispanic women is worse than other groups (AHRQ, 2006). To address these concerns, Congress mandated that the AHRQ prepare reports on healthcare quality and disparities. First released in 2003, the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR) reaffirmed that deficiencies in care were worse for minorities and the poor (AHRQ, 2006).

The AHRQ reports yearly on progress with prevailing disparities in healthcare delivery as they relate to racial and socioeconomic factors in designated priority populations. Minority groups, low income groups and women are all priority populations with unique healthcare needs or issues that require more attention (AHRQ, 2007).

Childbirth and reproductive care are the most common reasons for women of childbearing age to use healthcare resources. Although research is limited regarding how country of origin influences healthcare, data indicate that Hispanics have a disproportionately high prevalence of teenage pregnancy. Nationally, birth rates for Hispanic teens are more than three times those of white teens and above that of black teens. Mexican teens have the highest rate of births among Hispanic youths (CDC, 2007). Significant increases in the proportion of Hispanics are related to a rate of natural increase of 1.8% and a fertility rate 84% higher than Whites and 31% higher than Blacks.

Overall, in 2008 teen birth rates for all races was 41.5 while the Hispanic origin groups was 77.4 (CDC, 2007). Birth rates per 1000 population in age groups are shown in Table 2 for U.S. women (CDC, 2006).

Table 2

Percent of Births With Selected Demographic Characteristics

Age	Hispanic	All races
15-17	48.4	21.4
18-19	134.2	69.9

Note. From (CDC, 2006).

The ethnicity of one community, Collier County, is typical of Florida; a high percentage of the population is Caucasian. About 20% of residents identify themselves as Hispanic, 4.5% as African American; less than 1% as Asian, Native American or Pacific Islander (Florida Department of Health, 2005; U.S. Census Bureau, 2006).

Based on the 2000 Census, more than 46,071 residents in Collier County are immigrants. About one in five residents was born in another country; nationwide, the rate is one in nine (U.S. Census, 2000). The median Collier County income is $48,854, significantly higher than the state median of $38,819. The per capita income for the Hispanic population in Collier County, however, is substantially less than non-minority groups at $11,021. 10% of population lives below the poverty level, just under the statewide proportion of 12.5% (Florida Department of Health, 2003).

Table 3 illustrates the growth in Collier County to State of Florida.

Table 3

Population by Race in Collier County and State of Florida

Demographic	Collier County	Florida
Total	314,640	18,089,888
Population percent change 2000-2006	25.2	13.2
White	92	80.4
Black	5.9	15.7
Indian, Alaskan Native	0.4	0.4
Asian	0.9	2.1
Pacific Island	0.1	0.2
Hispanic	24.4	19.5

Note. From (US Census Bureau, 2007).

The Problem

A review of Census Bureau demographic data reveals that Florida's population grew at a rate of 13.2% from April 1, 2000 through July 1, 2006. Much of the increase in population was in families of childbearing age. Teens, unmarried women and minority women face higher risks of negative birth outcomes (U.S. Census, 2007). About 34% of the Hispanic population is younger than 18, compared with 25% of the total population. The Hispanic population has a median age of 27.6, compared with 36.6 for the entire U.S.

population. Overall, Hispanic women have less favorable outcomes than Caucasian, African American or other minority women (U.S. Census, 2007).

Despite an overall high quality of healthcare in the United States, women, minorities and the poor are not getting all of the health care that they need. Minority women are more likely to be single at delivery, have less prenatal care, and have higher maternal and infant death rates. Factors that contribute to poor health outcomes are language and cultural barriers, lack of access to preventative care, and lack of health insurance (Agency for Healthcare Research and Quality (AHRQ, 2006).

Almost 45% of the 235,901 births in Florida from 2006-2008 were to single women. During the same time period, 48% of the women in Collier County were single at the time of their first birth. The birth rate in Florida for women 15-44 is 66.2, however it is 77.8 for Collier County (Florida Department of Health, 2009) Table 4 is shown below.

Women have long recognized the special event of childbirth as fulfilling their dreams and the highlight of their family lives. They have also become increasingly sophisticated in their approach to maternity care and frequently request a family centered approach with a minimal number of medical interventions. Use of induction medications and epidural anesthesia has proliferated during the recent past and mothers delivering in a hospital setting are increasingly experiencing a shorter length of stay. Language, transportation, and costly elective pain management are challenges for minority women (AHRQ, 2004).

Table 4

County Birth Data Comparison for Collier County and State of Florida

Births	Collier County	Florida
Total white live births (per 100,000)	3,533	172,077
Total Non-white live births (per 100,000)	506	63,399
Births to mothers ages 15-19 (per 1000)	425	25,095
Births to unwed mothers (% of total births)	48.6	45.8
Infant deaths (per 1,000 births)	6.3	7.2
White infant deaths (per 1,000 births)	5.4	5.4
Non-white infant deaths (per 1,000 births)	11.9	11.9

Note. From (Florida Department of Health, 2009).

Research that examines and describes the experience of childbirth through the eyes and ears of modern minority women has been minimal. The changing face of women who are experiencing childbirth presents special challenges to maternal-child health nurses. Phenomenology in nursing research may be important in exploring complex concepts related to cultural heritage that influence health outcomes and childbirth satisfaction (Tiedje, 2005).

Callister (2003) interviewed 30 Guatemalan women to gain understanding of the cultural meanings associated with giving birth. The focus was on their birth stories and the perceptions of the sociocultural context for childbearing. The participants were of mixed Mayan and Latino heritage who had given birth to healthy full-term infants and were interviewed in the early postpartum weeks. The sociocultural context was described with common themes, beliefs about pregnancy, and the experience of childbirth. Thankfulness to God, the sacred nature of childbirth, and the significance of having children and family were themes that were identified. It is beneficial to nurses to gain understanding of the experience of childbirth through the eyes of minority women and to identify interventions to reduce negative birthing outcomes.

In 2003, Gallo as part of her doctoral dissertation, explored the lived experience of Latina women giving birth. The study participants lived in a predominately Mexican community in California. In this study 12 participants were asked to describe their childbirth experience and what it meant to them. All interviews were conducted in Spanish and English and the findings were validated by experts who had experience in caring for these women. Analysis of the interviews revealed that the meaning of

childbirth involved adapting to American culture and living through the process of labor. Three essential themes were identified as “Cultural adaptation,” “The unfamiliar journey in a foreign land,” and “Confirmation of choice”. By gaining a better understanding of the effects of culture on the childbirth experience, nursing can intervene in culturally sensitive ways to increase maternal satisfaction (Gallo, 2003).

Postpartum Depression

The childbirth experience marks a time that may involve stressful life changes. Most women proceed through this transition and achieve a sense of competency. For others, the transition makes them vulnerable to postpartum depression. Postpartum depression has been described as a living nightmare. Some new mothers describe anxiety attacks, consuming guilt and thoughts about harming themselves or their babies (Davis, 2008).

Seminal work in postpartum depression has demonstrated the effects of poor adjustment by mothers to their infants. Perceptions by the mother in the first five postpartum days affected the mother’s ability to bond and treat the neonate in caring ways. Neonatal risk has been positively associated with maternal postpartum depression and anxiety (Blumberg, 1980).

Research on depression among 104 Floridian Hispanic women compared confidence levels of postpartum depressed and non-depressed first time mothers (Dilmore, 2002). Participants were interviewed and determined to be depressed or non-depressed based on a postpartum depression survey. Maternal depression and illness undermine a woman’s ability to attain her role by decreasing self-esteem. It deprives the

new mother of the energy necessary to care for her new infant. She may be unhappy, have disturbed sleep, feelings of anxiety and panic, and feel guilty when things go wrong. The mothers' support systems, support satisfaction and infant temperament were inversely related to the incidence of postpartum depression (Dilmore, 2002).

More research into the complexities of postpartum depression and the effects of culture is needed. Between May and June 2002, a cross-sectional sample of 1,359 women who had delivered a single, live infant within the previous two years demonstrated evidence of continued mild and moderate-to-severe postpartum depression. The investigators found that older maternal age, higher income, education and employment had significant negative associations with depression symptom severity. Having more children had a significant positive association with depression symptoms (Mayberry, Horowitz & Declerq, 2007).

The nation's health status can never be as good as it could be if segments of the population have less favorable health indicators. Special challenges face minority women during the experience of childbirth. Language barriers may reduce communications with the nurse during Hispanic women's birthing experience. Evidence is increasing that pain management is undertreated in Black and Hispanic patients. Black and Hispanic women in labor are less likely to receive epidural analgesia (Giance, et al, 2007). Elective pain management in the form of epidural analgesia may also have limited application due to costs which many Hispanic women cannot afford (Callister, 2003).

Current information about the biological and genetic traits of minority and underserved populations does not adequately explain health disparities or differences in healthcare delivery. Cubans are a large Hispanic subgroup in the Floridian population. Nursing research demonstrates that promoting changes in nursing practice around the time of birth for minority women could make enormous differences in the proportion of normal births (Albers, 2003, p. 159).

The majority of health care research on Hispanic subgroups has been in the Mexican population, hence, more research in the subgroup of Cuban women is required to understand unique cultural traditions and beliefs surrounding the experience of childbirth. This work will contribute to understanding how culture affects Cuban women during the experience of childbirth (CDC, 2007; Mavalankar, 2005).

Purpose of the Study

The purpose of the study was to examine and describe the lived experience of childbirth among a group of Cuban women receiving intrapartal and postpartal care in a Florida hospital.

Design of the Study

A phenomenological exploratory descriptive design was used to examine and describe the lived experience of childbirth among Cuban women in Collier County, Florida. Phenomenology is a type of interpretive inquiry that uses the emic perspective to elicit meaning from the participant's point of view. It considers the way meaning is created through language. The method examines how it is possible for us to speak, think and act in various ways. "Ways of knowing" about the experience of childbirth in various

cultures has been studied on a limited basis. Phenomenology as a research method is a rigorous, critical, systematic investigation of a lived experience to explore meanings which are the essence of a phenomenon (Speziale, 2003). Phenomenology was used to uncover meaning in the feelings, thoughts, and behaviors of Cuban mothers during normal childbirth.

Phenomenology is well suited to learning about the lived experience of childbirth experiences among new mothers. The method generates rich, narrative descriptions that may otherwise be lost to numerical data. Phenomenology puts perceptions of human experiences into words that others can more easily understand (Morse, 2006).

Data from interviews of 29 Cuban first-time mothers in a southwest Florida hospital who had experienced childbirth within the previous 48 hours were collected. The investigator allowed each participant much freedom to describe the emotions and feelings of childbirth. By allowing new mothers to describe their childbirth experience in their own words, the investigator learned about their positive and negative perceptions.

Nurses have struggled for many years to provide optimal healthcare to women from various cultures and ethnic groups. This research may help nurses intervene in ways that increase positive perceptions related to the childbirth experience for minority women in a modern hospital setting. Understanding how pain is managed during the childbirth experience may increase satisfaction, decrease post-partum depression and improve perinatal outcomes (Mercer, 1981). Therefore, it is necessary to study the lived experience of childbirth among 21st Century Cuban women receiving obstetrical care.

Research Questions

Two open ended research questions guided this study:

1. What is the lived experience of childbirth among Cuban women in a Florida hospital?
2. What is the influence of Cuban beliefs and culture on the experience of childbirth among Cuban women in a Florida hospital?

A demographic questionnaire (Appendix C) and a semi-structured interview guide (Appendix D) were used to allow relevant information to be collected.

Definition of Terms

The theoretical terms that were used in this study were as follows:

Lived experience: Theoretically defined as the deeper meaning or significance of an aspect of the human experience (Speziale, 2003). This term is operationalized as the subjects' responses to questions on the Semi-Structured Interview Guide.

Childbirth experience: Theoretically defined as a process of commitment, attachment, and preparation for the infant by the new mother (Mercer, 2004). The term is operationally defined as participants' statements regarding their birthing experience in a Florida hospital.

Limitations

The study findings are limited to Cuban Hispanic women who have just experienced their first childbirth in a Southwest Florida hospital. The findings of this descriptive, phenomenological study are limited by using purposive sampling techniques at only one hospital. Since the interviews were collected in English, the risk exists that

this could influence interpretation of the statements made by the participants. Similarly, there may be some jargon used by the participants that is unfamiliar to the researcher. The findings are not generalizable to different age groups or different cultural and ethnic groups; however, understanding of the meaning of the childbirth experience may be useful for understanding similar phenomena in similar situations.

Relevance to Nursing

The personal experience of childbirth has immediate and long term effects on the health of the mother and her infant (Moy, 2005). By developing greater understanding of the lived experience of childbirth among Cuban Floridian women, nurses can incorporate effective interventions to reduce negative birth outcomes. Since Rubin (1967) first identified the maternal role as being a complex social and cognitive process and Mercer (1981) reported the influence of factors that impact the maternal role nurses have become interested in the differences in cultural practices. Current research about the biological and genetic influences among minority or underserved populations has not reduced disparities or improved the quality of healthcare. This study may provide insights not previously shared by Cuban women.

Phenomenology is thought of as the study of life as it is immediately experienced, before reflection rather than after conceptualization, categorization or further reflection. It offers plausible insights into experiences of people living in a particular culture (Speziale & Carpenter, 2003). Phenomenology is used in this study to gain deeper understanding of the meaning of experiences. Interviews with new mothers in the target population will promote new understandings of the phenomenon of childbirth.

Summary

Nursing competence in the care of culturally diverse mothers and families is necessary to achieve better perinatal outcomes. The primary initial positive outcome for mother and baby is to survive the birthing experience. Nurses who are familiar with the lived experience of childbirth among minority populations can improve outcomes in the clinical care of childbearing women of all ethnic and racial backgrounds (Hobbie, 2004). Nurses who become competent in the healthcare of diverse cultures and continuously endeavor to understand the preferences of others will enhance maternal and infant health outcomes and likely improve patient satisfaction with the childbirth experience.

Chapter II: Review of the Literature

This chapter reviews the literature that supports the purpose of this study. It is divided into the following sections: Standards of maternal-child health, research related to the experience of childbirth, cultural values and childbirth, health disparities, and the birthing experience on maternal satisfaction.

Standards of Care and Practice

Nursing practice is continually shaped by the explosion of knowledge and technological advances. Maternal and child health nursing has evolved in a similar fashion. More nurses are aware of the influence of cultural beliefs and practices of childbearing families; however, many caregivers could benefit from learning more about the preferences and perceptions of women who experience birthing in a hospital setting. Nursing standards of care and practice help ensure that mother and baby are safe and mothers are satisfied with their nursing care during the birthing experience (Lee, 2005).

Nurses are professionally responsible and accountable to families during the birth experience. The use of standards in obstetrical and neonatal care practice guides nurses toward safe delivery practices for mothers and their infants. Nursing education focuses on evidenced based best practices. Policies and procedures for individual institutions are developed with consideration for the standards published by professional nursing organizations (Carlton, 2005).

Careful assessment of culturally and linguistically appropriate services for the women who are in the early stages of labor is done at admission. Using the nursing process, the nurse analyzes the history that is specific to maternal needs throughout the three stages of labor and during the early postpartum period. A birth plan that expresses

culturally significant practices and prescribes strategies and alternatives is developed and implemented. Nurses are taught to include the wishes and preferences of the mother as much as possible. Ongoing evaluation of the experience is accomplished by survey of maternal satisfaction throughout labor and after childbirth (AWHONN, 2003).

Ethical principles of autonomy, veracity, beneficence, informed consent, standard of best interest, and obligations should be applied when providing care to women in labor and delivery. The International Council of Nurses (ICN) Code of Ethics states respect for human rights including the right to life, to dignity, and respectful treatment are universal in nursing (ICN, 2005).

Healthcare providers and hospital educators in maternal-child health must assess and monitor the competency of new mothers, whether married, single, or experienced. An important aspect of care is to assess maternal self confidence and to develop individualized teaching plans for new mothers and their families. Examples of adherence to ethical principles that apply to minority women during labor include allowing the patient to make as many decisions regarding the labor and delivery as possible, providing them with all available options for pain relief, and communicating in the preferred language of the mother. Maternal-child health nurses must encourage laboring women and new mothers to identify and use family and social supports available to them.

The ANA standards. The American Nurses Association (ANA) has actively engaged in defining the scope of practice of nurses and developing and refining standards of practice since the 1960s. In 2003, the ANA published *Nursing's Social Policy Statement* to address the practice of professional nursing within a social framework.

Professional nursing grew from a need in society and continues to evolve in response to changes in modern society. The authority for the practice of professional nursing is based on the social contract of professional rights and responsibilities and mechanisms for public accountability.

Self regulation to assure quality of nursing care is at the heart of this relationship (ANA, 2003). Specialty nursing organizations have established specific guidelines for practice that describe competent level of nursing practice and professional performance. In 2004 the ANA published Nursing Scope and Standards of Practice (Appendix E). By gathering data related to cultural preferences, nurses can improve cross-cultural communication, birth outcomes and patient satisfaction. Native cultural customs can be included during the labor and delivery to foster positive perceptions by the new mother.

AWHONN standards. The AWHONN has actively refined the standards for care of the laboring woman and her child and published the seventh edition of standards in 2009. The task force for revision of the AWHONN standards used the *Standards of Care and Standards of Professional Performance*, developed by the American Nurses Association as a model for standards that define maternal-child nursing practice to provide maternal health nurses with clear delineation of unique elements of the specialty.

The Standards of Professional Performance outline expectations for professional nurse practice and describe a competence level. Each Standard includes a goal statement and measurement criteria that recognize the values of AWHONN related to the care of women and their newborns. Continued development of evidence-based practices helps ensure nursing care derived from high quality scientific evidence and discourages

practice based on tradition. Currently, standards represent best practices based on evidence-based research (AWHONN, 2009; ANA, 2004; Carlton, 2005).

