The Childbirth Experiences of Native Born and Immigrant Women in Oneida County: A Preliminary Analysis

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Abstract

Recent academic and popular analyses of pregnancy and childbirth in the United States note two competing ideologies: one that values medicalization and one that critiques it. Proponents of both ideologies assert that their view provides the best outcomes for mothers and children, while empirical research indicates that women's perceptions of pregnancy and childbirth are more complicated, involving numerous contextual factors. Childbirth and pregnancy are even more complicated for immigrant women, as they face additional challenges navigating the health care system. In this preliminary report, we explore the past literature conducted on childbirth and pregnancy in the United States as well as the literature on immigrant populations. We then provide a statistical look at immigrant population in Oneida County as well as data on childbirth and pregnancy at the hospitals in the region. Finally, we lay out our proposed research plan to explore in depth the pregnancy and birth experiences of immigrant women in Oneida County.

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Introduction

In the United States, pregnancy and childbirth have been increasingly medicalized over the last century. Ninety-nine percent of all American births occur in hospitals (Jordan, 1993), though rates of home births have increased since the 1990s (MacDorman, Mathews, & Declercq, 2012). In the U.S., traditional midwifery, as *the* option as opposed to one of several options, has more or less died out in even the most marginalized American communities, such as the rural, African American community studied by Fraser (1998). During this period of transition, medical institutions and governments in the U.S. relied upon several tactics to disparage traditional midwifery: first, the reinforcement through institutional rhetoric, statistics, and legal action of various negative stereotypes about traditional midwives; second, through training programs for and attempts at the regulation of traditional midwives which suggested to both the midwives themselves and to the general public that traditional knowledge was outdated and in many cases simply wrong; and third, a constant valuation of modern medicine and technology as a means of progress.

Cartwright and Thomas (2001) track the emergence of a discourse of risk around pregnancy and childbirth, and the relationship between medical risk and cost-containment in American healthcare. The promise of control implicit in the management of risk appeals to nervous mothers-to-be and clinicians alike; for the latter, the promise of controlling risk introduces new implications from failure, including the much-feared malpractice suit. As a result, obstetric practices attempt to reduce risk "even in the absence of data supporting their routine use" (2001, p. 220). The gradual emergence of biomedicine as the sole source of what Jordan (1993) calls "authoritative knowledge" about reproduction came to seem legitimate over the course of the twentieth century. Like other forms of scientific-based knowledge, the development of modern gynecology and obstetrics appeared part of a natural evolution toward enhanced knowledge and technology.

In the United States, this trend has resulted in the widespread acceptance of what van Teijlingen (2005) calls the medical model of childbirth. According to van Teijlingen, the foundation of the medical model is the idea that "normal" childbirth must be supervised and controlled by medical professionals, who are able to step in at the first sign of pathology, because it is not possible to anticipate these problems. Most women in the United States today believe that the only safe place to have a child is in a hospital, due in large part to the widely disseminated risk reduction discourse that has been received and reinforced by generations of American women. The messages sent from these powerful institutions have been widely accepted by American women, particularly in the face of larger cultural obsessions with technology. Women often see hospitals as what Wendlund calls "sites of safety" for childbirth (2007). Because many American women accept the notion of pregnancy as a medical matter, sites staffed by medical practitioners seem logical places in which to give birth (Miller & Shriver, 2012).

However, in the late twentieth century, a small but growing minority of American women, mostly white, well educated, and middle-to-upper class, were forsaking physician-attended hospital births favor of the care of midwives in hospitals, independent birthing centers, or patients' own homes. Since this time, what was a fringe movement of sorts has entered the mainstream, with the critiques of larger numbers of American women echoing those of midwifery movements and feminist scholars. The 2008 documentary, *The Business of Being Born*, and the public embraces of midwife-attended births by celebrity mothers have intensified American interest in the "natural birth" trend (Pergament 2012). Like many other facets of American life, birth practices are increasingly framed as markers of identity and matters of choice, replete with rhetoric of "consumer rights" (Craven 2007).

