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Becoming a Mother Across Cultures: Challenges Nurses Experience Teaching Prenatal Care to Recent Immigrant Sudanese Women

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Running head: BECOMING A MOTHER ACROSS CULTURES

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This is to certify that **Cathy Miller** has successfully defended her Graduate Project entitled **"Becoming a mother across cultures: Challenges nurses experience teaching prenatal care to recent Sudanese immigrant women"** and fulfilled the requirements for the Master of Arts in Nursing degree.

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ABSTRACT

Becoming a Mother Across Cultures: Challenges Nurses Experience Teaching Prenatal Care to Recent Immigrant Sudanese Women

Cathy E. Miller

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__X__Field Project

The purpose of this project is to provide an overview of Maternal Role Attainment (MRA) theory as discussed in nursing literature and explore how separation from culture may affect the transition to becoming a mother. Nursing issues related to teaching and supporting recent immigrant Sudanese women will also be identified.

MRA is a complex developmental and transitional experience for women. In the United States, many women take on this role with the support of their culture, family, friends and community. However, over the past few years, the local public health agency has served a small number of immigrant pregnant Sudanese women in southeastern Minnesota. These women experience transition to motherhood without the support of their culture, family, friends and community. Nurses who serve this population are experiencing a lack of knowledge about how culture may influence MRA that is compounded by a lack of resources to educate and support these women in their transition to becoming mothers.

This project focuses on the shared experiences of recent immigrant Sudanese women having their first baby in southeastern Minnesota.

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Chapter 1

Background of project

The population of the United States continues to become more diverse. According to the census information for 2000, among the one million immigrants to the Untied States, more than half were women of childbearing age (www.census.gov). Consequently, nurses nationwide are increasingly encountering families from other cultures (Callister, 2005). This trend is also true for public heath nurses in southeastern Minnesota who increasingly find themselves working with women from different cultural backgrounds. Often these women are experiencing their first pregnancy. The nurses who work with these women make a plan of care that educates the first time pregnant woman about topics such as fetal growth and development, nutrition, breastfeeding, labor, delivery and newborn cares. Often the use of an interpreter is necessary to facilitate teaching and connecting the woman to community resources.

Frequently, immigrant women who settle here have the support of others from their culture, who live in the same geographical area and share similar language, culture and beliefs. For women that are part of a small minority group, such as the Sudanese here in southeastern Minnesota, sources of support are difficult to access, both for the woman and the nurse. In the 2000 Olmsted County census, only 67 people identified themselves as being of Sudanese ancestry (www.census.gov). One may speculate that individuals in this group experience isolation and loss of connectedness that may have an impact on the women.

Taking on the maternal role

The birth of a first child is a time of enormous change and vulnerability (Sanders, 2006). When these women are also in the process of transitioning from one country to

another, one culture to another, often middle class to poor, rural to urban living, and woman to mother they are especially vulnerable (Franktman, 1998; Meleis, Sawyer, Im, Messias & Schumacher, 2000). Meleis et al., (2000) points out that many of these transitions can occur concurrently leading to increased stress and uncertainty.

After caring for several pregnant immigrant Sudanese women and reflecting on field notes, the following key questions emerged over time:

- How do first time pregnant Sudanese women learn to become mothers?
- What are some of the cultural aspects related to transitioning to motherhood?
- How can nurses support women during their pregnancy in taking on the new role of mother?
- What are the issues nurses encounter providing culturally relevant education and support?

Madeleine Leininger's Sunrise Enabler is used to provide guidance in examining the issue of maternal role attainment, cultural diversity and transcultural nursing practice. Leininger (2002) states that "learning from people about their culture care values, beliefs and lifeways" (p. 117) is a way to understand their world and their needs. This knowledge is necessary to guide nursing care in a culturally competent way.

The purpose of this project is to draft an article to be submitted for publication to add to the body of knowledge related to nursing care of recent immigrant pregnant Sudanese women and their families. According to Meleis et al. (2000), nurses are in a position to provide care not only to culturally diverse women and their families; they are also in a position to help prepare the woman for an impending transition such as motherhood.

Chapter 2

Literature Review

The theory of Maternal Role Attainment as developed by Rubin and later expanded by Mercer, identified maternal tasks which a women moves through in taking on the role of mother. Meleis introduced the concept and framework of maternal role attainment as a life transition. She identifies other transisitons that may take place concurrently and may affect MRA as a life transition.

Maternal Role Attainment

Riva Rubin (1984) developed the theory of Maternal Role Attainment (MRA) in the 1960s. She was a nurse researcher with experience in maternity care. Rubin developed the theory through observation and nurses field notes of the nurse's interactions with mothers early in their pregnancy and followed them until one month postpartum. She integrated those observations into a theory about the development of maternal identity which she considered the end point of MRA. Rubin identified four maternal tasks that a mother progresses through: (a) seeking safe passage for self and baby, (b) ensuring the acceptance of the baby and self by other, (c) binding-in (bonding with fetus), and (d) learning to give of self. Rubin also identified a woman's mother as being her greatest influence or role model in taking on the maternal role. Rubin believed that maternal identity evolved over time and growth of the baby. Each child bearing experience is different and the mother works to incorporate each birth into her self and family system. More recent work by Mercer (2004) and Gichia (2004) also reinforces the significance of a woman's mother.