Culturally and linguistically appropriate standards. In 1997, The Office of Minority Health reviewed existing cultural and linguistically appropriate competence standards. By 1999 a draft report presented new national standards. A four month public comment period followed. The findings were reported to a 27 member committee with representatives from healthcare organizations, professional organizations, consumers, State and Federal agencies and accrediting bodies (Office of Minority Health, 2008).

In 2000, culturally and linguistically appropriate standards (CLAS) were mandated and are current federal requirements for all organizations that receive federal funds (Office of Minority Health, 2008). Individual providers of healthcare and healthcare organizations, including hospitals, are using the standards while caring for minority members of the community.

The standards were issued by the United States Department of Health and Human Services to ensure that all people entering the healthcare system receive equitable treatment in a culturally and linguistically appropriate manner. The intention of the CLAS in health care is to address the health needs of persons who, because of racial, ethnic, or linguistic reasons, experience unequal access to health services. Application of the CLAS Standards aims at eliminating racial and ethnic health disparities to improve the health of all Americans. The 14 standards are grouped by themes: culturally competent care, language access services, and organizational support for cultural competence (Appendix 6) (Office of Minority Health, 2008).

The Joint Commission standards. The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO, is an accrediting agency and has established standards for safety and quality of client care. In June of 2006, the Joint Commission, in conjunction with the Office of Minority Health, completed a two and a half year study examining how hospitals address language and culture. Results supported the use of institutional policies on cultural competence to provide equitable care, treatment and services across diverse populations (Joint Commission, 2007).

Adherence to the CLAS Standards makes language less of a barrier for minority women during childbirth since one requirement is that interpreters be available in person or by telephone. Family members may be used as an interpreter only if requested to do so by the patient. Hospitals are required to have individuals who speak the preferred language of the patient or have an interpreter service over phone lines available at all hours of service (Office of Minority Health, 2008).

Research Related to Childbirth

Reva Rubin first developed a role theory in 1967 to describe how a woman defines her maternal role performance in interactions with her infant. Maternal role attainment (MRA) is the process leading to the achievement of maternal role identity. It was defined as a process by which a new mother develops competence in her role and is able to integrate mothering behaviors into her established identity. Maternal perceptions of the delivery process itself, of past and present experience and values all contribute to maternal role attainment (Rubin, 1967).

MRA is a cognitive and social process, has family and cultural influences and is the integration of mothering behaviors. Three categories of self in maternal role-taking are: Ideal image, self image and body image. Mothering behaviors reflect societal norms and common beliefs about what a mother should or should not do. They are learned indirectly as the woman herself was mothered as a child and are culturally determined. Maternal personality traits and infant temperament are characteristics that also influence MRA. An interactionist approach to the study of MRA represents a continuum of schools of thought ranging from phenomenological concerns about subjective, spontaneous, indeterministic and unpredictable aspects of human behavior to aspects of role theory with concerns for more objective, deterministic, quantifiable and predicable factors (Rubin, 1967).

In the anticipatory stage of MRA which occurs during pregnancy, a woman seeks out role models from whom to learn. During the formal stage of mothering, which begins with the birth of the neonate, the mother develops her own special style. She moves through a predictable process of stages: (a) mimicry, when a new mother seeks information regarding her new role with the baby and finds role models to mimic; (b) role-playing, when a new mother projects how certain behaviors would be for her; (c) fantasy, developing an ideal image of motherhood, (d) introjection-projection-rejection, when a new mother examines her values and resets her priorities; and, finally (e) identity (Rubin, 1980).

Maternal confidence, age, and the infant's temperament are variables thought to influence role attainment. Mothers describe increasing harmony with the husband or

significant other. Positive feedback that is directed towards the mother from the baby's father and infant encourage additional positive mothering behaviors. During the early postpartum period, the mother gains confidence in her new role as she interacts with her new infant (Rubin, 1984).

Perceptions of the variables important in childbirth change over time and Rubin renamed two of the progressive stages in MRA. The words "mimicry" and "role-playing" were replaced with "replication" (with the woman's own mother as the strongest model). Fantasy was retained as a stage. "Introjection-projection-rejection" was replaced with "dedifferentiation". This represents a shifting or changing of an idealized model to the reality of herself in relationship with her new infant (Rubin, 1984).

In 1981, Mercer first proposed a theoretical framework for studying factors that impact maternal role attainment. First-time mothers in the U.S. represent a diverse population ranging in age from teenagers to women in their thirties. Both the young and the older mothers make dramatic changes in their lifestyles after the birth of a new baby. A theoretical framework provides an organizational context leading to the evolution of specific research design. The fluid and emergent nature of phenomenologic research makes the data gathering process compatible with maternal role attainment theory. Role strain or grief work is the conflict felt by the mother during the process of MRA as she leaves behind her former role and takes on the role of a mother with associated demands.

In Mercer's 1981 theoretical framework of maternal role, used as a basis for her 1983 research, used two important research questions emerged: What factors occurring during the first year of motherhood have the greatest impact on maternal role attainment?

and What other factors, separately or interacting variables seem to facilitate or deter attainment of the maternal role? Factors that appear to affect maternal role emerged from interviews and observations of the subjects at five time intervals were analyzed these with regard to the major predictive variables (Mercer, 1983).

An assumption of Mercer's theoretical framework of role theory is that although the mother's behavioral responses reflect her perception of her experiences in the role, her infant's and others' responses to her enactment of the role and the situational context lead to the creation of a "core-self" that is relatively stable in the way she will define situations and is acquired through socialization.

The mother's perceptions of the situation and her infant's and others' responses to her in terms of the maternal role can be measured as attitudes (manner of acting, feeling or thinking). The mother's "core-self" affects the way she defines situations and can be measured with standardized tests of the self and personality traits. The independent variables Mercer selected were: age, perception of birth experience, early maternal-infant separation, social stress, support system, maternal personality traits, maternal illness, childrearing attitudes, self-concept, infant temperament and infant illness. Questionnaires and attitude scales were developed as measures of each variable. Informal open-ended interviews and observations were used to obtain data on the identified variables.

Mercer's nursing theory held that mothering behaviors reflect societal norms and common beliefs about what a mother should or should not be. MRA is seen as a complex interplay of expectations, beliefs and desires for the future and as a process of mothers achieving competence in their mothering role. There is integration of mothering

behaviors so that harmony is achieved with their new identities. Role strain or grief work is the conflict felt by new mothers during the process of MRA as old roles are given up and new mothering roles appear (Mercer, 1981).

Positive MRA is a desired outcome for mother and baby and it is associated with positive birth experiences. As a mother assumes a new role, feedback from a partner and a social network are important to reinforce competent behaviors. The transition disrupts the stability of a woman's self esteem. She experiences disturbances in body functioning, mood, cognition and distress related to uncertainty (Mercer, 1981, Rubin, 1984).

The relationship of psychosocial, psychological and perinatal variables to the perception of childbirth was examined in studies completed during the 1980s (Mercer, 1983, 1985). In a study of 294 first-time mothers, perceptions of childbirth performance that may be indicators of later capabilities in the mothering role were examined. The research addressed the form and strength of the relationship between key psychosocial and perinatal variables and perception of the birth experience, the role of maternal age, and selected variable that accounted for the greater variance in perception of the birth experience (Mercer, 1983).

All women who met study criteria at a university hospital were approached during their postpartum hospitalization and invited to participate in the longitudinal study. Criteria for inclusion were that this was the first live birth infant without anomaly, at 37 weeks or more gestation. The subject had to speak and read English and give informed consent. The refusal rate was 44.2% and the majority gave no reason for refusing.

Data were collected during the postpartum hospitalization, the first of the study's five test periods. Data were analyzed for the total sample and three age groups. The 294 women ranged in age from 15-42 years: 66 were 15-19 years (Group 1), 138 were 20-29 years (Group 2), and 90 were 30-42 (Group 3). The majority of the sample was Caucasian (62%), but included, Black (15.3) and all others.

The dependent variable, perception of the labor and delivery experience, was measured using a 29 item questionnaire. The Cronbach-alpha coefficient reliability ranged from .80 to .87 in the study. Subjects rated each of the 29 items on a scale of 1(low) – 5(high) for possible score of 29-145. Higher score results reflected more positive perception of the childbirth experience.

Measures for independent variables were derived from a semi-structured interview guide and a personal/social history form. The interviewer completed an obstetrical and demographic data form. Variables had an initial factor loading of .50 or greater to be retained in the factor. Age, infant separation, positive and negative life events, emotional, physical and informational support, total positive self-concept, maternal illness, infant illness, maternal perinatal attitudes and types of delivery were all measured.

The results reflected a significant difference in the age groups' perceptions of the childbirth experience with older mothers reporting more positive birthing experiences. Those with a mate present or another support person had a more positive perception of the childbirth experience. Characteristics of the woman in the total sample who tended to have more positive birth perceptions were: earlier contact with the infant, greater positive

life events in the year prior to birth, greater network support, greater mate emotional support, a higher total positive self-concept, fewer maternal illnesses, healthier infants at birth, attitudes of choosing family-centered birth, breastfeeding, attending prenatal classes, accurate knowledge of infant competencies, a spontaneous delivery, a local or pudendal block for delivery or no anesthesia, Caucasian background and good feelings about the pregnancy were associated with a more positive birth experience (Mercer, 1983). A limitation of the study was the limited ethnic diversity in the study participants.

McBride and Shore (2001) suggested replacing maternal role attainment with becoming a mother to reflect a fluctuating process rather than a static situation.
In 2004, Ramona Mercer presented evidence for replacing the term "maternal role attainment" (MRA) with becoming a mother (BAM). The transition to motherhood begins with the birth of a new baby and continues for the first year, peaking in about four months. The new mother establishes her becoming a mother by a commitment to a new self. BAM means acquiring new skills and gaining confidence and more accurately describes the dynamic transformation of this life transition. Transition can be facilitated or inhibited a woman's personal situation, cultural beliefs, cultural practices and socioeconomic status.

In a study of 70 married and single mothers in two Southern urban hospitals, Copeland (2004) investigated the effect of marital status on maternal competence. 58 married, first time mothers and 21 single, first-time mothers were surveyed. The mothers were invited to participate in the study if they had given birth to a full term (37 weeks or more) infant with no complications. The single mothers in the sample were lower

income, younger in age, more ethnically diverse and less educated than the married mothers. The subjects ranged in age from 18-41 years, with a mean age of 27.07 years (SD=4.86) for married mothers and 21.55 years (SD=3.07) for single mothers. The majority of married mothers were Caucasian (91.4%); the single mother's group was Caucasian (54.5%) and African American (45.5%). Differences were also seen in education: more of the married mothers (74%) reported having some or completing college while only 26% of the unmarried mothers had some college. More than 50% of the married mothers had annual incomes greater than $50,000 and 45% of the single mothers had annual incomes less than $10,000. No differences were seen between the married (M) and single (S) groups in infant's gestational age, type of delivery, postpartum and newborn complications. Most women delivered at 39 weeks (M=41.4%; S=40.9%), had vaginal deliveries (M=63.8%; S=68.2%), and experienced few complications (M=67.2%; S=59.1%).

Negative Influences on the Childbirth Experience

Methods of pain control and management during labor and delivery have evolved in the last 20 years to current practices. Medications are given by injections, intravenous infusions and epidural infusion. One approach to help laboring mothers to cope is by administering systemic medications via parenteral routes. Opiods were first documented in ancient Chinese writings and current use remains at 39%-50% of all births (McCool, 2004). The most commonly used opiods are meperidine, morphine, fentanyl, nalbuphine and butorphanol. Sedatives and tranquilizers play a role in controlling anxiety and promote sleep. Promethazine and hydroxyzine are used most frequently.

Epidural anesthesia is often started during the first stage of labor and is administered using an indwelling catheter in the sacral canal. This route of administration allows more medication to be provided achieving deeper and prolonged anesthesia. The anesthetic drug bathes the S2-S4 nerve roots which include the pain fibers from the uterus, vaginal walls, and the afferent pathways from the pudendal nerve (Lasch, 2000).

Epidural anesthesia may relax the pelvic floor and allow for greater control over delivery of the fetal head and reduce the incidence of perineal laceration. Hospitals report epidural rates at 80% to 90% making it the most preferred method (Mayberry, 2003). Epidural anesthesia has been found to lengthen the first and second stages of labor in both primiparas and in multiparas. Women who had epidurals were more likely to have labors induced with oxytocin or augmented by oxytocin (London, 2007).

Previous individual experiences with pain, emotional state, cognitive input, stress and immune function, and immediate sensory input are all factors that impact a mother's perception of the pain. The primary cause of pain in labor is cervical distention. The pain is believed to be transmitted via afferent pathways with peripheral terminals in the cervix and lower uterine segment (Trout, 2004).

Regional anesthetic agents including epidural blocks, spinal blocks or a combination are administered by certified nurse anesthetists or anesthesiologists. Patient controlled anesthesia via infusion pumps is used in some facilities and patients report increased satisfaction with pain control (McCool, 2004). This may be of particular importance with Hispanic women who do not have the financial resources to afford some pain management therapies.

Fetal monitoring has been used extensively in the past and has an effect on the hospital birthing experience. The use of fetal monitoring varies across the disciplines: medical doctors use more and midwives use less. There is an equally wide variation in the birth positions used by the practitioners with mothers. Trends vary according to local practices and institutional policies (Callister, 2003).

Midwife-assisted births are on the rise and a part of their skill and expertise has to do with knowing when and knowing how to demonstrate caring to the mother. There has been a trend in midwifery and obstetric medicine toward promoting a more normal birth experience with less intervention. Mother-baby birthing units have increased, which vary in design and operation, but generally significantly enhance preferences of the mother during labor and delivery (Kennedy & Shannon, 2004).

The Lamaze International Education Council recommends that non-supine positioning (upright or squatting) and having mothers not push until they feel the urge to do so help promote the goals of normal childbirth. A position paper presented in 2004 recommends the use of non-supine positions. Upright and gravity neutral positions are useful in the rotation and descent of the fetus and have been presented as an evidence-based practice. Allowing the mother to assume a comfortable position reduced duration in the second stage of labor, reduced the number of episiotomies, and there were fewer non-reassuring fetal heart tones (Lothian, 2004). The World Health Organization (WHO) issued a position paper advocating six care practices. The practices are the gold standard for maternity care (Keen, Di Franco & Amis, 2004).

The Lamaze Institute for Normal Birth (2007) adopted these six care practices for use. The standards promote natural, normal and healthy approaches for childbirth. Labor should be allowed to spontaneously and women should be allowed freedom of movement under normal conditions. All women should have someone available to them as a birth partner. Interventions should be used only necessary for safety of the mother or baby. Women should use non-supine positioning and the mother and baby should not be separated after birth in an effort to encourage breastfeeding. Mothers report better bonding with their babies and are more satisfied with their birthing experience when these standards are implemented (Lothian, 2004).

Cultural Values and Childbirth

In Hispanic communities, family ties are very strong. Family values include pride, self-reliance, dignity, trust, intimacy and respect for older family members. Hispanic women have been described as having these same qualities. Many of these women would consult their husbands, significant others or important family members before making healthcare decisions (Clark, 2008).

Most families of Hispanic descent are Catholic; thus, they consider human life sacred. Contraception and abortion are not generally accepted for Hispanic women because life is considered a gift from God. The mystery of new life in Hispanic culture is celebrated with a variety of religious traditions (Clark, 2008). By adhering to specific practices and rituals, the new mother demonstrates respect for her culture and honors her own mother. Religious tradition typifies the most excellent role model for mothers, Mary,

who Pope John Paul II described as the one who accepted "Life" for all and for the sake of all. Through her acceptance and loving care for the life of the Incarnate Word, human life has been rescued. Mary's experience is seen as the incomparable model of how life should be welcomed and cared for (Angelini, 2001).

In general, many Hispanics believe women should become pregnant as soon as possible after marriage since children are a sign of a man's virility. Acceptable contraception is abstinence or natural family planning methods. "Hot foods" (which contain protein) should be avoided. Milk during pregnancy may result in a large baby. Some believe that fright or surprise will "leave a mark" on their baby. Many Hispanic women have used herbal remedies to maintain their health. Herbal preparations are drunk as tea to "warm the womb." Herbal remedies which are believed to stimulate labor and other herbal remedies are thought by some to relieve pain following childbirth (Clark, 2008).

Hispanic families' cultural beliefs and practices differ based upon their country of national origin. Little research on different Hispanic subgroups has been done to date. People of Mexican heritage may have strong belief in "evil spirits". Pregnancy is considered an illness or weakness in women. The placenta is called "el companero" which means companion of the child in Spanish. Cultural rituals associated with disposal of the placenta include drying it, burning or burying it in specific ways. Care of the newborn's umbilicus involves use of a binder or belly band, an application of oil and cord clamping. They may resist bathing themselves or their infants for 40 days after delivery. (Clark, 2008).

Active labor in healthy Hispanic women may last longer than other ethnic populations. Research into the length of active labor was designed to compare low risk non-Hispanic white, Hispanic and American Indian women (Albers, 1996). Descriptive statistics were presented for 1473 women at term who delivered at the University of New Mexico Hospital. Data included demographics, intrapartum care, complications and duration of the labor.

Results reflected a difference in the second stage of labor according to ethnic group; second stage was longer for Hispanic women and shorter for American Indian women. The mean length of the second stage of labor was 53 minutes for nulliparas (those having their first full-term birth) and 17 minutes for multiparas. American Indian nulliparas had significantly shorter second stages than non-Hispanic white women ($p \leq .05$) (Albers, 1996).

Nursing research has continued and evidence demonstrates that pain behaviors are culturally bound. Mexican women may moan and rub their thighs during labor. Puerto Rican woman often are emotive in labor and express their pain vocally (Callister, 2004).

Breastfeeding is higher among Hispanic women who are less acculturated than those who are more acculturated (Abraido-Lanza, 2006). The results of a national study to evaluate breastfeeding practices investigated acculturation status as a variable. Prevalence of breastfeeding was higher in less acculturated Hispanic women (59.2%) compared with highly acculturated Hispanic women (33.1%). The less acculturated Hispanic women were more likely to say that their child's condition was a reason to not breastfeed (53.1%) while the highly acculturated Hispanic women cited the child's

preference for a bottle. Highly acculturated Hispanic women were less likely to breastfeed their infant, even after education, age and income were taken into account (Gibson, 2002). Given the rapid growth in the numbers of Hispanic women of childbearing age, a better understanding of trends in breastfeeding is necessary.