Proponents of this ideal, which van Teijlingen (2005) terms the social model, argue that the medical model takes the control and agency of childbirth away from the woman and gives it to the doctor attending the birth. This can be seen in the very position of childbirth in the medical model – with a woman flat on her back pushing with her knees held up. This position shrinks the pelvis and often makes delivery more difficult for women, but allows for ease of access for her doctor. The social model would dictate that whichever position is most comfortable for the mother is the best, and so squatting is common, while sitting in a pool of water is another popular method. Another argument of the social model asserts that the emphasis in the medical model on supervision and technology often leads to unnecessary and dangerous interventions, which actually *increase* the risk to both woman and child. Lake and Epstein (2008) term this phenomenon the snowball effect of intervention – once a woman has the first epidural or pitocin injection, an eventual c-section becomes more likely.

This dichotomy of views has led to increasingly divergent beliefs about childbirth in the U.S. Proponents of the medical model assert that childbirth should occur at a hospital where supervision by medical professionals will ensure that intervention can be performed at the first sign of danger – at the end of the day, the goal is a healthy mother and child. Proponents of the social model argue that the birthing experience is just as important as the outcome, and therefore women are best served by a more holistic approach to childbirth. Advocates of both schools of thought believe that their models predict the best outcomes for women.

Research has suggested that the relationship between birth experience and outcomes is not so straightforward. Fox and Worts (1999) suggest that social context and support play a major role in how women view their birth experiences, while Miller and Shriver (2012) point to the importance of women's preferences. They point out that different women have different expectations, which are often constrained by their life circumstances. They posit that women's preferences are shaped by concerns of safety and risk, support, and desire to participate in the decision making process. Research indicates, therefore, that both the medical and social models of childbirth can lead to positive outcomes for women, with the intervening factor being the expectations and desires of the mother herself.

Childbirth Among Immigrants

In her seminal work about the birth experiences of women in a rural African American community, Fraser notes that the social model of childbirth was fueled by movements which "…are characterized by the force placed on a woman's and her family's freedom of choice" (1998, p. 177). In their introduction to *Pragmatic Women and Body Politics*, Lock and Kaufert write, "[W]omen's relationships with technology are usually grounded in existing habits of pragmatism . . . If the *apparent* benefits outweigh the costs to themselves, and if technology serves their own ends, then most women will avail themselves of what is offered" (1988, p. 2). Like the African American women studied by Fraser, many poor and foreign-born women, and their mothers and grandmothers before them, have had little say in the gradual demise of midwifery in their home communities. What is offered to them even today may pale in comparison to the options imagined by a more privileged mother-to-be as she crafts her "birth plan."[1] For economically and socially marginalized women, the available choice may only be whether or not to take advantage of various aspects of a lone model of care. Yet even when biomedical technologies are not fully available to women, they are often acutely aware of the medical model's ideals. Lock and Kaufert (1988) explain:

> Globalization has ensured that the majority of the world's people are aware, as never before, that other ways of being exist beyond the boundaries of their respective communities. This experience encourages reflection, heightens the possibility of a resistance to local social arrangements, or alternatively may lead to a reaffirmation of tradition (p. 5).

Still, in many parts of the world, the biomedical ideal has yet to be fulfilled. For migrant and refugee women who settle in the U.S., their new communities may present their first direct exposure to what they imagine to be high quality medical care. Therefore, immigrant women may be more likely to embrace the medical model because it is a symbol of status and prestige. However, research suggests that women's actual experiences of care are often shaped by a variety of other factors as well.