Building on Rubin's work, Ramona Mercer, (2004) a student of Rubin's, studied mothers of varied ages and experiences (women with more than one child) and developed the

practice oriented theory of MRA. It was designed as a framework for nurses to provide appropriate interventions to assist non-traditional mothers to attain a strong maternal identity. Mercer studied pregnant women and their infants through the first eight to twelve months postpartum. Mercer (2004) used Thornton and Nardi's four stages of role acquisition. Those stages are: (a) anticipatory (begins before pregnancy and continues during pregnancy), (b) formal (begins at birth and continues with mother seeking out expert advice and begins care-taking), (c) informal (mother develops her own way of mothering independently from other, (d) personal identity (satisfaction and confidence in maternal role). Mercer (2004) also identified variables that influence MRA and have some influence over the transition including maternal age, income, social support, temperament, self-concept, stress, perception of infant and maternal health. Infant variables include temperament, appearance, health status and responsiveness.

Role Transition

Meleis et al. (2000) introduced the concept and framework of maternal role attainment as a life transition. Mercer (2004) also supported that a woman's transformation in becoming a mother is congruent with psychosocial developmental and transition theories. Two classifications of transitions were identified by Meleis et al. (2000). They are: (a) developmental/lifespan (which includes pregnancy, childbirth, adolescence, parenthood, menopause, aging and death), and (b) social/cultural (marriage, divorce, migration, displacement, retirement and family care giving).These transitions have the potential to be a vulnerable time in one's health status (Meleis et al, 2000; Foss, 1996). Because transitions unfold over time, nurses have the opportunity to facilitate health outcomes with early assessment and intervention. With the transition to motherhood, nurses can provide

anticipatory preparation and guidance to facilitate the transition process (Meleis et al., 2000). Immigrant women may be dealing with multiple transitions at the same time. Examples of those transitions would include; immigration, pregnancy and childbirth, learning a new language, change in economic status, and loss of cultural and family support (Callister, 2001; Meleis et al., 2000). Immigrant women experiencing multiple transitions may be at increased risk for cultural conflicts, isolation, and depression which has the potential to impact their mothering role (Koniak-Griffin, Logsdon, Hines-Martin & Turner, 2006).

Immigration and MRA

Immigration adds to the level of complexity to maternal Role attainment. Lauderdale (2003) states:

> Great variations exist in the social class, ethnic origin, family structure and social support systems in the United States and Canada. Despite their differences many providers assume that the changes in status and rites of passage associated with pregnancy and birth are experienced similarly by all people. (p. 97)

The impact of immigration on this process is often overlooked.

There is very little literature related to MRA and the experience of immigrant women in the United States. Searches were done using CIHNAL and Academic Search Premier using the words, Sudanese immigrant woman, pregnant Sudanese immigrant, MRA and pregnant Sudanese women as late as April 10, 2008. There were no articles related to pregnant Sudanese immigrant women coming to the United States. There is literature related to maternal role attainment of 'diverse' women in the United States. The literature includes teenaged mothers, African American women and Hispanic immigrant women.

Gichia (2000) in work with African American, urban, poor women found that preparation for motherhood is a culturally grounded process that is learned from the family of origin. The woman's own mother, older female relatives and family influences a woman in role expectations well before adolescence.

While teenaged mothers are very ego-centric and are at a developmental stage of separation from their parents, a study by Kemp and Rosbridge, (1990) found that teenaged mothers (Hispanic, African American, and Caucasian) were able to develop a more secure attachment to their infant when they had the support of their family both prenatally and after the infant's birth.

In a study of Thai immigrant mothers living in Australia (Liamputtong & Naksook, 2003), cultural differences (immigrant vs. dominant culture) play a significant role in motherhood and the immerging role of mothering. Thai mothers felt isolated from their culture and the society they lived in, were aware of different childrearing and child disciplinary practices, and felt a strong need to preserve their Thai cultural ways. Liamputtong and Naksook advise looking at motherhood from a cultural perspective to provide better support for women becoming mothers in new lands. Motherhood and mothering is found to be more complex when it is combined with migration (Meleis, 2000; Liamputtong & Naksook, 2003).

The above research supports the significance of assessing cultural factors to determine what role culture may play in pregnancy, childbirth, illness and health. Also what role does culture play in maternal role attainment?