Early work by Pascoe and French (1988) revealed that the development of positive feelings after childbirth by first time mothers in their normal newborns occurred around the time of delivery in 30% of women, immediately at birth or on the first day for 42% and by the second or third day for 19% in an early study. Breastfeeding mothers were more likely to express positive feelings.

The National Center for Health Statistics and the Centers for Disease Control undertook a six year study to provide national estimates of health and nutrition. The Third National Health and Nutrition Examination Survey (NHANES III) collected the data between 1988 and 1994 in a series of cross-sectional surveys. There were 89 survey locations and 246,889,375 respondents in the sample. Racial and ethnic disparities in breastfeeding rates in U.S. infants were identified using nationally representative data. Breastfeeding rates for children 12 to 71 months of age were stratified for race, ethnicity, and a series of socioeconomic and health related factors. The most important positive predictors of breastfeeding behaviors were identified as being Mexican-American, older, shorter length of time in labor, and higher income status. In NHANES III the proportion of children who had ever been breastfed was 60% for whites, 26% among blacks, and 54% among Mexican-Americans.

The proportion of children ever breast fed was significantly higher among Mexican-Americans who were less acculturated. The proportion of children ever breastfed was lower among low-birth weight infants (<2500 g), those with mothers less than 20 years old, mothers who smoked during pregnancy or who were obese and those of families with less education, low income or from a rural area By six months postpartum, the proportion of women still breastfeeding decreased to 27%, 9%, and 23% correspondingly (Li, 2002; CDC, 2007).

The experience of childbirth is a major life event in which Hispanic Floridian women may have unique cultural perceptions and experiences. During this time, some restructuring of family goals, behaviors and responsibilities occurs. Evidence suggests that an exclusive reliance on biological factors will not provide a full understanding of current maternal attitudes and practices. Childbirth also involves many factors and may be influenced by the woman's personal conditions, cultural beliefs and attitudes, socioeconomic status, preparation for childbirth and societal factors.

Families who are of Cuban decent can benefit from caregivers who are aware and supportive of cultural influences. One useful framework for cultural assessment is the Leininger Sunrise Model (2001). This approach focuses on cultural differences and includes an array of important variables: economic, educational, and technologic; religious or philosophic; kinship or social; political or legal factors; and valued life ways. These dimensions have an effect on patients and nurses and bridge the chasm to the nursing care system, and professional systems.

Since each mother who gives birth is culturally unique, caregivers need to minimize cultural shock and become more sensitive to the needs of minority women during childbirth (Hockenberry, 2008). Cultural competence is the process of recognizing cultural differences, integrating cultural knowledge, and acting in a culturally appropriate manner. The five basic components in the process of developing cultural competence are:

1. Cultural awareness- a cognitive process which appreciates and is sensitive to cultural values of patients and families.
2. Cultural knowledge- formal and informal education that includes world views of different cultures, values, beliefs and perceptions about healthcare.
3. Cultural skill-including cultural data in the nursing assessment through the collection of cultural data in the interview.
4. Cultural encounter- seeking opportunities to engage in cross-cultural interactions directly or indirectly.
5. Cultural desire- using genuine and sincere motivation to work effectively with minority client; only achieved if the individual wants to engage in the process of acquiring cultural competence. (Munoz & Luckman, 2005, p.45).

Health Disparities

Maternal and child health professionals see some of the worst cases of health disparity. While life expectancy and overall health have improved in recent years; birth statistics for minority women and infants are less favorable. In the recent past, investigators did not adequately examine the racial and ethnic factors that affect minority health. Poverty was the most common explanation for disparities in maternal and child

health. There is an increasing need to develop better explanations for disparities in healthcare.

Factors that reflect disparities in obstetric care are mortality rates, prenatal care, marital status and income. In the U.S. among teens, more than 80 percent of the mothers are unmarried (National Center for Health Statistics, 2005). Language differences and lack of financial resources, variable access to prenatal care, and transportation barriers contribute to differences in birth outcomes for minority women and infants (CDC, 2007; Tashiro, 2004).

There is evidence of healthcare disparity across a range of illnesses and health needs. For Hispanic women, whose proportion in the U.S. is on the rise, health beliefs, religious beliefs, cultural customs and the strong emotions regarding childbirth may have great influence on the experience of childbirth. In Florida, women who are in minority groups may lack prenatal care or enter care late in the pregnancy; have higher maternal and infant death rates, and experience childbirth in less than ideal circumstances (Florida Department of Health, 2003).

Researchers have examined racial disparities and adverse maternal outcomes among four ethnic groups using data from the Healthcare Cost and Utilization Project (HCUP) A national inpatient sample of U.S. hospital discharges among more than one million women aged 13-55 who had delivered babies in 1998-1999 was used to examine all complications including pregnancy induced hypertension, gestational diabetes, preterm labor, infections and hemorrhage. Hispanic women were more likely than white

women, but less likely than black women to experience diabetes, placenta previa, an amniotic cavity infection and cesarean section (AHRQ, 2005).

Improvements to childbirth outcomes, including infant mortality, have been made, but disparities still exists even after adjustment for socioeconomic differences (Mavalankar, 2005). A range of patient-level, provider-level and system-level factors are involved. Mistrust, misunderstanding of provider instructions and poor outcomes were measured. Minority women had an increased rate of common pregnancy and childbirth complications. Minority patients were more likely to refuse recommended treatments, adhere poorly to treatment regimens, and delay seeking care (Smedley, 2003). Maternal satisfaction with the birth experience must be addressed to facilitate attainment of good outcomes. By increasing understanding of cultural influences progress can be made to improve minority birth outcomes. Providing safe and culturally appropriate care among Cuban women during childbirth in modern hospitals may reduce negative birth outcomes.

The Birthing Experience

It is meaningful to examine current trends in birthing practices to better understand how modern women experience childbirth. The use of continuous electronic fetal monitoring for all women during labor does not stand up to the application of research based evidence. Widespread use of monitoring is not necessary and recommended only when maternal or fetal complications arise during labor (Priddy, 2004).

The first stage of labor. At the end of gestation, about 38-42 weeks after conception, labor begins. Labor refers to the part of the birthing process in which the

uterine contractions become strong and regular. Ricci (2007) described the process of labor as having three stages. Stage one begins with the onset of contractions. Beginning at about 5-6cm of dilation and until the birth itself, the contractions cause increasing amounts of pressure and pain (p. 322-325). Many women have specific plans for this part of the birthing experience that should be considered to promote maternal satisfaction.

Language barriers can hinder communication between nurses and patients from different cultures. During the admission and assessment process, nurses can convey empathy by recognizing what the mother is experiencing. Showing respect by valuing what the mother feels is important. Nurses should establish a rapport by initiating social, friendly conversation, and active listening, by using verbal and body language, and use of concerned facial expressions while listening to the mother (Munoz & Luckmann, 2005).

The second stage of labor. Women experience a variety of sensations during the second stage of labor. Many will have an overwhelming desire to push while others may not have an urge to push and find it difficult and painful. The second stage of labor begins with full cervical dilation and continues until the birth of the baby. When the flexed fetal head reaches the vulva, it extends, bringing the base of the occiput into contact with the inferior margin of the maternal symphysis pubis. Extension continues to occur until the head is born. Once the head is exposed, the fetus rotates its occiput toward the mother's sacrum to allow for the passage of the shoulders through the pelvis. When the shoulders have cleared the symphysis pubis, the rest of the body is born (London, 2007).

The number of maternal pregnancies has an effect on the duration of each labor stage. Primiparous mothers typically complete the first stage of labor in 12-24 hours, while their multiparous counterparts typically last 4-12 hours. Second stage primiparous mothers give birth within 2 hours, while multiparous mothers have a second stage averaging only 15 minutes (London, 2007).

The lithotomy position has been widely used in the United States and elsewhere as a preferred position for childbirth. Midwives have been among those who have been encouraging the use of a sitting position to maximize on the use of gravity. Upright positioning and its relationship to the duration of the second stage of labor has been studied and the two appear negatively correlated (Callister, 2003). Women assume a variety of birth positions and some of them may be associated with better outcomes. Eight common maternal birthing positions are: (a) lithotomy; (b) recumbent; (c) sitting; (d) side-lying; (e) on all fours; (f) kneeling; (g) squatting; (h) standing (Simpkin, 2002).

Accumulating evidence shows that direct pushing within arbitrary time limits in a supine position is disadvantageous for mothers and babies. A systematic review of literature was done to assess the benefits and risks of using different positions used during the second stage of labor (Tillet, 2005). The search for randomized or experimental trials yielded 16 research projects. Of the 5764 combined participants in these trials, consistent findings of benefits using an upright or lateral positioning were demonstrated. There was a reduction in the duration of the second stage of labor, a reduction in the number of women allocated to the use of birth cushions, and a small reduction in the number of assisted deliveries. There was also a reduction in the number

of episiotomies, an increase in the number of second degree tears, and a slight increase in estimated blood loss. Pain associated with the second stage of labor was decreased and there were fewer abnormal fetal heart rate patterns (Gupta, 2004, Tillet, 2005).

Spontaneous pushing, which allows for mothers to follow their instinctual feelings and preferences, does not increase the risks of adverse effects. Now evidence suggests that, using the guide of maternal preferences, those mothers should be allowed to adopt positions which are most comfortable. The position can be varied as labor progresses, all the while encouraging fetal rotation and descent into the maternal pelvis (Chalk, 2004).

The third stage of labor. The third stage of labor begins with the birth of the new child. Contractions continue during this stage until the placenta disengages and is expelled from the body. Time elapsed from the birth of the baby until the placenta is expelled averages 20 minutes with minimal associated discomfort (London, 2007).

An alternate delivery method is also available. Cesarean birth (also called Cesarean section) is performed to remove the fetus from the uterus by an incision through the abdominal wall. This may be performed as a planned, elective surgery or because of problems that arose during the labor. The most frequent indication for Cesarean section is fetopelvic disproportion; the fetus is too large for the pelvic outlet. Other situations that may require surgical intervention include abnormal presentation of the fetus, maternal or fetal distress (London, 2007).

Episiotomy has been used to aid in the birth process. Episiotomies were introduced into common practice during the 1920’s and have been used ever since. The

justifications for the use of episiotomy are that it facilitates delivery, spares the fetal head from trauma and prevents perineal lacerations. Two types of episiotomies are midline and mediolateral. A midline episiotomy consists of making an incision into the perineum between the vagina and the anus to enlarge the vaginal opening. This type of incision is thought to be more comfortable for the woman and recovery is less complicated than mediolateral incisions. The second type, mediolateral, is an incision made from the lateral vaginal wall and is directed laterally and downward (London, 2007).

Use of the prophylactic outlet forceps protects maternal pelvic tissue and the fetal head. Forceps have been used by practitioners since the 1920s. They consist of two metal pieces, each with a handle and a blade which fit together. The blades cradle the contour of the fetal head and traction is applied to remove the fetus. It has been shown that forceps delivery shortens the second stage of labor and is often used if the fetus is in distress. Forceps may damage the pelvic floor or injure the fetal head so that their use has declined during the 1990s (London, 2007).

Vacuum extraction has developed as an alternative. In the use of vacuum extractors, a silicone rubber cap of appropriate size is placed over the fetal head and suction is applied. It has been found to result in fewer traumas to maternal soft tissue. The vacuum cap occupies no additional space in the pelvis and allows for the fetal head to rotate spontaneously and deliver in the position of least resistance (London, 2007).

In the 1994 research of Mercer and Ferketich, 128 antepartum high-risk women (HRW) and 182 antepartum low risk women (LRW) were recruited. All were 18 or older, fluent in English and, if unmarried, were planning to share parenting responsibilities with

a male partner. The HRW were recruited during an antepartal hospitalization for an obstetrical risk situation. Their problems were related to pregnancy (preterm labor, premature rupture of membranes, pre-eclampsia, Rh incompatibility, and bleeding). Only 7% had chronic health problems (diabetes, asthma, thyroid and renal disease). The LRW were recruited from the general obstetrical clinic. They had no chronic disease or pregnancy related problem that did not respond to routine care.

The purpose was to determine if there would be any differences in achievement of perceived maternal confidence and whether predictors of maternal competence were different for the two groups over time. The perceived competence was measured by a Sense of Competence Scale at the time of postpartum hospitalization, one, four, and eight months after delivery (Mercer & Ferketich, 1994).

There was no significant difference found in maternal confidence for the two groups. Mothers who were high risk during pregnancy had comparable confidence in care of their infants as those who were LRW. Competence increased over time above earlier levels in all groups. Selected variables explained 33% to 52% of HRW maternal competence and 29% to 51% of the LRW's maternal competence. Self-esteem and mastery were consistent predictors of maternal competence for both groups (Mercer & Ferketich, 1994).

Satisfaction

Women bring a variety of experiences, thoughts, feelings and expectations with them to the hospital when labor and delivery begins. How well the hospital birthing environment affects the quality of the childbirth experience is one variable in the overall

maternal sense of satisfaction. The choices made during this special life event will leave lasting impressions on the families involved.

Satisfaction with hospitalization is one of the most important health outcome measures for determining quality of care (Jackson, 2001). Measures of patient satisfaction are frequently the reported indicators for the quality of care being provided by a hospital (Lashinger, 2005). A woman's satisfaction with childbirth may have both immediate and long-term consequences on her health and her relationship with the newborn (Goodman, 2004).

Maternal satisfaction with childbirth has been linked to positive feelings toward her infant and adaptation toward the mothering role. Conversely, traumatic birth experiences have affected breastfeeding and bonding abilities (Torres, 2005).

One main predictor of childbirth satisfaction is the amount of pain experienced during the second stage of labor. Preventing and controlling pain and prevention of suffering in laboring mothers is a major concern. Mothers who were given epidurals, rather than any type of parenteral opiod labor analgesia, reported less pain and were more satisfied with their pain relief (Leighton, 2002).The analgesic method did not affect fetal oxygenation, neonatal pH, or five minute Apgar scores. New babies whose mothers did receive parenteral opiods (Demerol) and later required naloxone (a medication used to reverse the effects of parenteral opiods) had lower one minute Apgars. Epidural analgesia did not affect the rate of Cesarean sections, instrument usage for vaginal deliveries due to shoulder dystocia, or the onset of new back pain. Epidural analgesia was, however,

associated with a longer second stage of labor, more frequent oxytocin augmentation, hypotension and maternal fever (Leighton, 2002).

Pain medications, medical and nursing interventions, and complex technology have been the mainstays of traditional pain relief. The nurse can help the woman cope with pain by including a variety of non-pharmacological approaches. Reassurance, guidance, encouragement and unconditional acceptance of the woman and her partner are helpful. An ideal environment would be comfortable, private and allow the woman to remain active by walking, bathing or resting as labor progresses. Further analysis showed that there was greater benefit if the support person was not a member of the hospital staff, who may have other responsibilities. Rather, the support person should be there to provide continuous, uninterrupted coaching and support (Simkin, 2004).

Self-initiated comfort seeking movements are thought to accelerate the birthing process. Touch and massage reduced pain and suffering during labor. Hypnosis and visualization are techniques frequently used. Transcutaneous electric nerve stimulation applied to the lower back area has been shown to be effective in pain relief, as well. Aromatherapy, music therapy, and applications of heat or cold are other non-pharmacological techniques which may benefit laboring mothers (Simkin, 2004).

In a well controlled, correlational descriptive study of 60 low-risk postpartum mothers, Goodman and her group (2004) studied factors relating to childbirth satisfaction. The mothers ranged in age from 18-46 years and had uneventful vaginal deliveries at two United States medical centers. A background questionnaire was completed and the Labor Agency Scale, the McGill Pain Questionnaire, and the Mackey

Childbirth Satisfaction Rating Scale were used. Personal control was the most significant predictor of total birth satisfaction (P=0.0045). Other significant variables were self, partner, baby, nurse, physician and overall expectations. Having expectations met for labor and delivery was a significant predictor of self-satisfaction. Personal control during labor and delivery and assisting women to achieve control were also found to increase satisfaction with hospitalization (Goodman, 2004).

In a stratified random sample of 6,650 eligible cases drawn from 44 U.S. military hospitals a survey was mailed to randomly selected women to assess women's perceptions of the quality of childbirth care (Harriott, 2005). The study population returned 2,124 completed questionnaires. Unweighted frequency counts were used to describe survey respondents by demographic characteristics and childbirth delivery methods. The survey instrument was developed to assess a patient's perception of care in eight dimensions:(a) Respect for patient preferences;(b) Coordination of care; (c) Information and education; (d) Attention to physical comfort; (e) emotional support; (f) Involvement of family and friends;(g) Continuity and transition; and (h)Courtesy (Harriott, 2005).

Responses were categorized as a problem response if the respondent answered "Yes," "Sometimes" or "No." For each survey item, the data were collapsed from a 3, 4 or 5 point Likert scale to a two point scale to represent a "problem" or "no problem." Overall evaluation of the hospital experience was measured by response to the question, "Would you recommend this hospital to your friends and family?" The t-test was used to check for statistically significant differences between military hospital problems scores

and non military hospital national average problem score. A chi-square test was used for the categorical variables. This was followed by logistic regression model to determine the independent association between a respondent's unqualified willingness to recommend the hospital and specific measures of childbirth experience to include confidence and trust in providers. The survey also asked for comments on childbirth experiences of women who had discharged from a military hospital maternity unit (Harriott, 2005).