One of the biggest challenges that immigrant women face in their access to medical care is a linguistic barrier (Sargent & Marcucci, 1988; Jambunathan & Stewart, 2007; Niner, Kikanovic, & Cuthbert, 2013). Being unable to communicate with doctors and nurses while in labor can turn what could have been a positive experience into a nightmarish one. This linguistic barrier can be more problematic for refugee immigrants for two reasons. First, refugee women often speak languages whose use is relatively rare in the United States, and so finding translators can be especially problematic for the hospitals. That is, an immigrant woman speaking Spanish as a primary language is more likely to find someone who can communicate with her in her primary language than an immigrant woman who speaks Lao. Second, refugee women are often fleeing from traumatic experiences in their countries of origin, and the stress and pain of childbirth can exacerbate their distress. Niner et al. (2013) describe the experiences of a refugee woman who suffered hallucinations during her labor because of her past traumatic experiences in her home country. Her inability to communicate with the doctors and staff at the hospital to explain the situation eventually led the staff to physically restrain her while she was in labor to prevent her from harming them or herself.

Another challenge which is faced by many immigrant women, as well as native born women from racially marginalized and lower class groups, is a lack of preventative, prenatal, and postnatal care (Brubaker, 2007; Handler, Rosenberg, Raube, & Kelley, 1998; Lazarus, 1994). We tend to think about the birth experience as the experience of labor, but in truth continuity of care before, during and after the pregnancy is one of the most important things for women

[1] Childbirth educators began encouraging the use of written birth plans in the United States and England in the 1980s. The plans were designed to help women navigate instutitionalized, medicalized settings for birth and to communicate their preferences to caregivers (Kitzinger, 1992; Lothian, 2006).

(Lazarus, 1994). Again, immigrant women may face more difficulties in this respect than native born women because of a lack of access to biomedicine in their country of origin, as well as a lack of access to health care once they are in the United States. Prenatal care, in particular, can be especially important in determining an overall positive outcome (Handler et al., 1998).

Another difficulty that immigrant women face when giving birth in the United States is a lack of traditional components of care that they would receive in their country of origin. Research indicates that support during labor from medical staff, family, and friends can alleviate pain and anxiety, thus improving her overall experience (Fox & Worts, 1999). In some immigrant women's home communities, it may be common for birth attendants to work hand in hand with family and friends to provide support during labor. In a more medicalized setting, particularly if family and friends are not present, the woman may expect medical staff to fill that role. Miller and Shriver (2012) found that the women in their sample valued the freedom of choice and support that traditional birth attendants offered, while Niner et al. (2013) found that the women in their sample did not feel that the hospital staff provided the support they expected during their labor. This may especially be the case in the understaffed urban hospitals where many immigrant women give birth.

Finally, immigrant women, along with women of color, may face racism and discrimination in the health care setting. Brubaker (1997) found that race is an important factor to consider when investigating experiences within the health care system, as the experiences of women of color may differ significantly from those of middle-class white women. Immigrant status, along with race, is an important indicator of how the women are both perceived and treated by hospital staff (Niner et al., 2013).

Immigrants in Utica and Oneida County

Immigrants in upstate New York comprise a small but important segment of the population. They provided a population boom to dying urban centers, contribute to the economy, and create a global culture and economy. In Utica, immigrants represent 9.0 of every 1,000 residents, with the largest immigrant groups coming from Bosnia, the Ukraine, Burma, Belarus, and Vietnam (Regional Institute, 2008). 41% of the foreign born population in Oneida County is from Europe, 40% is from Asia, 17% is from the Americas, and only 2% is from Africa (See Table 1). 71% of the European foreign born population in Oneida County is from Eastern Europe, while 72% of the foreign born Asian population is from Southern Asia (See Tables 2 and 3). An important distinction of immigrants in Utica compared to the rest of New York is that 67% of immigrants in Utica are classified as asylum seekers or refugees, compared to 12% nationally and 10% in New York State. This is due, in large part, to the existence of the Mohawk Valley Resource Center for Refugees (MVRCR), which has brought a number of waves of refugees to Utica and the surrounding area. MVRCR is a resource that may impact immigrant women's experiences of pregnancy and childbirth, as its staff can serve as an intermediary between the women and the health care industry.