Chapter 3

Review of Practice Model

Leininger's Theory and Model

How do nurses gain knowledge related to other cultures? Is there a way to discover what is meaningful and apply that to nursing care of pregnant women from diverse cultures? Madeline Leininger developed her Theory of Culture Care Diversity and Universality in order to "establish a substantive knowledge base to guide nurses in discovery and use of the knowledge in transcultural nursing practices" (2006, p. 310). Care and caring are basic and essential human needs; but that care needs to be specific and appropriate to various cultures. Her theory "discovers culture care meanings, practices and factors influencing care" (Leininger, 2002, p. 190). Some factors that may influence care are; history, religion, economics, environment, cultural values, kinship, and gender. Leininger developed the Sunrise Enabler as a conceptual guide for nurses entering into the world of their client to discover significant information to provide holistic, culturally specific care. The purpose of the model and theory is to guide the nurse in discovering "culturally based emic (generic or folk) and etic (beliefs and practices of the nurse or other professional) care phenomena that are meaningful" to both the nurse and the client (Leininger, 2007, p. 9). Emic (generic knowledge refers to the learned, indigenous, traditional folk knowledge and practices that "provide assistive, supportive and enabling acts for others with current or anticipated health needs in order to improve wellbeing or to help with dying" (Leininger, 2002 p. 76). Etic (professional) care knowledge refers to non-indigenous, formally learned professional care knowledge and practices (Leininger, 2007, p. 9). The ultimate goal of the

theory and model is to "establish a body of transcultural nursing knowledge for current practices and for future generations of nurses in a global world" (Leininger, 2002, p. 76).

Another important factor in Leininger's theory and model is discovering universalities (commonalities) and diversities (differences). "Discovering what is diverse about care among cultures and what was universal" was an entirely new concept in nursing (Leininger, 2007, p. 8). She goes on to state that this knowledge is "essential to provide therapeutic, culturally congruent care and to prevent cultural stresses and conflict and the imposition of practices often evident in caring for diverse cultures" (p. 7).

The Sunrise Enabler contains three modes of nursing actions and decisions to provide culturally congruent care. These three theoretical modes change traditional intervention practices into therapeutic, culturally based ones. The modes for transcultural care decisions and actions are; 1) culture care preservation and/or maintenance, 2) culture care accommodation and/or negotiation, and 3) culture care repatterning and /or restructuring (Leininger, 2002, 2006). Leininger predicted that the use of culturally based specific care values, beliefs and practices would assure and maintain culturally congruent care. The care decisions or actions would be developed in collaboration with the client (cultural informant) and would guide nurses away from using inappropriate and or routine practices that might not be culturally acceptable to the client (2007).

Background of Sudanese Immigrants

To have a better understanding of the Sudanese people, it is helpful to know something of their country. Sudan is Africa's largest country and is among the poorest. Its citizens are the least literate in the world (World Health Organization, 2000). The people in Sudan have endured many years of civil war, famine, religious and political persecution.

Because of the civil war that has been ongoing since its independence from Britain in 1965, the Sudanese have become refugees to neighboring countries in Africa and around the world (see Appendix A). The Sudanese have been accepted for resettlement to the United States since 1990 and have been settling in southeastern Minnesota since the late 1990s (www.census.gov). The number of refugees in southeastern Minnesota continues to be small and isolated from larger Sudanese populations.

Case Study

"Betty" (not her real name) was the first Sudanese woman that this author met and provided home visits for the duration of her pregnancy. She was referred by a local clinic that had identified her as being an at-risk pregnant woman. Her risk factors included first pregnancy, non-English speaking, less than high school education and a recent immigrant. An Arabic speaking interpreter was used during home visits who was a woman from the Sudan and had given birth to children both in Africa and the United States. She was employed by the local public health agency. The interpreter was always present for home visits. When we arrived at the apartment together, Betty always greeted us at the door with a smile, and invited us in. The apartment was well kept but was sparsely furnished. There were two pictures on the wall in the living room: one of Jesus and a wedding picture of Betty and her husband on their wedding day four months earlier in Egypt. Betty and her husband arrived in the United States two months before our first home visit and three months after being married. They lived in an apartment complex where it appeared that they were the only Sudanese people.

Betty wore a traditional caftan and a turban-like scarf around her head, covering her hair. She was very shy (my interpretation), had down-cast eyes and made very little eye

contact. She rarely asked questions during our home visits, with the exception of asking if this author was married and had any children. Betty's husband had a full time job, but no health insurance. He was only present at the beginning of one home visit, but left the room early during the visit. After each home visit, I would consult with the interpreter about my impressions and perceptions about the visit and ask for feedback from her about the client's noticeable lack of questions or concerns about the prenatal teaching. It was hard to judge if Betty comprehended the information she was receiving and if it was meaningful to her.

At that time of the initial home visit, the assessment tool used to guide prenatal teaching did not address the cultural life ways and traditional (emic) knowledge of the client. It was the lack of response to my teaching and the lack of knowledge about my client that inspired this author to keep a journal of observations, reflections and questions about how pregnant Sudanese immigrant women might be better served.

According to Leininger (2002), "the Sunrise Model is an invaluable guide to discover new knowledge or to confirm knowledge of cultural informants" (p. 82). Looking back on those early home visits and visits made to other pregnant Sudanese women, this author made some observations using the Sunrise Enabler and exploring three factors of the model; kinship and social factors, cultural values and lifeways, and economic factors. The information gained may explain why some nursing interventions did not work well and what assumptions might have contributed to ineffective nursing interventions.