The demographic data of the study population showed that most participants were white, married, and active duty or dependents of active military personnel. Nearly 75% had some college, trade or technical school education. Most women reported having a vaginal delivery, and 53.4% had no previous childbirth experience. The mean age for respondents was 27.3 years. The comparison of military hospital problem scores and the non military national average, for nearly all measures, showed that military hospitals performed below the non military national average on measures of their experiences and evaluation of obstetric care. Scores on the scales were negatively associated with unqualified willingness to recommend the hospital to family and friends. Respondents who reported a problem on the dimension "respect and dignity" were one-half as likely to recommend the hospital to others (Harriott, 2005).

Torres and Guo (2005) examined quality improvement techniques to improve patient satisfaction in hospitalized women. They reported that by using quality improvement techniques it was possible to enhance performance in key processes so that high levels of patient satisfaction can be achieved. Since one of the main goals of any

healthcare organization is to exceed patient expectations, improving satisfaction is critical to success.

In recent years, women want more involvement in the decisions related to their health. In a study conducted by Harrison (2003) to examine women's experiences of satisfaction with healthcare decisions in their own high-risk pregnancies, 47 women were interviewed after the birth of their babies. They had all received prenatal care either at home with community nurses in an outreach program or when they were admitted to the hospital immediately preceding the birth. In-depth interviews were audiotaped and transcribed. Data were analyzed using a constant comparative method. The women stated that they felt increased feelings of responsibility for the health of their babies, but differed in choosing active or passive involvement in decision-making.

Women who wanted to be actively involved achieved it by one of three processes: struggling for, negotiating or being encouraged. Women who chose to remain passive used the process of trusting in the expertise of the nurses and physicians. Women expressed satisfaction if the care from the caregiver was congruent with how they preferred to be involved (Harrison, 2003).

In a study by Carlton (2005) of childbearing women, nurse researchers interviewed 33 primiparous and multiparous women for their thoughts and feelings regarding their childbirth experience. In this descriptive, qualitative study, the participants were interviewed within one month of delivery. Women were asked about which factors influenced their change in birth preference from an unmedicated to a medicated birth. Themes included wanting an unmedicated birth, changing to a

medicated birth, feelings of disappointment and ambivalence, or satisfaction and reflection on the change.

Lashinger, Hall, Pederson and Almost (2005) studied patient satisfaction with general nursing care in 14 Ontario hospitals using patient self-report to measure satisfaction defined in terms of the consistency between the patients' expectations and the actual care which they received. Further, it was the patients' actual subjective evaluation of the cognitive-emotional responses which resulted from the interaction between expectations of nursing care and the perception of actual nursing behaviors and characteristics. Satisfaction was viewed as a mediator between patients' perceptions of quality and their future intentions to come again to the hospital and recommend maternal-child service to others.

For Cuban women experiencing childbirth to receive the best health practices available, clinical experience combined with scientific evidence is necessary. Nurses can assist in the reduction of health disparities by learning effective methods to meet the desires of Cuban childbearing women. Nurses who listen to the wishes of clients and learn about their health beliefs show respect to the cultural heritage of the birthing family. Accommodating maternal and familial preferences with respect, trust and dignity will enhance health outcomes. Efforts by nurses to increase understanding of patient choices and maternal preferences for childbirth experiences will facilitate positive birthing experiences.

Summary

Growing diversity in the U.S. population has strong implications for nurses in general and for perinatal nurses in a more specific way. By the year 2050, people of African, Asian and Hispanic backgrounds will make up half of the population (Hawke, 2004). While young Hispanics as a group are growing most rapidly, research related to childbirth beliefs and practices among Hispanic women is limited. Some nursing research to date has been studied among Mexican Hispanic women during childbirth, however none has been conducted with Cuban women of Southwest Florida. Efforts by nurses to increase patient choices and maternal preferences for childbirth experiences facilitate positive birthing outcomes (Gallo, 2003).

Cultural competence by the nurse is demonstrated by showing willingness and ability to adapt to specific cultural preferences in the practice of healthcare. Careful assessment of new mothers family's cultural customs by the nurse during admission and updated throughout the hospital stay should be incorporated into the individualized care plan for childbearing families. Cultural competency by nurses enhances effective nursing interventions with patients from diverse cultural backgrounds. Respecting cultural customs and traditions may increase understanding of the lived experience of childbirth and lead to an improvement in positive birth outcomes and reductions in postpartum depression and other negative birth outcomes. Nurses who develop non-judgmental acceptance of cultural differences can use diversity as an asset to facilitate mutually acceptable healthcare goals (Clark, 2008).

Chapter III: Methodology

Study participants were Cuban first time mothers who were asked to describe the lived experience during childbirth in a modern Florida hospital within 48 hours after a normal vaginal delivery of a normal, healthy neonate. The use of qualitative methods by the investigator endeavored to uncover and understand the essence or perceived meaning of a lived experience or phenomenon about which little is known: The experience of childbirth for a Cuban first time mother. Phenomenology was selected as a research approach to guide this study because new mothers are the individuals who have just experience childbirth and provided descriptions in their own voices.

In the period shortly after the Renaissance, scientists developed an increasing awareness of the importance of the matters pertaining to science, and an increasingly attitude in new philosophical ideas. Galileo and Descartes demonstrated that all physical objects in the world could be described quantitatively by mathematical formula. Others developed an interest in perceptions of life experiences as relevant. In 1879 in his laboratory, Wilhelm Wundt created what is currently known as the scientific method. As time went by, German philosophers defined “essences” as elements related to the ideal or true meaning of something.

The phenomenological movement grew during the early twentieth century. Intuition was thought to be the common understanding about an experience. Initially, much effort was spent demonstrating the scientific rigor of phenomenology. Colaizzi first published his treatise on the phenomenological process in the late twentieth century. His view of the world is rooted in the discovery of the meaning of everyday common experiences. Assumptions underlying his phenomenological methodology are: (a) nature

is governed by laws; (b) these laws regulate all entities in nature as causes; (c) natural causes determine psychological events (Colaizzi, 1978).

The phenomenon of interest in this study is the childbirth experience of Cuban women. According to Mercer (1981), new mothers who have recently given birth are eager to relive and tell the story of their birth experience to others. Data gained from interviews with the new mothers was collected by the investigator and facilitated by the use of the Demographic Data Sheet (Appendix C) and the Semi-Structured Interview Guide (Appendix D). It is by understanding the lived experience of childbirth among Cuban women, that nurses can design enhanced, culturally competent, positive interventions. The investigative style of Colaizzi was used for methodological interpretation (Speziale, 2003).

Sample

A total of 29 Cuban Floridian first-time mothers who had uncomplicated vaginal deliveries within the previous 48 hours were selected by purposive sampling to provide interviews. Participants who met the study criteria were invited to participate in the study until enough participants were recruited until no new data emerged. The inclusion criteria included first time mothers of Cuban decent (native or foreign born) who were fluent in English (a respondent who speaks English at home), 18 years of age or older who had vaginally delivered a normal, healthy single baby in the previous 48 hours. The exclusion criteria included maternal factors such as history of mental or psychological disorders, rape or physical abuse associated with the pregnancy or women who had deliveries with maternal or infant complications.

Setting

The setting for this study was a large, 681 bed hospital spread over two campuses in a Southwest Florida hospital's obstetric unit with 20 private birthing suites typical of other Florida hospitals. Of the 350 women who give birth in the hospital each month, 30% are Hispanic. The interviews were conducted during routine post-partum hospital stays at a quiet time of the day while each mother was alone with her baby.

Instruments

The instruments for the research were developed using a review of established scientific evidence and after review by two maternal-child health experts. Two instruments were used in the study; a Demographic Data Sheet and a Semi-Structured Interview Guide (Appendix C, Appendix D).

Demographic data sheet. Frequency counts were used to describe the participants. The Demographic Data Sheet (Appendix C) included questions of a general statistical and demographic nature including age, marital status, education, country of origin and years of residency in the U.S. The information was pooled and analyzed to facilitate a better understanding of the sample.

Semi-structured interview guide. Trustworthiness was demonstrated through a pilot test of the interview questions with two subjects using the Semi-Structured Interview Guide (Appendix D). A content review of the Semi-Structured Interview Guide for accuracy and identification of themes was done and verified by an expert in qualitative methods. The questions were created with a reasonable degree of confidence

that they are comprehensive, valid and that nothing is omitted. Scientific rigor was maintained through attention to truthfulness, applicability, consistency and neutrality.

The Semi-Structured Interview Guide questions related to the experience of childbirth and provided a loose framework for gaining additional information on a topic that a participant spoke about. Each participant answered freely and was allowed great range in revealing her perceptions about the childbirth experience. When the researcher found significant statements that seemed relevant to an understanding of the topic being studied, additional questions and verbal probes were used. These probes provided the opportunity to obtain additional information that helped to clarify individual responses and validated the description of the phenomenon of interest.

Procedure

Following university and clinical facility approval, participants were identified by a staff nurse at the hospital study site. The primary nurse of the potential participant was first to identify and approach a potential participant who met the study criteria. The primary nurse asked the potential participant for permission before the investigator entered the birthing suite. Participation was entirely voluntary and an explanation of the purpose of the study, including potential risks and benefits, the ways in which data would be gathered from the interview and from chart reviews, and ways in which privacy and confidentiality would be maintained, was given to each participant. Each mother was given an opportunity to ask questions and was asked if she would like to participate. Each mother was reassured that her health care or the health care of her new baby would not be affected if she refused to participate or if she opted to withdraw from the study. When the

participant agreed, the investigator obtained a signed Informed Consent Form (Appendix B) from that participant.

Face to face interviews with the participants by the investigator were conducted and audio-taped using two recorders. The interviews were conducted in the participant's private birthing suite in the immediate postpartum period; each lasted approximately 45 minutes to 1 hour. The tape recorders were placed conveniently so that the participant had the ability to stop for any reason.

The interviews were conducted at relaxed pace for the participant using the Demographic Data Sheet and a Semi-Structured Interview Guide. Brief pauses of less than 20 minutes were taken during the interviews and noted when applicable. Participants were asked general, open-ended questions designed based on the research questions. Relevant probes and follow up questions were used to elicit additional information and included statements such as, "Tell me more." or "Can you tell me what that was like for you?" No participant asked to end their interview and all participants continued to the completion of their interview.

Rigor was maintained throughout. Confidentiality was observed by interviewing all participants in a private place and by the use of code numbers on all data forms. Further, demographic and interview data are stored separately from signed informed consent forms. The major thrust of the inquiry was inductive and was crucial to the validity of the study. Those participants who have a recently lived experience of childbirth were best able to validate that the reported significant statements that represent their childbirth experiences. Credibility was demonstrated through prolonged engagement

with the subject matter and the responses of the participants during the interviews. This was done by probing the participant for meaning associated with the significant statements and by repeating statements back to the participant for verification and accuracy. An audit trail recorded the activities over time so that other investigators with an interest in the topic can follow (Morse, et al., 2002).

Protection of Human Subjects

Approval for this study was obtained from the Committee for Human Subjects at the Catholic University of America, following site facility's administrative and Institutional Review Board approvals. A full explanation of the research and an Invitation to Participate (Appendix A) was presented to the participant. Ethical considerations for the study participants included obtaining an informed consent and maintaining confidentiality while handling the participants' sensitive health information (Figure 1.). The Informed Consent (Appendix B) explained the purpose, risks, benefits and obligations associated with the study. It was signed by each participant and collected from the participants by the investigator. Participants were advised of their rights to refuse any questions, to ask any questions prior to, during or after the interview, and to ask that the tape recorder be turned off at any time or that the interview be terminated. They were informed that in the unlikely event that they became distressed during the interview, the interview would be stopped. No participant asked for assistance or expressed untoward reactions to an interview during this study.

Selection biases were minimized by randomly choosing participants for the sample from hospitalized Cuban women who met the selection criteria and agreed to

participate in the study. The interviews were conducted in a Southwest Florida hospital over a five month period in late 2009 and early 2010. Systematic bias was minimized by careful attention to detail designed to reduce inaccuracies. Measurement biases were lessened by having the investigator make conscious effort to remain neutral while collecting the interview information. Insensitive measure bias, involving the measurement tool's ability to detect important differences, was reduced by using expert review during the development of the instruments. This study used maternal-child and qualitative methods experts in the development of the Demographic Data Sheet and the Semi-Structured Interview Guide. Bracketing by the investigator about the experience being examined was accomplished by experience with the phenomenon of interest (Speziale, 2003).

Participants had the opportunity to relive and tell about their childbirth experience and express their emotions regarding their perceptions throughout without interruption. The participant's primary nurse was aware of the interview at the time it took place and was available to assist with any physical or emotional needs. Confidential participant personal and health information were protected. Written transcripts of the interviews and audiotapes will be maintained for a period of five years, then clipped into six inch strips and discarded. Written transcripts and the audiotapes will remain available for Federal or State licensing organizations to inspect or copy as required by law.

Respect for each participant was demonstrated by speaking using a concerned voice and with empathetic facial expressions. There was no compensation for participation; however, participants did volunteer an hour of time for the interview.

Participants' identity was not disclosed and pseudonyms were used in publication that includes any direct quotes. Figure 1. illustrates important ethical considerations.

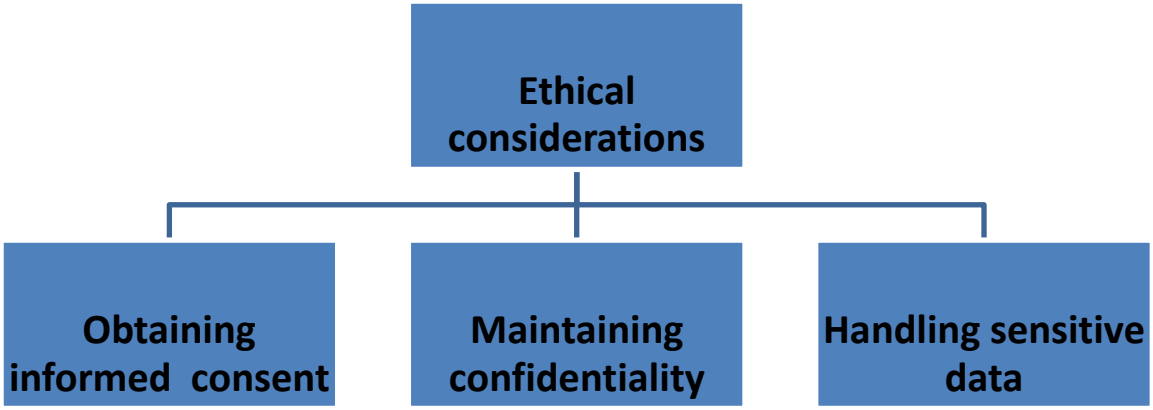


Figure 1. A model of ethical considerations.

Data Analysis

The interviews were analyzed by interpretive approach in the phenomenological tradition of Colaizzi (1978). The seven steps of analysis described for interpretation of the qualitative data were used. Interview responses from the Demographic Data Sheet describing selected demographic characteristics of the women were summarized. Semi-Structured Interview Guide responses were tape recorded and all audiotapes were transcribed verbatim. The accuracy was verified by reading the transcription while simultaneously listening to the tape.

This process was chosen for the study because of well-established steps and high levels of acceptance by the discipline. The philosophical underpinnings are holistic in nature and the steps in the method are clearly defined. The purpose of using each step is

to logically process the information gained during the interviews while finding the essence and meaning associated with themes that appear. Steps in Colaizzi's methodology are listed below (Figure 2).

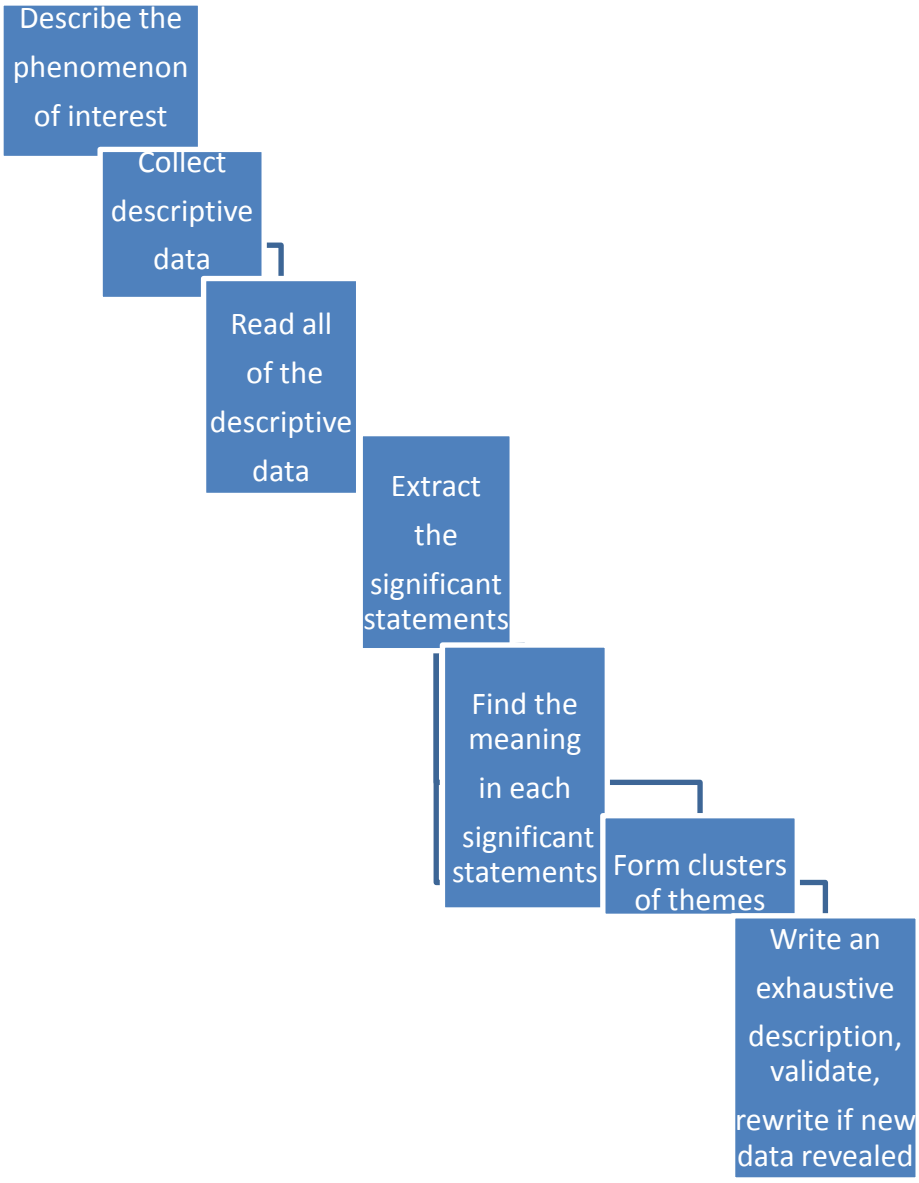


Figure 2. A model of Colazzi's method.