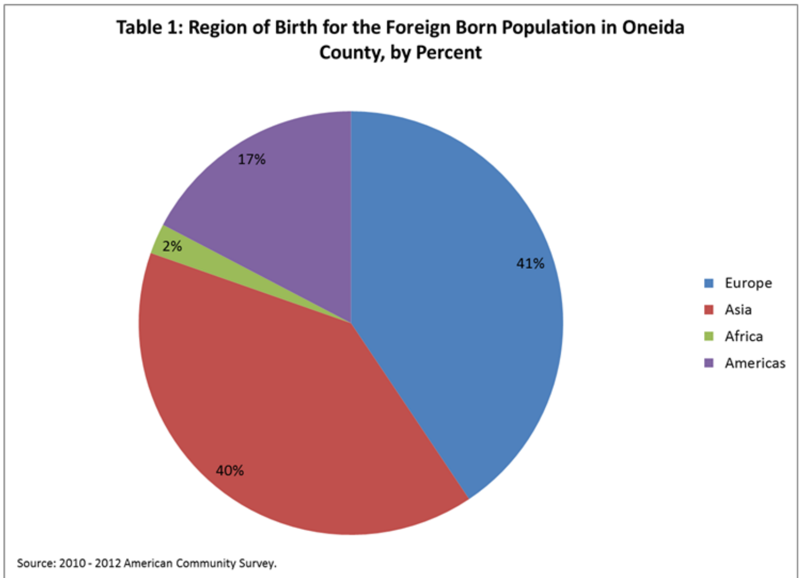


Table 1: Region of Birth for the Foreign Born Population in Oneida County, by Percent
17%
2%
41%
40%
Europe
Asia
Africa
Americas
Source: 2010 - 2012 American Community Survey.

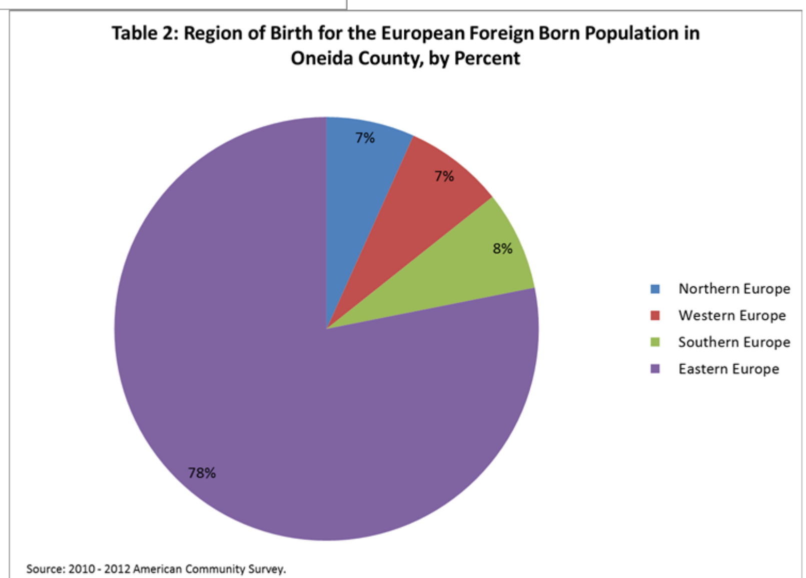


Table 2: Region of Birth for the European Foreign Born Population in Oneida County, by Percent
7%
7%
8%
78%
Northern Europe
Western Europe
Southern Europe
Eastern Europe
Source: 2010 - 2012 American Community Survey.