Kinship and social factors

It appeared that Betty and her husband valued being together as a family in this country. Cooperation with in the family group is important: the interest of the family is a priority over personal interests (Kemp & Rosbridge, 2005). She described being away and

apart from her family, some of which were still in Egypt. She spoke to her mother and sisters by phone as often as she could. When asked about women friends in the area, she said that she hadn't made any close friends yet. It was likely that she was experiencing isolation. She and her husband attended a local church with other Sudanese families. This was the only socialization time she usually had to visit with other women. From this author's experience with other Sudanese women, Betty may also need to consider what tribe a Sudanese woman was from to know whether or not a new acquaintance may be a potential friend or enemy. Tribal rivalries are sometimes still very important even after resettlement in another country. Because of the history of religious conflict in the Sudan, she needed to associate herself with other Christians not Muslims. This is not considered an important factor for a casual meeting but could become an issue later.

According to Betty, gender roles are very specific for men and women and she and her husband found comfort in maintaining those traditions. Women's work is to take care of her family, raise children and care for the home. Pregnancy and childbirth are female oriented and while the husband may provide support, it is the women's female relatives that support the pregnant woman and teaches her what she needs to know about pregnancy, childbirth and caring for the baby (Kirdli, 2000) .

Cultural values, beliefs and lifeways

In the Sudanese cultural tradition, the family is held in the highest regard. There is deep respect for authority and elders. Religion and its practice are important. Having faith, praying, and fellowship with others are valued (Kemp and Rosbridge, 2005).

Culturally, pregnancy is seen as a natural, noticeable state of well-being. Betty and her husband didn't have much experience with preventative medicine. Health care was not

thought necessary unless there is a problem or complication. Betty stated that when a Sudanese woman is pregnant, she receives support from her family. That support is maintained by her relatives helping with household chores such as cooking, cleaning or taking care of the other children so the pregnant woman can rest. This lack of support can create conflicts between what is traditionally expected and what will actually happen. While a large family is valued (many children), Betty questioned how many children she and her husband could afford to support. She said that it was much easier (and cheaper) to have a large family back in the Sudan. This also provides another potential area of conflict with Betty anticipating fulfilling the traditional role of mother by staying home to care for her infant against the reality of needing to go to work to supplement the family's income while leaving her infant with someone other than a family member.

Economic Factors

Betty's husband works, but does not have health insurance for himself or Betty. Betty was covered by state funded medical coverage until 6-8 weeks postpartum. An unexpected illness could be a hardship for this family. Because the family still values traditional gender roles, Betty wants to stay home with her baby and not go out and look for work to supplement the family's income. They live in low-income housing, buy food and some household items, but have little left over for other necessities. Paris and Bronson (2006) found that while many refugees come to America to improve their economic standing, most experience impoverished conditions and lack access to resources that may improve their resettlement.

The information provided in the three previous factors is an example of what kind of cultural information may need to be included when planning client care. In the next chapter,

Leininger's three modes of nursing care actions will be discussed as a guide to help nurses to provide congruent, meaningful nursing care.

Chapter 4

Discussion

Transcultural Care Decisions & Actions

Leininger's three modes of nursing care actions or decisions help the nurse provide appropriate, congruent and meaningful nursing care that is decided jointly by the nurse and client. In Betty's case, Culture Care Preservation and/or Maintenance refers to what traditional lifeways the nurse can continue to support that will help the client maintain a sense of cultural connectedness. When Betty was asked by this author, "if you were in Africa with your family, how would you learn about pregnancy and childbirth?" This author was looking for a way to acknowledge that it was understood that Betty had knowledge and different ways of being other than what this author knew and have experienced. Locsin (2000) suggests that through inquiry, nurses can acknowledge differences while building on similarities to promote understanding of human beings as persons. By demonstrating a desire to learn what was important to her, a safe place was made for dialog and learning that was reciprocal. Eventually we were able to negotiate that she would still ask for support and information form her mother and other relatives (via phone conversations) but that the nurse was now going to be the "elder woman" from another village who would give advice and pass on knowledge.

Culture Care Accommodation and/or Negotiation refers to provider care actions or decisions that help one adapt or negotiate with others for culturally congruent care. This was demonstrated by this author by acknowledging and accepting that gender roles need to be respected. Just because a family has left their culture and country, does not mean that traditional values have been left behind also. While labor and delivery teaching is (in this

country) traditionally done with men and women present, Betty was not comfortable attending classes with or without her husband. She was also not willing to seek information from someone that she did not know (perinatal educator). Betty and this author watched videos, and with the help of the interpreter, were able to provide her with an overview of labor and delivery. Also it was not assumed that the husband would participate in labor and delivery at the hospital. Plans were discussed with Betty that she needed to ask for an interpreter at the hospital and that a nurse (female) would be able to provide some comfort and support with the husband participating as he was able.