Interviews were transcribed verbatim. The verbatim transcripts were examined line by line. Initial themes emerged and were further analyzed to identify clustering. Themes and clusters of themes were derived from the interview responses of the participants. N-Vivo 8.0 computer software was used to facilitate coding of themes. This method allowed the investigator to change focus and pursue leads revealed by the ongoing analysis (Speziale, 2003). The investigator was able to uncover the meaning in the lived experience of childbirth among Cuban women.

Summary

A qualitative mode of inquiry was used to gain understanding of the birthing experience and how cultural influences Cuban women during childbirth. This understanding the will facilitate progress toward the elimination of maternal-child health disparities. This chapter discussed the methodology of the research including the research design method described by Colaizzi. Included was the setting for the interviews, criteria for subject participation and the sampling technique. Credibility was achieved by prolonged engagement and persistent observation. Dependability was demonstrated by multiple instances of common themes and a redundancy in the descriptions of the childbirth experience. Confirmability was seen in this study by the establishment of an audit trail. Finally, this chapter revealed how transferability was obtained using the exhaustive descriptions given by study participants that allowed for the development of plausible conclusions (Hoye, 2007).

Chapter IV: Introduction

The purpose of this study was to examine and describe the lived experience of childbirth among a group of Cuban women. Data from 29 participant interviews were analyzed to identify the meaning of the birthing experience among Cuban first-time mothers. Purposive sampling was used to select participants for this study. Two open-ended research questions guided the study: (1) What is the experience of childbirth among 21st Century Cuban women in a Florida hospital? and (2) What is the influence of Cuban beliefs and culture on the experience of childbirth among Cuban women in a Florida hospital?

In order to answer these questions, the inductive, descriptive methods first developed by Colaizzi were utilized for the data collection. Phenomenology is well suited to learning about the lived experience of childbirth among new mothers because it generates rich, narrative descriptions. Phenomenology puts perceptions of human experiences into words that can be more easily understood by others interested in the phenomenon of interest (Morse, 2006). Therefore, in order to identify essential themes and uncover the meaning behind the event of childbirth in this study, Colaizzi's method of data analysis was used.

This chapter is organized into two main sections: (a) presentation of demographic data and (b) presentation of qualitative data from participant interviews. It begins with a presentation of demographic data of the study participants. It finishes with a presentation of the qualitative data according the themes and clusters of themes that emerged.

To determine the feasibility of the study and trustworthiness of the instruments, a pilot study was conducted with 2 participants who met the study criteria. Results from the

sample data from the pilot study were included in the full study. The participants were purposively selected first-time Cuban women who had recently given birth in a Southwest Florida hospital. No participant expressed resistance or a desire to not participate in the pilot or the study. The participants did not express difficulty in understanding the purpose of the study or difficulty in signing the Informed Consent Form. Each audio-taped interview began with approximately 5-15 minutes gaining consent and continued for approximately 40-55 additional minutes.

Description of Participants

The participants included 29 first-time Cuban mothers who had recently given birth. They were living in south Florida and delivered their babies in a large community-based non-profit hospital. Interviews were collected between October, 2009 and February, 2010.

A typical sample participant in this study a young single or married woman who had been living in the U.S. and had completed high school before the birth of her first child. Most women in this study said that they had worked part-time or full-time during the pregnancy.

Nationally, the average age for all first time mothers has been reported as 25.1 years (CDC, 2010). The mean maternal age in this sample was 20.1 years. Twenty-one of 29 participants (73%), were between the ages of 18 and 20.

Birth rates vary greatly by maternal age and U.S. birth rates are higher for Hispanic women than rates for either non-Hispanic black women or non-Hispanic white women in every educational attainment category (C.D.C., 2005). Educational level

among participants in this study varied. Years in school ranged from 11 to 16 years with a mean of 12.2 years. Most of the women, 12 of 29, (62%) graduated high school. Six of 29 participants (20%) had not completed high school. Five of 29 (17%) completed college.

Interestingly, in this study 80% of the Cuban women had graduated from high school, had some college education or had completed college. This finding raises more questions about Cuban women in Southwest Florida who may be unique from other Hispanic groups of women.

Fifty percent of U.S. women marry before the birth of their first child (U.S. Department of Health and Human Services, 2000) and most of the women in this study (55%) were married. Women who were single at the time of first childbirth constituted 45% of the participants. Most of the women described having a relationship with a husband or significant other at the time of the experience of childbirth. Some said that their partner lived in another city or country and had plans for the future. Some did not have the baby's father active in their family lives.

Most of the women and their families were Catholic and expressed a desire to raise their children in the faith. Some women described themselves as Christian and a few said that they did not have any religious preference.

The length of time residing in the U.S. before giving birth for the first time ranged from less than 1 year to 25 years. The mean length of residency in the U.S. was 15.2 years. A majority of the women had lived in the U.S. for more than 10 years, however two of 29 (6%) had emigrated to the U.S. in the preceding 3 years. Participants'

demographic characteristics and descriptive maternal traits at the time of first live birth are summarized in Figure 3.

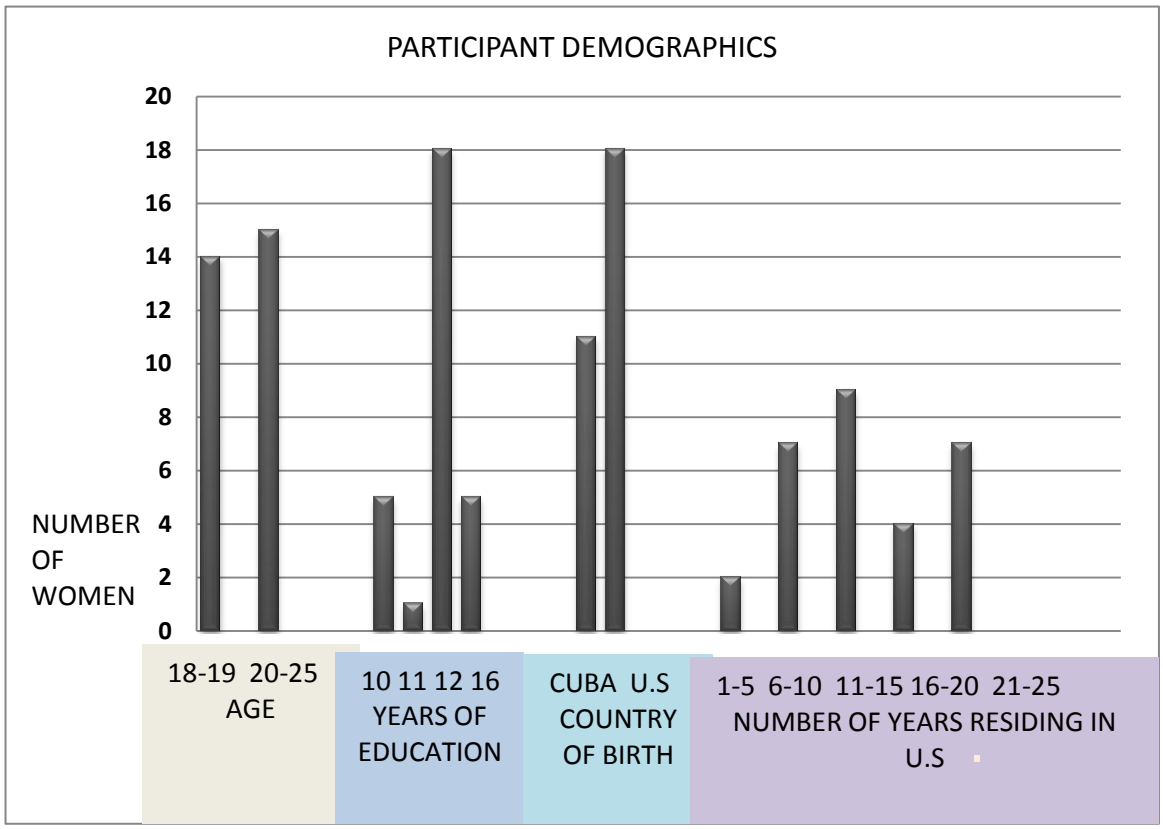


Figure 3. Demographic characteristics of the participants.

Description of Procedure: Colazzi's Phenomenological Method

In this study, Colazzi's methodology was used to describe the phenomenon of interest; the experience of childbirth among women of Cuban descent in Southwest Florida. The goal of using these seven steps is to help clarify and find the meaning in the phenomenon of interest using the words of the person who has lived through the experience. Interviews were conducted by the investigator and incorporated as probes to

confirm identified themes. The researcher provided examples, following Colazzi's method, that extracted the significant statements from the descriptive data. Themes emerged and clusters of themes were organized by the researcher to construct meaningful groups. An exhaustive description was written and confirmed until no new data emerged from the interviews and saturation was achieved. The procedure for data analysis in this study, as described by Colaizzi (1978) has seven steps.

1. The researcher identifies and describes the phenomenon of interest.
2. The researcher collects descriptive data to gain a general sense of a phenomenon of interest.
3. The researcher reads all of the descriptive data.
4. The researcher identifies and extracts out all of the significant statements about a phenomenon of interest.
5. The researcher finds the meaning in each significant statement.
6. The researcher forms clusters of themes.
7. The researcher writes an exhaustive description of the phenomenon.

Presentation of Findings

Data collection provided a total of 707 minutes of audio taped interviews from the 29 participants. The interviews were transcribed verbatim and entered into the computer assisted qualitative data analysis software program, N-Vivo 8.0. The data was then coded and yielded a total of 1327 nodes. The emergence of eight themes which described the experience of childbirth among Cuban women were identified as follows: "Anticipating the birth", "Working", "Experiencing emotions", "Laboring", "Feeling pain",

"Supporting the birth", "Going home" and "Adhering to customs and traditions". Three main sections or clusters of themes emerged from the significant statements. The theme clusters were: "Preparing", "Birthing" and "Integrating". First, the clusters of themes revealed a period of time when preparing for childbirth as a Cuban first-time mother. The experience was described as physically and emotionally intense. Tica commented,

> Well, I first have to let you know that it was a surprise when my friend asked me to go with her to CVS. She bought a box with 2 pregnancy tests in it. I said to let me use the other one because I am two days late with my period and, you know. Well, guess what? The test was positive and she was negative. I located a doctor right away and it was a female… She gave me an appointment and told me to buy prenatal vitamins over the counter. I never went to any newborn classes because I took care of my nieces in Cuba and I knew what to expect.

Second, the clusters of themes reflected each unique labor and delivery as experienced and perceived by a participant. Asia described her experience this way,

> I had taken flax seed on Sunday, in preparation for my scheduled labor the next day, but I had gone into labor on my own first before going to the bathroom so I was convinced that I really did have to go, despite what the nurses said, that my case was different. I begged for an enema. I was convinced I would go all over the place while in labor.

Third, a cluster of themes emerged reflecting all of the behaviors seen as supporting the family immediately after the birth and in the early postpartum period. Liz stated,

Everything was fine and normal baby that they brought into me. I held him. I looked at him and I gave him a kiss and I told my mother, "OK, you can have him and I'm going to sleep now." I was very, very exhausted. Ya, I was tired.

The three main clusters of themes that emerged during the analysis of themes are outlined in Table 5 with clarifying examples using the words of the participants.

Table 5

Emergence of Themes

Cluster of themes	Themes	Examples
Preparing for birth	Anticipating	"We eat well, wear loose clothing, regular activities…"
	Working	"…because I was working until a week ago…"
	Experiencing emotion	"I don't regret any of it and I'm very excited and happy of it."
Birthing	Laboring	"As I was getting off the bed, my water bag broke."
	Feeling pain	"Around 5 am I start to have pain."
	Supporting the birth	"That's one of the things I wanted. They put her up on my bare chest and I got to hold her, you know, try to feed her. I think I fed her right away, actually"
Integrating	Going home	"We need to rest so we can get some strength"
	Adhering to customs and traditions	"A lot of the Cuban traditions that I was brought up with I see with myself… Cuban moms make everything homemade for their baby. I will feed her the puree until she reaches one year old and I start giving her rice when she gets her teeth."

Preparing

The first cluster of themes is "Preparing." The lived experience of childbirth for a Cuban woman in Southwest Florida begins with preparation by the woman and her family for the experience. Culture influences a woman's life from the moment that she first learned of her pregnancy until the birthing experience and beyond. Maternal role attainment (MRA), defined as a cognitive and social process of integrating mothering behaviors, has been found to have both familial and cultural influences (Rubin, 1967). Cultural preferences and traditions influence the new mother's willingness to develop positive feelings around the time of birth.

There are three themes that emerged in the cluster of themes designated as "Preparing". They are:

1. Anticipating the birth
2. Working
3. Experiencing emotion.

Anticipating. Most mothers described learning that they were pregnant as a nice experience. They described a desire to learn about pregnancy and childbirth in preparation for the baby. Popular topics were physical changes during pregnancy and fetal growth and development during pregnancy. Books were identified as an important source of information to the mothers while two of the 29 participants (7%) used the internet. It is interesting to note that one of the women used the internet while pregnant and still living in Cuba.

Four of the 29 participants (14%) did not intend to become pregnant, either at that time or at all. Most learned of their pregnancy on or before 20 weeks gestation and received prenatal care with a provider throughout the pregnancy. A few mothers in this study (10%) revealed that they had moved to the area recently, had late prenatal care or had multiple providers during the pregnancy.

The following are some examples of anticipating the birth of their first child for Cuban women. One mother said,

> It's so…It's beautiful and shocking at once. A couple of weeks after that settles in, you become attached so fast, you know, um, you go from not thinking, really, about having a baby to all of a sudden, there's something growing in me.

Another mother explained, "Cubans are very, very, very family oriented". Major life decisions are often discussed with extended family and decision-making is a shared family responsibility.

Cuban cultural influences affected these women during pregnancy in their daily lives and decisions in practical ways. For example, women in this study felt that Cuban women routinely take exceptionally good care of themselves during pregnancy. Participants expressed a desire to cleanse their bodies in preparing for the birth by avoiding alcohol or coffee. They expressed their efforts to eat foods considered nutritious like malted milk and peanut rolls during their pregnancies.

Thirty-eight percent of the participants took vitamins during their pregnancies, however, only 8 of the 29 (27%) said that they had taken prenatal classes. Two of the mothers were still finishing high school which negatively impacted their ability to attend

prenatal classes. Those who attended classes reported learning things about the pregnancy, labor and delivery, post-partum, breastfeeding and infant care that were previously unknown to them.

Gloria stated,

> The prenatal classes were kind of… they were interesting. You know they were interesting and a little bit of an eye opener…The breathing techniques helped a lot to get through the birth and the initial pain of breastfeeding.

Working. Working emerged from the interviews in the study as the second main concept in this cluster of themes, "Preparing for Birth". Many new mothers faced considerable challenges by taking time off from employment to care for their new babies. Most of the women in this study were employed during their pregnancy and described their experiences of being pregnant while working as challenging.

Jacqueline worked up until shortly before her delivery and said, "(it was) very tiring…and painful. My feet swelled up and that hurt a lot". The women described a variety of ailments common to pregnancy. Coralia said,

> I was trying to save enough money so I can, at least, take a month or two months off. Pero (but) I want to spend some time with the baby. Some of the women said that they had an easy pregnancy and did not have any problems working at all.

As for plans about returning to work in the future, Myrna said,

> I truly feel fulfilled doing what I am doing right now, but because I want to be a good role model to my daughter…in nine months or a year, I hope that I can find some part-time work.

Experiencing emotion. Experiencing emotion is the third theme that emerged in the cluster of themes, “Preparing for Birth.” Pregnancy creates major changes physically and emotionally and women’s strong emotions frequently accompany those major changes. Women in this study had emotions that varied widely. Most mothers described feeling intense emotions at some time during the pregnancy and childbirth experience. Some mothers expressed anxiety, others felt depressed and many expressed great joy. Feelings of conflict identified as grief work are experienced by new mothers during the process of MRA and strain is created by old roles that are necessarily given up while new mothering roles appear (Mercer, 1981).

> Some of those feelings are exemplified by Rosa’s comments when she stated, Because one minute you’re living a lifestyle where you are drinking wine and going out and then, literally, the next minute that your test happens, your whole life changes… so ya, it’s a life changing experience!

Another new mother described it this way, “I mean, I had moments where I was emotional but it wasn’t sadness or depression. It was more of, if … I just I don’t know. I would cry over a clown. I mean it was stupid. I was sensitive…”. Ophelia whispered, “I was just… in disbelief, actually. She was inside of me. I still don’t believe it. I was happy. Yes, I still am amazed. You really… I don’t know how to explain it. It was so emotional”. When probed about feelings of sadness, two of 29 (7%). Berta shared, “I was past due. That was real depressing for me”.

Most mothers did not voice a particular preference for the sex of the first baby. Frequently they expressed joy and said that they preferred a healthy baby of either sex.

Responses showed that one mother preferred a girl, and three mothers preferred a boy and ten did not have a preference for the sex of the child. While most mothers did not have a preference for the sex of the baby, when a preference was expressed, most often it was for a male.

The urge to have a boy in a Cuban family is strong. Ophelia said

> Just because, you know, big brother takes care of the little ones. Once I knew, it didn't matter. She was perfect, no matter what and I'm just so happy.