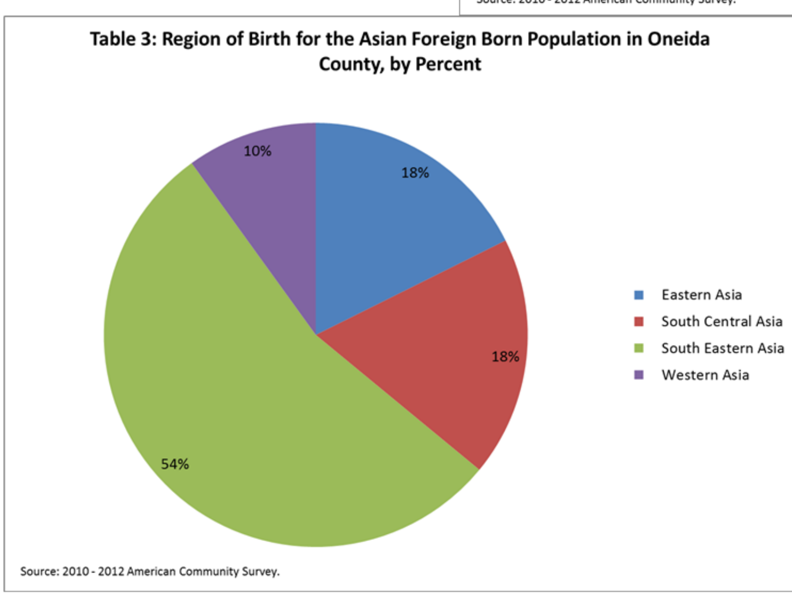
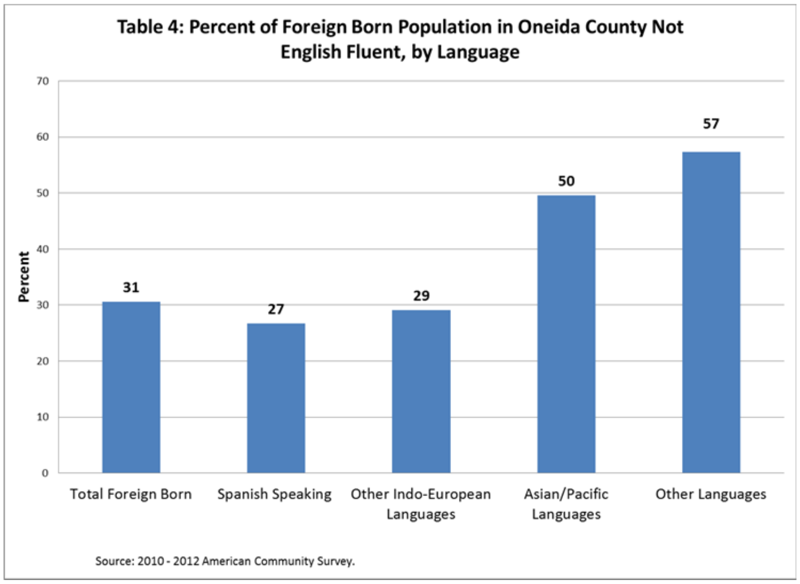


Table 3: Region of Birth for the Asian Foreign Born Population in Oneida County, by Percent
10%
18%
18%
54%
Eastern Asia
South Central Asia
South Eastern Asia
Western Asia
Source: 2010 - 2012 American Community Survey.

As English fluency is one of the most important barriers that immigrant women face in the health care system, it is important to note differences in English fluency by country of origin for immigrant women in Oneida County. The Bosnian and Ukrainian populations are the most likely to be English fluent at 71%, while those from Asia were only 50% likely to be English fluent, and only 43% of those from other countries were English fluent (see Table 4). This can likely be explained, at least in part, by time spent in the country. The waves of resettlement from Bosnia and Ukraine were earlier than those from Asian and other countries, and therefore the former groups have had more time to assimilate linguistically.



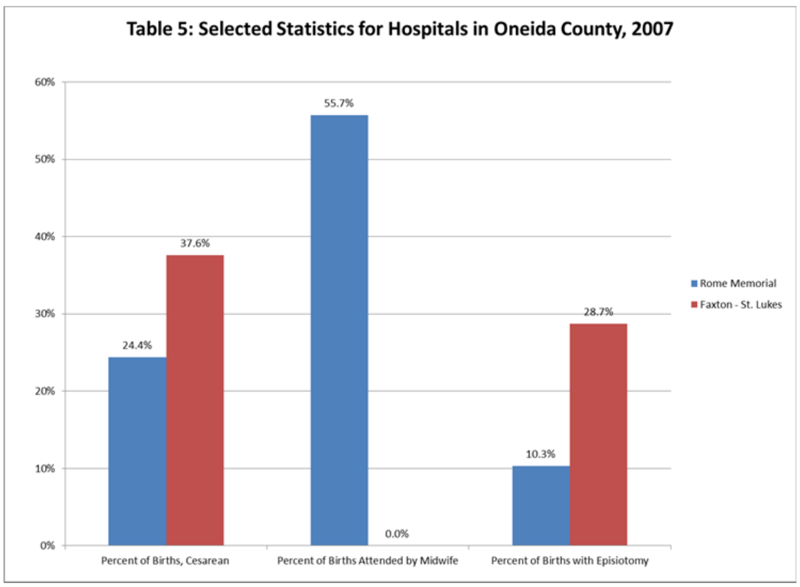
A Brief Look at Maternity Care in Oneida County