Culture Care Repatterning and/or Restructuring refers to helping the client change or modify their lifeways for beneficial health care outcomes. Betty had little opportunity for preventative health care in the Sudan. While the Sudanese culture values Western medicine, medical care is not thought necessary unless there is a problem or complication (Kridli, 2000). Her culture values pregnancy as a natural time in woman's life that reflects her good health and fertility. The need for medical care during pregnancy is hard to justify when a woman is healthy (Kridli, 2000). Betty needed reassurance that her pregnancy was going along smoothly, even though she was seeing the doctor monthly. Betty understands that someone went to the doctor when they were sick. How did going to the doctor monthly preserve the health of her and her baby?

Even though it appears that some accommodation was made on the part of the client and the nurse, that benefited the client, the resources did not seem to fit the reality of the client's situation.

Chapter 5

Reflections, Conclusion, and Recommendations

Reflections

Many factors related to cultural traditions and lifeways can influence the effectiveness of nursing care. Language and communication are examples of the barriers that need to be overcome; whether that communication is spoken, written, listened to or viewed. Even with the use of an interpreter, there can still be miscommunication and a lack of meaningful dialog between the nurse and the client.

In providing teaching to pregnant Sudanese women, this author was always mindful of the lack of appropriate cultural resources available to Sudanese women. The videos available were generally of Caucasian women and few women of color. None of the videos were in Arabic. All printed information was in English. The small number of Sudanese women served here in southeastern Minnesota makes finding and purchasing appropriate materials hard to justify with funding sources continuing to be stretched. This author located some free printed material from the U.S. Committee for Refugees and Immigrants (www.refugees.org) on pregnancy. The handout is one page, front and back and pertains to going to the doctor for prenatal care, eating right and avoiding harmful substances. The handout is printed in Arabic, with further internet sources printed in English. This resource was welcomed, but lacking in information about labor and delivery, breastfeeding, and postpartum care. If the Sudanese woman is illiterate, this printed information is not helpful. Another resource that is also available on line and free was from a partnership of Mount Carmel Health, Ohio State University Medical Center and OhioHealth (www.healthinfotranslations.org). The information sheets were printed in English and Arabic

and offered more information about pregnancy, birth and breastfeeding. Again if the client is not literate, this won't be helpful. However, if the client is able to read, this is important information that the nurse can leave with the client to share with her partner and others. Having the information printed in English gives the nurse a chance to preview the information for accuracy and content.

Another area of concern is the lack of cultural information about working with Sudanese families. Leininger (2006) discussed many issues pertaining to a refugee family that she recently sponsored in Nebraska. The issues such as safe housing, income and connecting to resources could pertain to any immigrant or refugee family. The information she was able to gather over a period of time while working with the family revealed issues such as trauma, hunger and safety that were continuing to impact this family here in the United States even though they were not currently experiencing it at the time. Using Leininger's theory and Sunrise model to discover what may remain hidden demonstrates that the practice of gathering cultural information and using it to direct the nursing process is essential.

According to Mercer (1985), "mothering behaviors reflect the common beliefs about what mothers should do" (p. 203). What are the common beliefs and behaviors for Sudanese women and how do they influence becoming a mother?

This author visited another pregnant Sudanese woman over a period of 10 months, starting early in her pregnancy and following her until several months after the birth of twins. She was put on bed rest early in her pregnancy which increased the frequency of my home visits to her. This woman spoke English, had only been in the United States for a few months, was married, and experiencing her first pregnancy. On one of my home visits, this

author decided to use a tool that is meant to provide anticipatory guidance for the pregnant woman. The tool allows for discussion on the expectations of motherhood and to reflect on the kind of mother she wants to be by reviewing Motherhood Myths (a set of true/false questions) developed by Solchany (2001). Its use with diverse cultures has not been studied. Two of the questions we reviewed were, "mothers should be with their babies 24 hours a day for the first three months" and "mothers have to pick up their crying babies immediately". The answers to both those questions from this author's perspective (and the developer of the tool) are false. But from my client's cultural perspective, she expressed that mothers are responsible for their children and it is up to them to be with their children to care for them and protect them at all times. She already had an idea about what a mother looks and acts like (role expectations and responsibilities) which is a component of maternal role attainment. Perhaps it would be helpful to ask our clients what a competent mother looks like and what does she do?

Conclusion

The research on MRA is largely based on white middle class women, which becomes the "prevailing measuring stick by which all mothers are measured" (Koniak-Griffin, et al., 2006, p. 672). Koniak-Griffin et al. proposes that the role of mother is learned and influenced by both her cultural environment and her culture of origin. Cultural displacement has an impact on maternal role attainment and the many transitions that she may need to work through. The pregnant woman may struggle to integrate both cultures while taking on the role of mother. Without knowledge about a woman's culture, the nurse may be ineffective in supporting the transition process and providing guidance.

culturally congruent way, PHNs can help women identify the role expectations and responsibilities of becoming a mother that also supports the transition process and is specific to a woman's needs.

As nurses, we need to be aware of our own cultural beliefs and values and make sure our client's needs are not overshadowed by our own needs and professional care practices. We also need to remember not to generalize information about cultural groups. What may be true for one person may not be true for another person from the same culture.