Birthing

The second cluster of themes was "Birthing". Three themes were included:

1. Laboring
2. Feeling pain
3. Supporting the birth.

Laboring. Laboring is the beginning of the birthing process. The mothers in this study revealed much about their perceptions of people and events during this time period. Some of the participants described how they began labor when it was not expected. One mother told of how she was out of town when labor began earlier than expected. Many relayed their particular wishes and preferences for how they wanted the experience of childbirth to be.

The great majority of women anticipated the event of labor leading up to their childbirth experiences. Tica said, "I had certain expectations, not necessarily plans, you know. She was my first baby so I didn't know how anything was going to be". Tica was

eager to explain, “The contractions were the ones that were painful. Pushing and getting her out was nothing.”

Terisita, a new mother who delivered her baby 24 hours previously mentioned that she did not prefer natural birth. She said, “I was not prepared for natural labor and I didn’t do well with feeling my contractions”.

Amarile explained her experience during labor with her husband,

> In Cuba, the men are not allowed in the hospital while the women are giving labor plus, it’s not private like this. If you see a movie from the 1950 where there is 20 women lined up; just curtains between them. That’s how it is in Cuba.

Women frequently revealed a use of technology during their child birthing experience. Each experience was perceived differently by each woman, but most deliveries included some use of continuous fetal monitoring, vaginal examinations, intravenous fluid administration, inductions through artificially rupturing membranes during labor, prostaglandins cervical ripening agents (Prepidil, Cervidil) or (Cytotec), use of synthetic oxytocin (Pitocin), epidural anesthesia, use of narcotics, episiotomy or perineal sutures.

In keeping with current recommendations by AWHONN, most mothers were allowed to move freely during labor. Most women preferred to have family members resent to support them during the labor process and at the actual delivery of the baby.

Feeling pain. Feeling pain is the second theme in the “Birthing” cluster of themes. In a modern hospital, most women are offered medication for pain management. Of the 29 participants, only 2 mothers had only intravenous medication and no epidural

anesthesia. Odelia said, “It didn’t take away the pain. It just kind of helped me relax through each contraction… the contractions started coming, you know, closer together and they were stronger and more intense”.

Rachelle described, “Painful! Painful! A lot! 10! They put medicine in an IV…it got better then I, like, quickly, like for 2 hours to a 1 hour, then it comes again.” When probed regarding pain, this mother replied, “Si! 10! Mucho dolor!”.

Narrative descriptions about management of their pain and control over their bodies were found frequently in the study. Dusnielle described her experience with an epidural, “… then I didn’t feel any pain at all. I didn’t even know I was pushing. I pushed just 3 times and then she was born”.

Feelings of pain were replaced by an ability to focus and feelings of happiness when pain was managed effectively. Most women in this study reported adequate control of their labor and delivery pain with epidural or intravenous medication or a combination of both. The number of participants and the type of pain management that each was offered are shown in Figure 4.

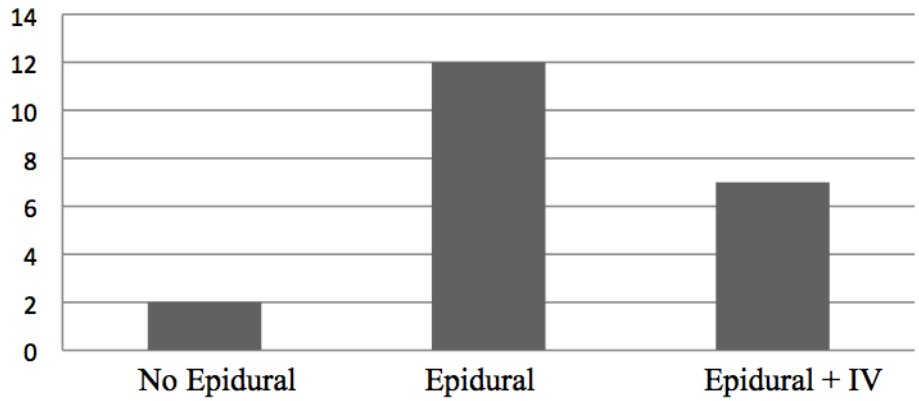


Figure 4. Pain management during labor.

Supporting the birth. Supporting the birth is the third theme in the "Birthing" cluster of themes. These are interventions that facilitate MRA early after birth and include having a family support person present during the delivery, having new mothers breastfeed immediately or as soon after delivery as possible, providing culturally and linguistically appropriate language for the mother during delivery, and using maternal cultural preferences during labor and delivery. As an example of how her husband supported the birth, Delia said,

> The whole time he was encouraging me and saying what did I need? Any ice chips? And he, you know, did I need to sit up? Do I want a massage? I mean, just the whole time he was just so supportive, so uplifting.

A few new mothers had negative experiences with nursing staff during the childbirth experience. This mother stated,

> At that point, my contractions were excruciating and there was only about ten seconds between the end of one and the start of the next. While preparing me for the epidural, the clumsy old nurse knocked the IV out of my hand with no apology. Evil woman! So I had to have a new IV in the other hand, just before having a second epidural during contractions...all the worst parts, for a second time! I had had IVs earlier in the week at the monitoring hospital and that nurse had to stick me twice since I have tiny, uncooperative veins so I tried to relay the lessons learned by the previous nurse form that experience but the hateful delivery nurse wouldn't let me speak and said she knew what to do. I can't emphasize enough how much a mean nurse ruins the whole experience.

Many of the participants voiced a strong preference to breastfeed and most began breastfeeding shortly after birth. Also in keeping with current AWHONN birthing recommendations, most of the women said that the babies were usually placed on their chests at birth. Kay said, "That's one of the things I wanted. They put her up on my bare chest and I got to hold her, you know, try to feed her. I think I fed her right away, actually, within the first half-hour for a few minutes".

Most women perceived that the nurses in the hospital encouraged them to breastfeed. Sixteen of 29 (55%) of the new mothers revealed that they were currently breastfeeding, four (14%) reported bottle feeding and 3 (10%) said they intended to both bottle and breastfeed their babies. Guillermina said, "Well, my mother breastfed us that way and my mom and my sisters told me that it was better for the baby… I wanted him to have the antibodies in the milk".

Wanda had an unusual experience. She said,

> I breast fed him because my breast were like (gesturing) this full of milk. My friend who had already delivered her baby girl could not breast feed her baby because she had no milk due to the medications given to her during her C-section and right away they gave me both babies. I breast fed both, my friend's baby girl I fed with my baby boy breast feeding, breast feeding, breast feeding. It was very beautiful. They let my husband cut the umbilical cord and that was beautiful! My husband would go like this (gesturing) you know, it gives you a tremendous impression, but it was beautiful, beautiful!

Lactation consultants were mentioned occasionally by the participants in their early efforts to breastfeed. Most of the breastfeeding mothers described early assistance with breastfeeding efforts by nursing staff or a lactation consultant in the hospital as both informative and helpful. One mother said that it was appreciated when offered to her. Another mother stated, "I definitely wanted to nurse…that was the hardest part about having a baby…It's when you are alone with the nursing part of it". Selina, whose own mother had breastfed her as a child also said,

> They had me nurse her right after she was born and she did amazing. She took right to the breast and fed for a long time… I wasn't sure if I wanted to breastfeed or not. I was breastfed. My husband was breastfed. I felt a little bit of pressure from my husband and his family to breastfeed, but it was my decision. Honestly, before she was born the whole idea of it kind of freaked me out. I just told myself that I would give it an honest try and keep an open mind.

Maternal feeding preferences for their babies in this study are shown as breast, bottle or both in Figure 5. Most Cuban mothers chose to breastfeed their infants.

Integrating

"Integrating" is the third and final cluster that was revealed during the analysis of the data in this study.

Going home. Going home is the first theme in the cluster of themes. Family traditions such as food and dress were common topics described as customary in Cuban homes. Almost all mothers described in detail the places that were chosen for baby to sleep at home. Geraldine said,

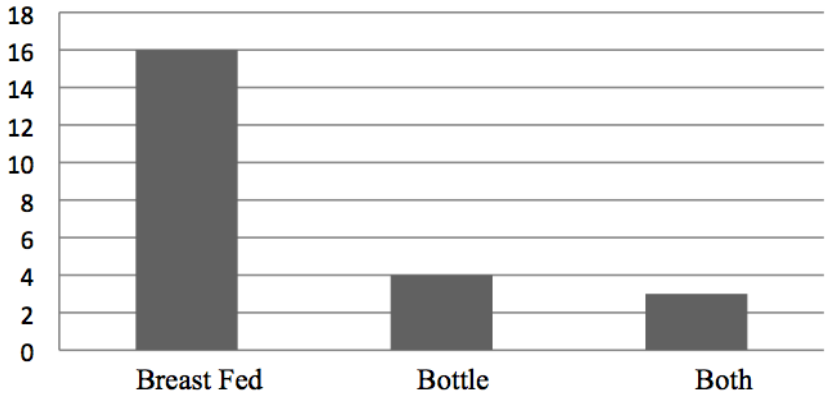


Figure 5. Feeding preferences for baby.

> I have everything planned for him. It's been ready for six months. Is the room is green because the clothes that are going to be out today is green, too, so everything is, like, green. His bed next to mine, yes…a bassinet for now.

While describing the place at home she had prepared for the baby, Guerline stated,

> We live with my parents. I live with my mom, stepfather and my brother. I'm doing it all the Cuban way; the baby's crib has a white mosquito net that is embroidered with pastel color ribbons. I also have a pin called the Asavache with the Dios Me Bendiga engraved on it… You definitely need to pin one on the baby's clothing in the hospital for people who have evil eyes.

Celebrations of the birth were most often described as a meal with the family. Jacqueline said, "Well, we're going to have dinner, of course…then we will have a dinner and everyone wants to see the baby. Everyone just showed up. Everyone took the day off ".

Language was not initiated as a topic during the interviews by any participant, however when specifically probed, all participant responded negatively initially when asked if language was a problem during the hospitalization. One participant provided clarity by saying, “No. A little bit, you know, it’s not my first language”. Another said that it was necessary for the family members to have assistance with the language by stating, “No, but it has to be translated for the family”.

On a related note, one participant said, “Yes, that’s the only problem that I had here. They assumed we look Spanish and everything they gave us was in Spanish”. While speaking about language, many were passionate in their desire for their babies to learn both languages and stated, “Even as of now, while I’m here with him, now I speak both English and Spanish with him”.

Geraldine discussed nursing support during the hospital stay and the preparations for going home. She said, “I had a great nurse; a really great nurse. She was really caring, I don’t know, reassuring me and constantly coming in to check on me.”

Recent research by Goldbort (2009) found that caring, particularly when there were unexpected events during the birthing experience, was not reflected in the support that women received by their nurses. The findings reflected the loss of three critical elements; caring, connection and control over the situation. Not every mother in this study expressed satisfaction with her nursing care. One of the mothers stated, “I hate to complain…when I was in pain and I asked for the medicine, it took her awhile”. Another commented, “They still haven’t explained to me why it took so long to bring him to me”.

Adhering to customs and traditions. The last theme to emerge was "Adhering to Customs and Traditions." Nearly all of the women talked about how important it was to adhere to their Cuban customs. Some described specific customs such as food or dress as being important. Maia explained some of the relationships within a Cuban family,

> Well, you know, a mom and a daughter are typically very close in the Latin culture… I see a very big difference in the closeness that there is between a mother and daughter in the Latin culture. It is very like my mom is like my Bible.

She went on to describe how her own mother participates in integrating the baby within the family. Lizette said, "The moise (bassinet) is extremely traditional...My mom made mine". Each generation is intimately involved with the new baby and a bassinet may be passed from mothers to daughters in the family over generations. Lizette said, "We keep it…and I will keep mine and probably give it to her when she gets older. The one that I got was my mother's and my mother remade it".

Frequently, the new mothers did not go to their own homes, but went to stay with their own mothers or another family member's home for a period of time. Marta explained, "I won't be going home to my home. I'll actually going to hers… within that week or two, she will probably give me every lesson in the book while I am there".

Special traditional dress is described by one mother, "…the canastilla cubana outfit to bring the baby home in. It is a white, two piece shirt with the booties and the asavache, which is a gold baby pin engraved with *God Bless me* on it, with a set of Santa Lucia eyes attached to it".

A minority of women did not feel that their cultural heritage influenced them. One stated, “I am not too attached to my country, you know, culture so I think I will go with what I learned in school…”.

Religion was broached by seven mothers in the interviews who said that they were Catholic, three who said they were Christian and two who said that they did not have a religious affiliation. The remainder did not mention religion during the interviews.

Amarile relayed,

> We are Catholic and we like to baptize a baby first by water when the baby’s about 4 months and before the year, baptize them by church. I still don’t have a set day for it yet but I’m guessing when I get home, when I have more time to rest and everything, I will decide everything.

Further, Guerline stated, “The same religious values that I was brought up with I would like her to be”.

Particular Cuban customs include food preference for the baby. Francie stated, “Well, they boil the beans and take the broth for the baby…Malanga and they mix it with veggies and blend it and give her that rather than baby food. I will start feeding her puree”. Guerline also stated, “Cuban moms make everything homemade for their baby. I will feed her the puree until she reaches one year old and I start giving her rice when she gets her teeth”.

For colic, Cuban mothers sometimes use anise. Amarile described what she learned from her own mother,

> When babies have a lot of colic we give them anise star. I boil it with the same water as the vegetables. You are not going to go out in the middle of the night if the baby has colic's to get some anise.

Another interesting tradition concerning a baby's tooth is told by Alda,

> When the baby loses his second tooth, I stand outside the front door and toss the tooth backwards up to the roof so the little mouse will eat it and bring a new one…for the little mouse to bring a new tooth.

In summary, the new mothers in this study generally expressed satisfaction with their birthing experience. They described good pain management and support for themselves and their families from the nursing staff during labor and delivery. Most women expressed great pride in being Cuban. Several of the mothers expressed a desire to teach their children how to speak both English and Spanish. Most stated plans to raising their own children with the cultural traditions that they had grown up observing and celebrating.

Summary

The participants were eager to tell the story of their babies' births and were interested in having their voices heard. First, transcripts were generated by the audiotaped interviews. The transcripts were examined and grouped into themes and clusters of themes, based on word by word analysis, memoing after each interview to capture the feelings and impressions during each interview.

Thematic analysis of the written transcript was accomplished using Colaizzi's seven step phenomenological methodology and with guided direction by experts in the

fields of maternal-child health and phenomenology. The themes that were generated in initial interviews helped guide further interviews. The results of a thematic analysis were integrated into an exhaustive description of the experience of childbirth among Cuban mothers. Trustworthiness of the data was established by verifying with the participants that the narrative interviews accurately described their opinions of childbirth.

The findings reflected the presence of three clusters of themes. “Preparing” was the first cluster of themes and contained “Anticipating”, “Working” and “Feeling Emotion”. “Birthing” was the second cluster of themes and included “Labor”, “Feeling Pain” and “Supporting the Birth”. “Integrating” was the third cluster of themes and included “Going Home” and “Adhering to Customs and Traditions”.

Two open-ended research questions guided the study: What is the experience of childbirth among 21st Century Cuban women in a Florida hospital? What is the influence of Cuban beliefs and culture on the experience of childbirth among Cuban women in a Florida hospital? The resulting interviews in this study were representative of the lived experience of childbirth among Cuban women in a modern southwest Florida hospital. Customs and traditions are a significant influence on a first-time Cuban mother. Nurses who exhibit cultural competency for childbearing mothers are a positive influence on many individuals. As more evidence is accumulated about Cuban mothers during childbirth, appropriate care can be tailored to include maternal preferences.

Chapter V: Discussion of the Findings, Conclusions and Recommendations, and Summary

The purpose of this study was to examine and describe the lived experience of childbirth among a group of Cuban women in Southwest Florida. The study proposed to answer the following questions: (a) What is the experience of childbirth among 21st Century Cuban women in a Florida hospital? and (b) What is the influence of Cuban beliefs and culture on the experience of childbirth among Cuban women in a Florida hospital?

The phenomenological methodology first developed by Colaizzi (1978) was employed to answer the research questions. This method was an ideal way to uncover the meaning of the experience of childbirth among Cuban women since the steps in the method are clear and logical. Assumptions underlying the methodology are: (a) nature is governed by laws; (b) these laws regulate all entities in nature as causes; and (c) natural causes determine psychological events (Colaizzi, 1978).

An interview guide was developed using a review of literature related to general childbirth knowledge and childbirth among Hispanic women. Data gained from interviews were collected by the investigator and facilitated by the use of a Demographic Data Sheet (Appendix C) and a Semi-Structured Interview Guide (Appendix D). Throughout the study Cuban mothers were eager to participate and tell their birth stories, revealing their perceptions of the birthing experience and increasing understanding of their points of view. The interviews were audiotaped and transcribed verbatim.

Study participants consisted of 29 women of Cuban descent. They ranged in age from 18 to 25 years old. By comparison, the average age for a Cuban woman giving birth in this study was young, at just over 20 years of age. Important to the planning of nursing interventions and health teaching, 80% of the women in this study were 20 years old or less while the average age for a woman having her first baby in the US was almost 25 years old (U.S. Census Bureau, 2007).

The essential structure of the lived experience of childbirth for each of the Cuban women in this study was joyful and personal. The birth of a first child is dramatic and life altering for all members of a Cuban family. Women are expected to become pregnant and have children to fulfill their duties as a wife. Mothers have great status in the family structure and in their communities. Survey results indicated dreams, hopes and desires of Cuban women matter deeply.

Rubin's role theory used descriptive narratives to define maternal role attainment. The process by which a new mother achieves maternal role identity begins with her preparations for new life. Maternal perceptions of the labor and delivery experience, past and present experiences and cultural values all contribute to successful mother and infant attachment (Rubin, 1967).

In recent years there is an increase in studies about minority women and specific findings among them. There is also an increased realization of the value of research into the many individual cultural differences that influence parent and their babies. With a better understanding of the role of maternal cultural preferences, nurses can influence belief systems of minority women that can influence maternal attachment.