There are only two hospitals in Oneida County that have maternity wards. Therefore, women in the surrounding area have only two choices if they opt for a hospital birth, which approximately 99% of women in the United States do (Epstein & Lake, 2008; Jordan, 1993). Faxton-St. Luke's is located in the city of Utica, and Rome Memorial Hospital is located about sixteen miles away in the city of Rome. One practice, comprised of both physicians and midwives, attend all births at Rome Memorial, while attending privileges at Faxton-St. Luke's are shared by physicians from about a dozen obstetrics practices in Utica proper and in neighboring communities.

Table 5 presents selected statistics from these hospitals. Midwives attended no births at Faxton-St. Luke's, while 55.7% of births at Rome Memorial had a midwife in attendance. Faxton-St. Luke's had a cesarean section rate about one-third higher than Rome Memorial, and women giving birth at Faxton-St. Luke were 18.4 percent more likely to require an episiotomy. The differences in the available services and medical procedures conducted indicate that there may be significant differences between the birth experiences of women based on the hospital in which they give birth.

Yet the communities in which the hospitals are located may also play a significant role. Although the obstetrical/midwifery practice that attends births at Rome Memorial is located in

Rome itself, it also has a satellite office in the Utica suburb of New Hartford, likely attracting middle-class women from that community and others close by. Presumably, some of those women seek out this practice for its certified nurse midwives (CNMs). The city of Rome itself is more ethnically homogenous than Utica, with significantly smaller non-white populations (2000 Census). Furthermore, median household income in Utica is nearly $10,000 less than in Rome. However, Rome Memorial also serves many low-income women who become patients through the hospital's Prenatal Care Services; in 2011, more than 40% of women who delivered at the hospital had been patients at PCS (Rome Memorial, 2012). The administration of Faxton-St. Luke explains that its higher than average c-section rate reflects the demographics of its patient population (Roth, 2013). The hospital's chair of obstetrics and gynecology has pointed to a multicultural patient population with unstable access to and familiarity with biomedical care, including prenatal care, as well as to a higher than average frequency of risky conditions like diabetes and high blood pressure in the area's general population (Roth, 2013).



Proposed Research

We intend to conduct intensive interviews with a sample of native-born and immigrant women in Oneida County to investigate their perceptions of childbirth. In the course of our research, we hope to answer a number of important questions. First, what factors shape the perceptions of women in Oneida County who have recently given birth? Past research indicates that a variety of factors, including the expectations of women, English fluency, and social support play a major role in a woman's perceptions of birth, regardless of what type of birth she has. What factors do the women in Oneida County find important? How do experiences vary between the two hospitals in the area?

Second, how are the experiences of the immigrant population different from those of the native-born population? Research indicates that immigrant populations face a number of obstacles when interacting with the medical system, and these problems may be exacerbated for refugee immigrants, which is the majority of immigrants in Oneida County. What unique obstacles, if any, do immigrant women face when giving birth in Oneida County?

Finally, how do the experiences of the women in our sample fit into the medical and social models of childbirth? These two disparate views are often presented in opposition, but recent research shows that different women may gravitate towards different types of childbirth experiences. Following Lock and Kaufert's (1988) argument about the pragmatism of women's relationships with technology, many women likely select elements from both models, reflecting nuanced and varied experiences and ideologies.

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