Making nursing care actions or decisions based on the cultural (emic) knowledge and the needs of the client in partnership with the nurses' (etic) knowledge and resources will guide the nurse away from what is inappropriate or non-therapeutic, benefiting the nurse and the client.

Additionally, having an understanding of a cultural group provides the nurse with a knowledge base upon which she can become an advocate to guide nursing practice and possibly affect change in public policy related to health and reimbursement issues of the immigrant and refugee families our state serves. Providing services that include helping a woman become confident in her role as a mother has the potential to affect a secure mother-infant attachment, produce a confident, secure child, who then has the potential to become a well adjusted human being.

Because cultural care assessments have a different emphasis from traditional physical and mental health nursing assessments, this author proposes that a cultural assessment be completed with every pregnant woman along with the traditional assessment (Leininger, 2002). Asking the following questions on a cultural assessment would be helpful in learning more about how culture may affect becoming a mother. (1) If you were with your family now, how would you learn about pregnancy and preparing for birth? (2) What kinds of things would you need to learn about? (3) What kind of activities do mothers do? (4) What kind of activities do fathers do? (5) Are there any traditional foods or medicines that you are using now? (6) How can the nurse support you through your pregnancy?

Recommendations

Further research needs to be conducted to improve the understanding of MRA across diverse cultural groups and how concurrent role transitions may put a woman at risk for role strain. Also insight into what nursing interventions facilitate role transitions would be helpful. This research will also add to the body of transcultural nursing knowledge and may ultimately guide practice.

In an early study by Mercer (1984) she proposed that parenting support groups would be a valuable tool to support women who find themselves isolated and lacking support during pregnancy and the first year postpartum. The group would be especially helpful with routine information about normal growth and development and every day concerns of new mothers. Ideally, this group would be culture specific and targeted to woman who lack family and community support.

Home visitation by public health nurses (PHNs) to provide support and education during the prenatal and postpartum period may be an effective means of support. In a

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Appendix A

Map of Sudan, Africa

Appendix B

Draft of Article

Becoming a Mother Across Cultures: Challenges Nurses Experience Teaching Prenatal Care to Recent Immigrant Sudanese Women

Abstract

The purpose of this project is to provide an overview of Maternal Role Attainment (MRA) theory as discussed in nursing literature and explore how separation from culture may affect the transition to becoming a mother. Nursing issues related to teaching and supporting recent immigrant Sudanese women will also be identified.

MRA is a complex developmental and transitional experience for women. In the United States, many women take on this role with the support of their culture, family, friends and community. However, over the past few years, the local public health agency has served a small number of immigrant pregnant Sudanese women in southeastern Minnesota. These women experience transition to motherhood without the support of their culture, family, friends and community. Nurses who serve this population are experiencing a lack of knowledge about how culture may influence MRA that is compounded by a lack of resources to educate and support these women in their transition to becoming mothers.

This project focuses on the shared experiences of recent immigrant Sudanese women having their first baby in southeastern Minnesota.

Background of Project

The population of the United States continues to become more diverse. According to the census information for 2000, among the one million immigrants to the Untied States, more than half were women of childbearing age (www.census.gov). Consequently, nurses nationwide are increasingly encountering families from other cultures (Callister, 2005). This trend is also true for public heath nurses in southeastern Minnesota who increasingly find themselves working with women from different cultural backgrounds. Often these women are experiencing their first pregnancy. The nurses who work with these women make a plan of care that educates the first time pregnant woman about topics such as fetal growth and development, nutrition, breastfeeding, labor, delivery and newborn cares. Often the use of an interpreter is necessary to facilitate teaching and connecting the woman to community resources.

Frequently, immigrant women who settle here have the support of others from their culture, who live in the same geographical area and share similar language, culture and beliefs. For women that are part of a small minority group, such as the Sudanese here in southeastern Minnesota, sources of support are difficult to access, both for the woman and the nurse. In the 2000 Olmsted County census, only 67 people identified themselves as being of Sudanese ancestry (www.census.gov). One may speculate that individuals in this group experience isolation and loss of connectedness that may have an impact on the women. taking on the maternal role.

The birth of a first child is a time of enormous change and vulnerability (Sanders, 2006). When these women are also in the process of transitioning from one country to

another, one culture to another, often middle class to poor, rural to urban living, and woman to mother, they are especially vulnerable (Franktman, 1998; Meleis, Sawyer, Im, Messias & Schumacher, 2000). Meleis et al. (2000) points out that many of these transitions can occur concurrently leading to increased stress and uncertainty.

After caring for several pregnant immigrant Sudanese women and reflecting on field notes, the following key questions emerged over time:

- How do first time pregnant Sudanese women learn to become mothers?
- What are some of the cultural aspects related to transitioning to motherhood?
- How can nurses support women during their pregnancy in taking on the new role of mother?
- What are the issues nurses encounter providing culturally relevant education and support?