Similarly, this study's findings Cuban women's experiences giving birth for the first time are comparable in many ways to women's first pregnancy in any other culture. For instance, women of other cultures also describe being filled with a sense of happiness and harmony related to fulfillment of the pregnancy.

Three themes emerged during interviews with the participants. First, *Preparing for the Birth*, was described as a period of growth associated with the body changes during pregnancy and in the psychological preparation during that time. Upon learning of their pregnancy, many of the mothers expressed an interest in finding out more about the pregnancy and delivery process.

Preparing for the birth of a first child, details about the laboring and birthing process and how mothers integrate a new baby into the family were common topics to be revealed in this study. Frequently, they described the feelings of surprise, anticipation and excitement of first finding out about the pregnancy. The descriptive narratives from the women are unique and reflect the feelings of joy and hope for families surrounding the birth of a child.

Most women revealed that their own mothers were their best source of information on becoming a mother. A few women did not have their own mothers available due to death or geographic separation. These women expressed they received support from a husband or significant other, a sister or sister-in-law, or a mother or mother-in-law during the delivery of the baby. Some women described printed books that had been helpful and two of 29 (14%) used the internet as a source of information. Only

27% of the women attended prenatal classes with reasons for not attending most often attributed to transportation issues, scheduling conflicts with work or school schedules.

Second, *Birthing* was described as the possibly painful and certainly emotion-filled experience of laboring as well as the actual delivery of the newest family member. The advice given to Cuban mothers was from older, more experienced women in their families who serve as role models.

Third, *Integrating*, was described as the process by which mothers and their families incorporate a new baby into their lives. Most new mothers in this study described their plans to include Cuban customs and traditions in raising their new infants. Cultural customs and traditions play an important role in the family structure of growing up Cuban. One young mother said that when she had disagreements with her husband, she frequently remembered her mother saying there will never be a divorce because, "I am Cuban, and not only that, I am Catholic".

Few studies of the experience of childbirth among Hispanic women have been done. Gallo (2003), conducted a phenomenological study of the lived experience of childbirth among a group of mostly Mexican women from southern California in an unpublished dissertation.

In Gallo's research, the Mexican Latina women were interviewed about their childbirth experiences. Three essential themes emerged*; Cultural Adaption, The Unfamiliar Journey in a Foreign Land,* and *Confirmation of Choice.* She also identified incidental themes: "Cultural differences" as distinctions experienced by Latina women in medical interventions, folk care and language; "La familia" being family members

providing essential support during pregnancy, labor and delivery; "Spirituality" revealed as attitudinal dimensions such as belief in God, religious orthodoxy, commitment to a faith and seeing one's own religion as a source of strength, "Emotions of Labor" as suffering during labor and beauty during the experience of childbirth; "Timeliness of Labor" as personal accounts of the delivery process by the participants perceived a long labor; "The Ultimate Reward" described as a bittersweet paradox of giving birth, suffering in silence and delivering a child to her husband; and "Realization of Motherhood" seen by Latina women as the most important social role a woman can achieve.

Gallo's study of the lived experience of childbirth concluded that the Latina women had a desire and need to become a mother. The women described decisions regarding whether to give birth in their native country or in the U.S. The women weighed the options and considered the inherent security of citizenship in the U.S., most made the decision to deliver in the U.S. During the labor and delivery and with the support of their families and strong spiritual faith, the Latina women proceeded through an unknown journey. Barriers or uncertainties were identified as lack of knowledge, lack of prenatal education, inability to understand the English language, use of medical procedures, interventions and timeliness of the labor.

By comparison, this study of the lived experience of childbirth was in a Cuban population rather than a Mexican population. The importance placed by Cuban women on family life was revealed. The women shared cultural beliefs and birthing preferences for their childbirth experience. The findings of this study of Cuban women were similar

to the findings of Gallo's work in that barriers exist to knowledge and prenatal education. The results of this study reaffirm the findings of Gallo's study of Mexican women in that the women each have a desire and need to become a mother.

Discussion of the Findings

The intent of this discussion is to consider the findings of this study with regard to current and historical research related to the experience of childbirth in general and related to Cuban women in particular. Eight themes emerged which described the experience of childbirth for the first time among Cuban women. The themes were identified as: "Anticipating the birth", "Working", "Experiencing emotions", "Laboring", "Feeling pain", "Supporting the birth", "Going home", and "Adhering to customs and traditions".

These themes emerged from the significant statements taken from the mothers during interviews for this study data and clustered into three main sections. The clusters of themes were *"Preparing", "Birthing", and "Integrating".* An in-depth analysis of the literature was conducted after the data was collected and analyzed.

First, the clusters of themes revealed "Preparing" first time pregnant, physical and emotional experience. A discussion of specific themes begins with the cluster of themes that reflects the theme of "*Preparing".*

Anticipating the birth. Cuban women described taking good care of themselves physically while preparing to give birth. Almost all took prenatal vitamins and had prenatal visits with a primary care provider. They drank malted milk and ate high protein

foods, such as peanuts during the pregnancy. They avoided alcohol, tea, coffee and chocolate while pregnant and wore loose-fitting clothing.

Most of the women interviewed for this study wanted to become pregnant either prior to or at the time they became pregnant. No mother had used special help from a doctor or clinic to become pregnant. Several of the women said the pregnancy had not been planned. A majority of the women in the study were in the 18-20 year old age group: the sample can be described as young mothers. About half were married and had completed high school before becoming pregnant.

All of the women described enjoyment and excitement in preparing the baby's room and gathering baby belongings. Detailed descriptions were given of the colors used to decorate and a variety of ribbons strung around the house. Traditional Cuban colors for babies are yellow and green, rather than typical pink or blue shades familiar in the US. Many of the items used for the baby, including the Moise (the bassinet) and La Canastilla (the gown) are passed from mother to daughter through the generations. Since mothers and daughters in Cuban families are closely emotionally attached to each other, many of the new mothers go to their own mother's house for a period of time while recovering from the birth. Friends and family helped to celebrate with showers of gifts and food for the expectant mother and for the baby-to-be.

In a recent study of minority expectant women Berman (2008) explored the prenatal education needs of foreign-born, Hispanic and minority expectant mothers. She used their perceptions to help identify barriers to attending childbirth education classes. She found that the culture environment needs to be considered by childbirth educators.

Transportation was identified as being the most frequent barrier for women to participate in prenatal education.

As in previous studies, this study of Cuban mothers found transportation one of the biggest obstacles to prenatal childbirth education classes. Because positive outcomes of childbirth education are well known, more research is suggested into the reasons why Cuban women did not value prenatal classes. As nurses learn more about the beliefs held by this group of Hispanic women, teaching strategies can be incorporated to increase the importance of prenatal childbirth classes. One mother said that she had learned all that she needed from her mother, aunts, sisters and other female role models while she was growing up herself.

Working. Many women described working during the pregnancy. A few said that they had no physical problems and continued to work up until delivery. Mia said,

> Actually, it wasn't too bad. I had a really easy pregnancy. I never had morning sickness and never had Braxton- Hicks contractions. In the beginning I was always really tired and then again toward the end. I travel a lot for my job, all over the state, so I stopped traveling once I got in my 3rd trimester so that I could be close to home when the baby came. My family was very supportive and my younger brother would travel with me so that I didn't have to be alone. I worked until the day before the baby was born.

Working while pregnant was not always easy, however. Most of the women who worked admitted to leg and foot pain or swelling during the last months of the pregnancy, feeling tired after working or other common minor discomforts. Occasionally, mothers

discussed their employment patterns after they had their baby. For those mothers who were not currently employed, regardless of earlier employment status, the majority cited a desire to stay home with the baby.

Joli said,

> The biggest change I made for my pregnancy was to quit my job in the first trimester. I had had two miscarriages earlier in the year. They were very early miscarriages, at 5 and 7 weeks, the egg never attached and they happened to be at very stressful times at work and I didn't think that was a coincidence. I had been a training developer and technical writer for a team that supported a new system for a school district… because I had more seniority than the other full time employees, I would be sent out of town to our worst sites so, I gave my boss a month notice, finished what I was hired to do and left when I was less than 3 months pregnant.

Experiencing emotions. In this study women described in detail complex and powerful emotions during their childbirth experience. Yurisledi recalled,

> I didn't sleep… I was too anxious about the whole motherhood thing. I recall stressing about the future. My back started .hurting badly, and then after they checked my cervix, that started hurting too. Of course the pressure was insane.

The findings of intense, often conflicting emotions at the time of delivery was consistent with the findings in a current study, "Listening to Mothers II". The researchers reported that new mothers reflecting on their emotions at the time of their childbirth

experience and reported feeling capable 50% of the time. They reported feeling frightened 40% of the time; overwhelmed 56% of the time and powerful 27% of the time.

Cuban mothers in this study had a range of emotions. Some described the experience as “Glorious! Glorious!” while another said, “At that point my contractions were excruciating! and there was only about 10 seconds between the end of one and the start of the next.”

Interestingly, the researchers asked mothers who should make most of the decisions about their labor and deliver, assuming there were no medical complications. Most (73%) felt that they should make the decisions after consulting with a caregiver. (DeClerq, 2006).

Several possible reasons exist for this finding of experiencing strong emotion during labor and delivery. The goal of maternal nurses is to facilitate positive emotions and reduce the negatives feeling of pain or fear. In this study most of the women were young. Many are still learning what it takes to be a mother, themselves.

It is known that nationally, 11% of the population is immigrants. This study was completed in Collier County, Florida, where one in eight people living in Collier and Lee counties were born somewhere other than the US. By county, 18% of Collier residents were born outside the US; twice the rate of Lee County (US Census, 2010). Consistently, many of the women in this study were born outside the US with potential language and cultural needs.

Also, according to the interview data, many women described struggling to earn money for the costs of a hospitalization and bringing home a new baby. Most of the

money that a Cuban woman and her husband have comes as a result of their own work efforts. Frequently money is sent back family members still living in Cuba.

Second, the clusters of themes reflected "Birthing" with narratives of each unique labor and delivery experience that each women described in vivid detail. A discussion of specific themes begins with the theme of "Laboring" and ends with the theme "Feeling pain".

Laboring. A great majority of pregnant women are healthy and have every reason to expect an uncomplicated childbirth. Cuban women in this study begin the labor and delivery with similar expectations. According to the Standards for Professional Nursing Practice in the Care of Women and Newborns nursing practice is individualized to meet the unique needs of laboring women. By formulating outcome measures that are culturally appropriate, women have a voice in their special event (AWHONN, 2009).

All of the women in this study received supportive care by a family member, nurse and physician. This helped to make them more comfortable and provided emotional encouragement. Most women received such care from a family member and expressed happiness while sharing the moment of birth of their first-born child. One woman described the sadness that she felt while being alone without her family at the moment of birth when her family had all stepped out to the cafeteria. No midwifery care was reported available at this study site or anywhere in Collier County.

Feeling pain. Looking at the pain of childbirth is something that has a peculiar centrality for women. As mothers and female beings the pains of birth tell us about

suffering and joy. Some births are short but intense while others are long and hurtful. In the end, many women feel some degree of pain during the experience.

The Lamaze Institute for Normal Birth adopted these six care practices for use. They promote natural, normal and healthy approaches to laboring women. The six care practices include: Labor should be allowed to begin spontaneously. Women should be allowed freedom of movement under normal conditions. All women should have someone available to them as a birth partner. Interventions should be used only necessary for safety of the mother or baby. Women should be encouraged to use non-supine positioning and, lastly, mother and baby should not be separated after birth in an effort to encourage breastfeeding (Lamaze, 2007).

Sara recalls her particular situation,

> Doctor order some medication and an IV with Pitussin (sic). Due to this, I started having really bad contractions very close to each other and it made me dilate even faster. I said to her, "I can't stand the pain anymore!" so she ordered the epidural and I was calm.

Labor was experienced differently by every woman; however, all but two of 29 (14%) had good pain management. About half of the women had their labor induced or augmented as a consequence of post-maturity or stalled labor. Most described nursing staff as supportive and helpful.

Generally, the women in this study were allowed to follow their preferences including suggested care practices. Most women were able to ambulate freely during labor. Some mothers stated that they would like to have moved around more. A few

women said that they would have preferred not to deliver in a dorsal-recumbent position but were not given an opportunity to use that position.

Third, a cluster of themes: “Integrating” reflecting all of the behaviors seen as assisting with the family immediately after the birth and in the early postpartum period. A discussion of specific themes begins with “Supporting the Birth” and “Going home” and ends with a discussion of theme “Adhering to customs and traditions”.

Supporting the birth. Interventions that participants identified as supportive early after birth included having her husband or family support person present during the labor and delivery, breastfeeding immediately after delivery, having culturally and linguistically appropriate language interpretation as needed for themselves and their families, and being allowed freedom to celebrate in culturally appropriate ways including specific requests for foods and dress.

Rea relayed,

> So exactly 24 hours after my labor started, my baby girl was born. My husband was scared to death. He kept saying he didn’t want to let me down, but I said it was OK. So instead my mother stayed in the room with me. When the baby was finally born, they briefly held her above my head…

A large survey of women in the U.S. indicated that 51% of new mothers exclusively breastfeed their new baby at one week. Prevalence of breastfeeding was higher among Hispanic women. Development of positive feelings after childbirth by first time mothers occurred around the time of delivery. Breastfeeding mothers were more

likely to express positive feelings.(Declerq, E., Sakala, C., Corry, M., & Applebaum, C. (2006).

This study found a similar rate, with 16 of 29 (55%) Cuban mothers breastfeeding exclusively after delivery. The mothers reported the hospital staff was helpful in initiating the first breastfeeding encounter and in encouraging them to continue breastfeeding in spite of early difficulties. Occasionally, a lactation consultant came to a new mother's room to provide information, hands on instruction related to breastfeeding techniques and nutritional guidance.

Going home. Cuban traditions, such as food and dress, were common topics described by the new mothers in this study. Many of the women reported that family members had already come to the hospital to visit and almost all of the women said that family members would be coming to visit their newest member when they go home.

Mayra said,

> She will sleep in a bassinet in our room the first few nights. If that doesn't really work, we will put her in her own room. My husband has surprised me-pleasantly…And he is much more into the baby than I thought… he never had been interested in babies. He paid attention to his nieces… He used to call babies little blobs. But he is totally engrossed our baby. He appreciates the magic of having an infant. How adorable they are when they are tiny… he says he doesn't want her to grow up. That he hopes she stays this tiny forever because she is so cute.

Adhering to customs and traditions. The women were eager to share their childbirth experiences and revealed a preference to follow the customs and traditions they had been raised with. The women learned about childbirth and childrearing from observing and helping with their own mothers and extended families.

Terisita explained,

> Preparing for my first baby my mother helped me a lot in that. She was, like, my mentor and everything (laughing). She helped me decide what I wanted to do first. She helped me go to the doctor and prepare everything. It was kind of confusing, but after all, we decided that we was going to keep the baby. Preparing everything was very easy with the help of my mother.

Latest numbers show birth rates for Hispanic teens are three times higher than for whites and blacks. US birth rates for women 15-19 by race in 2004 showed white race birth rate of 26.8 and Hispanic race birth rate of 82.3. It is thought Hispanic teens are traditionally less likely to use contraception or talk about using protection (CDC, 2010).

One mother summarized her family size as huge. She said,

> We both come from pretty big families so… it seems that there is always a new addition to the family. Our families are very close and get together regularly and have big dinners and hang out. My mom is the oldest of eight children so I have tons of cousins. She practically raised all of her brothers and sisters herself. In fact, 3 of her younger brothers and sisters moved to Florida with her before they were 18 to get a better education.

Additionally, recent data show birth rates to teenagers in Collier County higher than state averages. Birth rates per 1,000 to mothers age 15-19 from 2002-2004 are 56.8 compared with 42.8 for Florida birth rates. Figure 6 reflects this information.

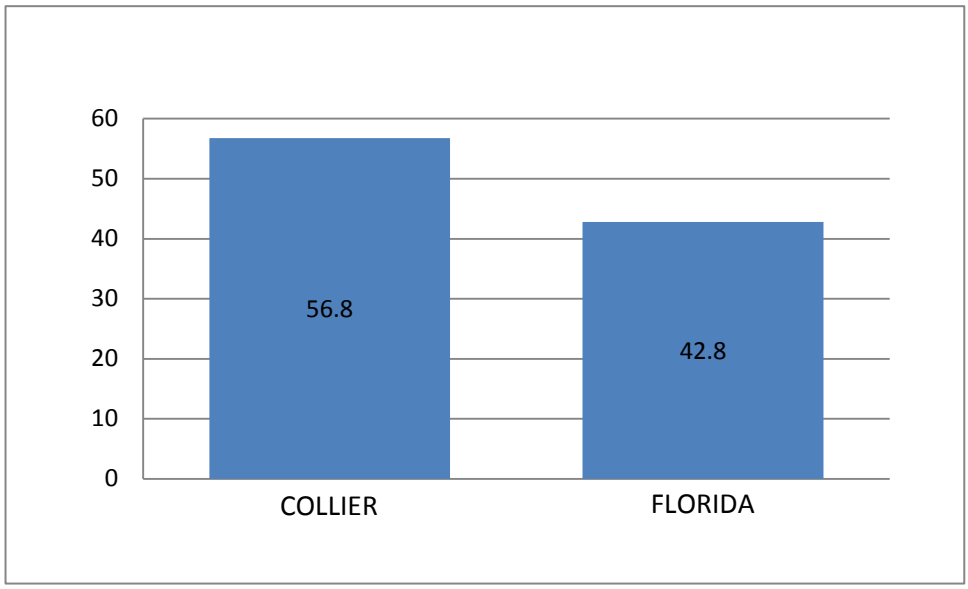


Figure 6. Pregnancy rates.