Madeleine Leininger's Sunrise Enabler is used to provide guidance in examining the issue of maternal role attainment, cultural diversity and transcultural nursing practice. Leininger (2002) states that "learning from people about their culture care values, beliefs and lifeways" (p. 117) is a way to understand their world and their needs. This knowledge is necessary to guide nursing care in a culturally competent way. According to Meleis et al. (2000), nurses are in a position to provide care not only to culturally diverse women and their families; they are also in a position to help prepare the woman for an impending transition such as motherhood.

Literature Review

Riva Rubin (1984) developed the theory of Maternal Role Attainment (MRA) in the 1960s. Rubin developed the theory through observation and nurses field notes of the nurse's interactions with mothers early in their pregnancy and followed them until one month postpartum. Rubin identified four maternal tasks that a mother progresses through: (a) seeking safe passage for self and baby, (b) ensuring the acceptance of the baby and self by other, (c) binding-in (bonding with fetus), and (d) learning to give of self. Rubin also identified a woman's mother as being her greatest influence or role model in taking on the maternal role.

Building on Rubin's work, Ramona Mercer, (2004) a student of Rubin's, studied mothers of varied ages and experiences (women with more than one child) and developed the practice oriented theory of MRA. It was designed as a framework for nurses to provide appropriate interventions to assist non-traditional mothers to attain a strong maternal identity. Mercer studied pregnant women and their infants through the first eight to twelve months postpartum. Mercer (2004) used Thornton and Nardi's four stages of role acquisition. Those stages are: (a) anticipatory (begins before pregnancy and continues during pregnancy), (b) formal (begins at birth and continues with mother seeking out expert advice and begins care-taking), (c) informal (mother develops her own way of mothering independently from other, (d) personal identity (satisfaction and confidence in maternal role). Mercer (2004) also identified variables that influence MRA and have some influence over the transition including maternal age, income, social support, temperament, self-concept, stress, perception of infant and maternal health. Infant variables include temperament, appearance, health status and responsiveness.

Role Transition

Meleis et al. (2000) introduced the concept and framework of maternal role attainment as a life transition. Two classifications of transitions were identified by Meleis et al. (2000). They are: (a) developmental/lifespan (which includes pregnancy, childbirth, adolescence, parenthood, menopause, aging and death), and (b) social/cultural (marriage, divorce, migration, displacement, retirement and family care giving). These transitions have the potential to be a vulnerable time in one's health status (Meleis et al., 2000; Foss, 1996). Because transitions unfold over time, nurses have the opportunity to facilitate health outcomes with early assessment and intervention.

Immigrant women may be dealing with multiple transitions at the same time. Examples of those transitions would include; immigration, pregnancy and childbirth, learning a new language, change in economic status, and loss of cultural and family support (Callister, 2001; Meleis et al., 2000). Immigrant women experiencing multiple transitions may be at increased risk for cultural conflicts, isolation, and depression which has the potential to impact their mothering role (Koniak-Griffin, Logsdon, Hines-Martin, & Turner, 2006).

Immigration and MRA

Immigration adds to the level of complexity to maternal Role attainment. Lauderdale (2003) states:

> Great variations exist in the social class, ethnic origin, family structure and social support systems in the United States and Canada. Despite their differences many health care providers assume that the changes in status and rites of passage associated with pregnancy and birth are experienced similarly by all people. (p. 97)

The impact of immigration on this process is often overlooked.

There is very little literature related to MRA and the experience of immigrant women in the United States. There is literature related to maternal role attainment of 'diverse' women in the United States. The literature includes teenaged mothers, African American women and Hispanic immigrant women.

Gichia (2000) in work with African American, urban, poor women found that preparation for motherhood is a culturally grounded process that is learned from the family of origin. The woman's own mother, older female relatives and family influences a woman in role expectations well before adolescence.

While teenaged mothers are very ego-centric and are at a developmental stage of separation from their parents, a study by Kemp and Rosbridge (1990), found that teenaged mothers (Hispanic, African American, and Caucasian) were able to develop a more secure attachment to their infant when they had the support of their family both prenatally and after the infant's birth.

In a study of Thai immigrant mothers living in Australia (Lamputtong & Naksook, 2003), cultural differences (immigrant vs. dominant culture) play a significant role in motherhood and the immerging role of mothering. Thai mothers felt isolated from their culture and the society they lived in, were aware of different childrearing and child disciplinary practices, and felt a strong need to preserve their Thai cultural ways. Liamputtong and Naksook advise looking at motherhood from a cultural perspective to provide better support for women becoming mothers in new lands. Motherhood and mothering is found to be more complex when it is combined with migration (Meleis 2003; Liamputtong and Naksook, 2003).

The above research supports the significance of assessing cultural factors to determine what role culture may play in pregnancy, childbirth, illness and health. Also what role does culture play in maternal role attainment?

Leininger's Theory and Model

How do nurses gain knowledge related to other cultures? Is there a way to discover what is meaningful and apply that to nursing care of pregnant women from diverse cultures? Madeline Leininger developed her Theory of Culture Care Diversity and Universality in order to "establish a substantive knowledge base to guide nurses in discovery and use of the knowledge in transcultural nursing practices" (2006, p. 310). Care and caring are basic and essential human needs; but that care needs to be specific and appropriate to various cultures. Her theory "discovers culture care meanings, practices and factors influencing care" (Leininger, 2002, p. 190). Some factors that may influence care are; history, religion, economics, environment, cultural values, kinship, and gender.