Mercer's nursing theory is reflected by many of the narrative descriptions given by the participants in this study. Her research found that mothering behaviors after giving birth reflect societal norms and common beliefs about what a mother should or should not be. Harmony is achieved with the increasing integration of positive mothering behaviors into their new identities (Mercer, 1981).

As an example of how food is used by a new Cuban mother to integrate her baby into the family with food, malanga (a type of puree) is described. One mother described malanga in magnificent detail:

> Puree at 2 months old. I will make his food fresh all kinds; malanga, platano, carrots, broccoli with chicken. I will blend all that in the blender and that's what I will feed him. I will also give him fresh tropical fruits I will blend mango, papaya, melon, guava, and put it all through the blender. Very important if the baby has too many soft stools to take guava pulp and put it to boil and boil for about 10 minutes with water and a little sugar because sometimes the guava is a little sour. Also, mango pulp if the baby is constipated and to refresh his stomach, some papaya in between feedings for snacks. I will also give him water in between feedings and three months I will give him fresh squeezed orange juice and baby vitamins. Between 3-4 months I will start giving him cooked rice with lots of water to make it very soft but at the same time have the rice texture because by time the baby is 1 year old, he is not going to want to eat rice. He is going to want to continue eating baby puree. Beans are very important. Not just the broth but the actual bean itself and the broth. Put it all through the blender with a steak and that's the best protein they get.

When Cuban mothers leave the hospital, they described family celebrations. One new mother said, "Everybody comes…mucho comida (laughing) and a party at the house!"

The research published to date does not account for the cultural effects of Cuban heritage. Additional studies making comparisons between groups and across time can be developed to gain evidence relevant to nurses. In the hospital setting, standards provide guidance for best practices. More research is accumulating about the lifelong implications

for babies related to cultural and social environment during this crucial period. Numerous opportunities present in the clinical setting for nurses to optimize maternal birthing experiences and perceptions of their childbirth experience.

The experience of childbirth as seen through the eyes of a Cuban mother who has recently given birth is unique and has not been defined in previous literature. Research can act as an impetus for more research while developing deeper insight into the effects of cultural beliefs and practices among women during this special event.

Conclusions and Recommendations

This study provides valuable information explaining and describing the lived experience of childbirth among Cuban women in a Florida hospital. Data from the interviews provided insight into the meaning of the experience of childbirth as seen through the eyes of a new Cuban mother. Findings of this study have implications for nursing practice, education and research.

The lived experience of childbirth among Cuban women is profound and joyous. The women were healthy, had low risk pregnancies and uncomplicated deliveries. This study offers an unprecedented look at the experiences of Cuban women and their infants in a 21st Century Southwest Florida hospital.

Nursing practice recommendations include maternity care enhanced by nurses who are culturally competent. This involves good assessment skills to determine client's unique cultural values, beliefs and practices. Munoz and Luckman (2005) reported guidelines for communicating with clients. These are:

1. Convey empathy by experiencing what that person is experiencing.

2. Show respect by valuing that person and viewing them as special.
3. Build trust by having confidence or faith in that person.
4. Establish a rapport by initiating social, friendly conversation first.
5. Listen actively by giving verbal and body language.
6. Demonstrate genuine interest by using words of concern.

Participant women described a typical experience during labor and deliver as a dramatic event. Support from families and staff during this time of childbirth was strong. The participant interviews did highlighted many opportunities to close gaps between actual and optimal birthing experiences for Cuban mothers.

Patient preferences that support the birth during labor and delivery are an area of ongoing research. The hospital experience of childbirth should begin by incorporating maternal preferences, including cultural customs and traditions, into their individualized nursing care plan. This involves good assessment skills to determine client's unique cultural values, beliefs and practices. Language translation by interpreters necessary to facilitate the birth during the hospitalization should be provided. Standards should be used to guide nursing practice in this setting including allowing women the ability to move about during labor and to position themselves for comfort during delivery.

Accordingly, evidence shows that labor care is within the nurses' domain. Five areas in which there is investigation on patient preferences include: Management of admission and of progression during the first stage of labor, fetal monitoring, care and comfort practices during labor, and the management of second-stage labor (Gennaro, Mayberry & Kafulafula, 2007). Management of labor can be timely and efficient while

also taking patient preferences into consideration. Maternity care for Cuban women can be enhanced by nurses who are culturally competent.

Nursing education can benefit from intrapartum nursing models. The three most common clinical practices for which nurses have primary responsibility with laboring mothers are: maternal-fetal assessment, management of oxytocin infusions and second-stage labor care. Nurses who develop skill in primary care processes are currently within the realm of nursing practice. Nursing education programs can help promote cultural competency by teaching nurses the necessary skills to ensure safe and effective maternity practices to all mothers. Further education is needed for nursing interventions that promote maternal-fetal well being (Simpson, 2005).

Efforts should be directed at encouraging early prenatal care and increasing the utilization of childbirth education classes by Cuban mothers. Hospital-based prenatal classes should have late evening or weekend schedules to accommodate Cuban women who may have difficulty with fixed schedules. Prenatal classes having some content designed to encourage participation of the fathers- to-be would be of value. Breastfeeding should be promoted with content in the classes. Since the role of grandmothers is very important to Cuban mothers, one of the classes could devote an hour to "grandmother classes" to reinforce healthy habits. Some women said that they used web-based pregnancy educational programs. It is suggested that a web-based prenatal classes could be implemented for mothers to view online as their schedule allows. It would be valuable, in addition, for hospitals to distribute lectures in DVD format.

Nurse researchers who study cultural differences and maternal preferences can develop evidence-based nursing interventions to meet a critical health care need. Suggestions for future research include: the role of advanced practice nurses in childbirth, using language-appropriate versions of a postpartum depression survey and other written material for dissemination among women whose first language is not English, and using methods designed to ensure safe and effective care that is appropriate for child-bearing women. Research priorities should be focused on filling in gaps in nursing knowledge about the childbirth experience among Cuban mothers.

Summary

In this chapter, a discussion of findings was presented. The participants described the essence of their childbirth experiences from their own viewpoint as Cuban women. Maternal-child health nurses play an important role in all aspects of perceptions of the birth experiences of Cuban women and their families. Relevant conclusions were presented and discussed. Recommendations were made for clinical nursing practice, nursing education and nursing research to strengthen the ties of cultural support for Cuban women and their families during childbirth.

Appendix A

Semi-structured Interview Guide

Semistructured Interview Guide

Thank you for allowing me to come into your room and agreeing to participate in this study. My name is Jane Cox and I am a student at The Catholic University of America School of Nursing and I am working on my doctoral degree in nursing. How are you and your family doing with the new baby? Did you choose a name?

Description of the Process

The purpose of this study is to gain understanding of the experience of giving birth and becoming a mother for Cuban women in Florida. I will be asking you a few questions about your birth experience. You may choose to answer or not. You may end the interview at any time. I will be tape recording this interview. You can stop the recorder at any time Will that be fine with you? I will be taking some notes, too. Could you please tell me about giving birth to your baby?

The Interview

First, may I ask some questions about you and your family life? Did you work during your pregnancy? Full-time? For how many months of the pregnancy? Did you take childbirth classes before the birth of your baby? Did you take prenatal vitamins or any other supplement? If so, what?

The birth experience

Had you ever been in the hospital before this? Where? During the pregnancy, were there times when you felt depressed or sad? At what point in the labor did you arrive at the hospital? Was there anything that you expected?How have you felt after the delivery? Were you able to get some rest? Was your pain managed effectively?

Expectations and Reality

Can you explain how you wanted this birth experience to happen? How was your birthing experience similar to what you expected? Can you describe how the labor experience was for you? Who from your friends and family were with you?

Pain management

How much pain did you experience during the birth? On a scale of 1-10 being the most painful) What was done to make the pain better? Was there anything that surprised you or that you did not expect? What was the hardest part of the experience? The best part? Did you picture the baby as a boy or girl during your pregnancy? If yes, did you have a preference? Can you share a dream that you had during pregnancy about childbirth?

The Baby

Can you describe how you are feeding your baby? How was the time when you first saw your new baby similar to what you had expected? Have you been separated from the baby at any time since the delivery?

The hospital experience

During the labor were you allowed to get up and walk around? How can this hospital make becoming a mother a better experience for you? Was language a problem for you during your stay at the hospital? What would you change about your experience in this hospital? Can you tell me about the place at home that you have prepared for baby? How will the baby's father help with you and your new baby? Will any other family member some to help? Was there anything that you believe you needed but did

not receive? Is there anything that you would change about your experience in the hospital?

Going Home

How will you celebrate when you go home? How did you learn about your pregnancy? What, if any, religious faith do you follow? How did what you learned growing up influence your labor and delivery? What Cuban customs will you follow in raising your baby? How much have you been able to rest after the delivery? Where will you take your baby for medical visits? On a scale of 1-10 (10 being most satisfied) are you with your birth experience? Thank you for sharing with me. Is there anything else that you would like to share with me about your childbirth experience. May God bless you and your new baby.

Appendix B

Demographic Data Form

Demographic Data Form

Code _____

	Age
	Country of Origin
	Born in what country
	Number of years in the U.S.
	Marital status
	Years of education
	Hospital

Appendix C

Invitation to Participate in a Research Study

Invitation to Participate in a Research Study

You are invited to participate in a study of the experience of childbirth of Cuban Hispanic women. You have been invited because you, your family and your baby are important to us. This study is being done as part of a doctoral nursing study at The Catholic University of America School of Nursing. I hope to better understand what the experience of giving birth is for special women like you. Your help may assist us to understand the Hispanic culture and to identify your concerns and needs during childbirth in this hospital.

If you choose to participate in this study, you will be interviewed in your hospital room by the investigator, who is a maternal-child nurse, for approximately 60 minutes. You will be asked questions about your birth experience and your family. I am interested in hearing what it is like for you to become a mother in our hospital, in your own words. This interview will be tape recorded and I may be making notes during the interview. Any information you provide will be protected and will be kept private. The findings of the study will not identify you by name. You may withdraw from the study or turn off the tape recorder at any time. If you choose not to participate or you withdraw for any reason, your care here now and in the future will not be affected. If you are willing to be a part of this study, please sign below. Thank you.

Jane E. Cox

___ Yes, I want to participate.

Appendix D

Informed Consent Form

THE CATHOLIC UNIVERSITY OF AMERICA
School of Nursing
Washington, D.C. 20064
203-319-5400

Informed Consent Form

NAME OF STUDY: The Lived Experience of Childbirth among 21st Century Cuban Women in a Florida Hospital

INVESTIGATOR: Jane E. Cox, Ph.D., C.R.N.P.
Doctoral candidate

SUPERVISOR: Patricia McMullen, Ph.D., J.D., C.N.S., C.R.N.P.
Telephone: (202) 319-6290

QUESTIONS: Jane Cox
Telephone: (239) 649-7999
Email: jane.cox@ nchmd.org

DESCRIPTION AND PURPOSE OF THE STUDY:

I understand that I am being asked to participate in this research study. I understand the purpose of this study is to describe the experience of childbirth among Cuban women in a Florida hospital. The results of this study may help nurses, doctors, and others who care for Cuban women have a better understanding of the childbirth experience. I understand that this study is being carried out to fulfill degree requirements for a Doctor of Philosophy Degree in Nursing at The Catholic University of America.

DESCRIPTION OF PROCEDURES: I understand that I will be interviewed by the person conducting the research in my hospital room. The interview will be audiotaped and I may turn off the tape recorder at any time during the interview. The interview will take about one hour, including the completion of an interview, and some personal information about my child and family. I give my permission for the person who interviews me to review my medical records.

FORSEEABLE RISK, INCONVENIENCES OR DISCOMFORTS: There are no known risks. A minor risk is that I may become tired or I may be upset, the person conducting the interview will let my nurse know and the nurse will help me with the issues that made me upset.

BENEFITS THAT MAY OCCUR: I understand that I will be asked questions about my labor, delivery, and after delivery experience, which can be helpful for other Cuban women. This study will also help nurses and other healthcare workers understand the

childbirth experience for Cuban women. I understand that I will not be paid to participate in the study.

CONFIDENTIALITY OF SUBJECT IDENTITY/RESEARCH RECORDS: I understand that I do not have to participate in this study. I understand that I can stop participating in the study at any time and for any reason. If I decide I do not want to participate in the study or want to stop participating at any time it will not affect my care or the care of my baby in the hospital. I understand that no study information will give my name or the name of my baby and that code numbers will be used. Identifying data, such as my name, my baby's name and the informed consent form will be kept separate from the interview tapes and transcriptions. Only the investigator will have access to the information related to this study.

USE OF AUDIO EQUIPMENT AND SUPPLIES/ STORAGE OF STUDY TOOLS: I understand that all study materials will be kept in a locked storage area for five years at a location controlled by the investigator, after which time audiotapes will be clipped into 6 inch pieces and destroyed by crushing. Written material will be shredded.

TERMINATION OF PARTICIPATION: I understand that my participation in this study is entirely voluntary. I understand that I may refuse to participate or discontinue my participation at any time during the study without losing any benefits to which I am entitled. I understand that any information obtained as a result of my participation in this research will be kept as confidential as legally possible. I understand that my research records may be subpoenaed by court order or may be inspected by federal regulatory authorities.

I have had an opportunity to ask any questions about the research and my participation in the research, and these have been answered to my satisfaction.

I understand that I will receive a signed copy of this consent form.
I volunteer to participate in this study.

_____
Date

_____ _____
Participant's signature Investigator's signature

Any complaints or comments about your participation in this research project should be directed to Secretary, Committee for the Protection of Human Subjects, Office of Sponsored Programs and Research Services, The Catholic University of America, Washington, D.C. 20064; Telephone (202) 319-5218.

Appendix E

Institutional Approval

NCH Downtown Naples Hospital
350 Seventh Street N.
Naples, FL 34102
(239) 436-5000

NCH Healthcare System

NCH North Naples Hospital
11190 Healthpark Blvd.
Naples, FL 34110
(239) 552-7000

May 13, 2010

Jane Cox PhD, RN, PNP
720 5th Avenue South #201
Naples, FL 34102

RE: The Lived Experience of Becoming Mothers in 21st Century Hispanic Floridian Women

PI: Jane Cox, PhD, RN, PNP

Dear Ms. Cox:

On May 13, 2010, the NCH IRB met and approved the renewal of the above mentioned study for a period of 1 year. It was indicated that there were (29) patients enrolled in the study this past year and there were not any serious adverse events that were reported for the previous year. It was also indicated that there was no protocol or informed consent change.

This renewal covers a one year period and will need renewal in May of 2011.

If you require further assistance, please contact Kathy Ward, CIM; NCH-IRB Secretary (239) 436-5258.

Sincerely,

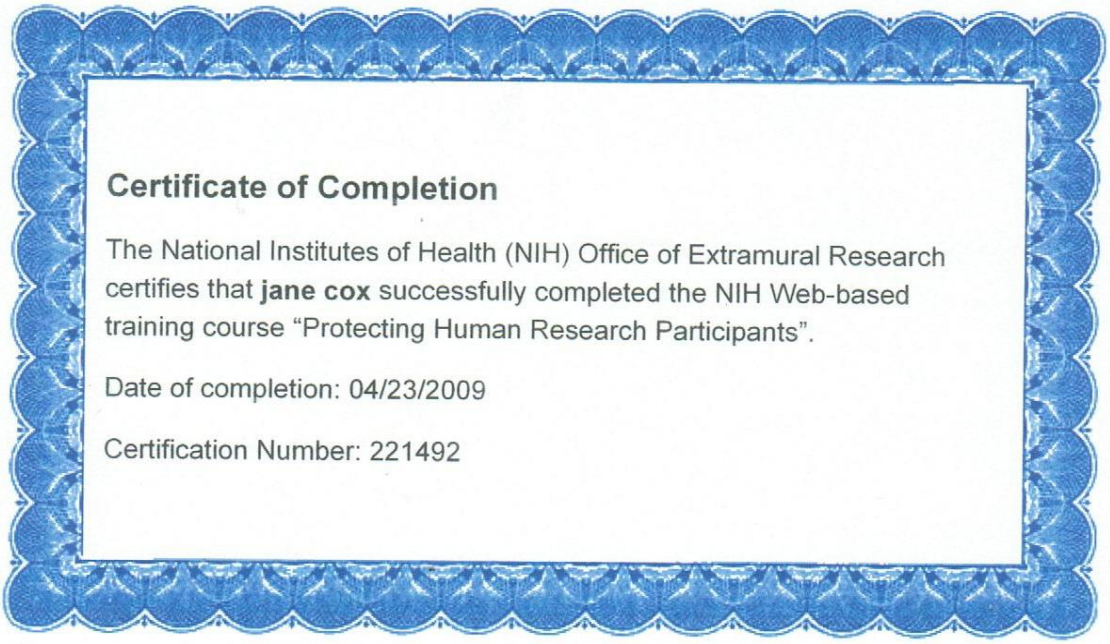
James Talano, MD
NCH-IRB Chair

Kathy Ward, CIM
NCH-IRB Secretary

APPROVED - NCH IRB
KWard, CIM 5/13/10

Appendix F

Certificate of Completion



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **jane cox** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 04/23/2009

Certification Number: 221492

Appendix G

ANA Standards of Practice

ANA Standards of Practice

Standard 1. Assessment

The registered nurse collects comprehensive data pertinent to the patient's health or the situation.

Standard 2. Diagnosis

The registered nurse analyzes the assessment data to determine the diagnoses or issues.

Standard 3. Outcomes Identification

The registered nurse identifies expected outcomes for the plan individualized to the patient or the situation.

Standard 4. Planning

The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

Standard 5. Implementation

The registered nurse implements the identified plan.

Standard 6. Evaluation

The registered nurse evaluates progress toward attainment of outcomes.

Appendix H

Standards on Culturally and Linguistically Appropriate Services

Standards on Culturally and Linguistically Appropriate Services

Standard 1

Healthcare organizations should ensure that patients receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3.

Healthcare organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4

Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner and during all hours of operation.

Standard 5

Healthcare organizations must provide to patients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient).

Standard 7

Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8

Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

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