Leininger developed the Sunrise Enabler as a conceptual guide for nurses entering into the world of their client to discover significant information to provide holistic, culturally specific care. The purpose of the model and theory is to guide the nurse in discovering "culturally based emic (generic or folk) and etic (beliefs and practices of the nurse or other professional) care phenomena that are meaningful" to both the nurse and the client (Leininger, 2007, p. 9). Emic (generic knowledge refers to the learned, indigenous, traditional folk knowledge and practices that "provide assistive, supportive and enabling acts for others with current or anticipated health needs in order to improve wellbeing or to help with dying" (Leininger, 2002, p. 76). Etic (professional) care knowledge refers to non-indigenous, formally learned professional care knowledge and practices (Leininger, 2007,

p. 9). The ultimate goal of the theory and model is to "establish a body of transcultural nursing knowledge for current practices and for future generations of nurses in a global world" (Leininger, 2002, p. 76). This knowledge is "essential to provide therapeutic, culturally congruent care and to prevent cultural stresses and conflict and the imposition of practices often evident in caring for diverse cultures" (p. 7).

The Sunrise Enabler contains three modes of nursing actions and decisions to provide culturally congruent care. These three theoretical modes change traditional interventions practices into therapeutic culturally based ones. The modes for transcultural care decisions and actions are; 1) culture care preservation and/or maintenance, 2) culture care accommodation and/or negotiation, and 3) culture care repatterning and /or restructuring (Leininger, 2002, 2006). The care decisions or actions would be developed collaboration with the client (cultural informant) and would guide nurses away from using inappropriate and or routine practices that might not be culturally acceptable to the client (2007).

Background of Sudanese Immigrants

To have a better understanding of the Sudanese people, it is helpful to know something of their country. Sudan is Africa's largest country and is among the poorest. Its citizens are the least literate in the world (World Health Organization, 2000). The people in Sudan have endured many years of civil war, famine, religious and political persecution. Because of the civil war that has been ongoing since its independence from Britain in 1965, the Sudanese have become refugees to neighboring countries in Africa and around the world. The Sudanese have been accepted for resettlement to the United States since 1990 and have been settling in southeastern Minnesota since the late 1990s (www.census.gov). The number of refugees continues to be small and isolated from larger Sudanese populations.

"Betty" (not her real name) was the first Sudanese woman that this author met and provided home visits for the duration of her pregnancy. She was referred by a local clinic that had identified her as being an at-risk pregnant woman. Her risk factors included first pregnancy, non-English speaking, less than high school education and a recent immigrant. An Arabic speaking interpreter was used during home visits who was a woman from the Sudan and had given birth to children both in Africa and the United States. She was employed by the local public health agency. The interpreter was always present for home visits.

Betty was very shy (my interpretation), had down-cast eyes and made very little eye contact. She rarely asked questions during our home visits, with the exception of asking if this author was married and had any children. After each home visit, I would consult with the interpreter about my impressions and perceptions about the visit and ask for feedback from her about the client's noticeable lack of questions or concerns about the prenatal teaching. It was hard to judge if Betty comprehended the information she was receiving and if it was meaningful to her.

At that time of the initial home visit, the assessment tool used to guide prenatal teaching did not address the cultural life ways and traditional (emic) knowledge of the client. It was the lack of response to my teaching and the lack of knowledge about my client that inspired this author to keep a journal of observations, reflections and questions about how pregnant Sudanese immigrant women might be better served. Looking back on those early home visits and visits made to other pregnant Sudanese women, this author made some observations using the Sunrise Enabler and exploring three factors of the model; kinship and social factors, cultural values and lifeways, and economic factors. The information gained

may explain why some nursing interventions did not work well and what assumptions might have contributed to ineffective nursing interventions.

Kinship and social factors

It appeared that Betty and her husband valued being together as a family in this country. She described being away and apart from her family, some of which were still in Egypt. She spoke to her mother and sisters by phone as often as she could. When asked about women friends in the area, she said that she hadn't made any close friends yet. She and her husband attended a local church with other Sudanese families. This was the only socialization time she usually had to visit with other women.

According to Betty, gender roles are very specific for men and women and she and her husband found comfort in maintaining those traditions. Women's work is to take care of her family, raise children and care for the home. Pregnancy and childbirth are female oriented and while the husband may provide support, it is the women's female relatives that support the pregnant woman and teaches her what she needs to know about pregnancy, childbirth and caring for the baby (Kirdli, 2000) .

Cultural values, beliefs and lifeways

Culturally, pregnancy is seen as a natural, noticeable state of well-being. Betty and her husband didn't have much experience with preventative health care. Health care was not thought necessary unless there is a problem or complication. Betty stated that when a Sudanese woman is pregnant, she receives support from her family. That support is maintained by her relatives helping with household chores such as cooking, cleaning or taking care of the other children so the pregnant woman can rest. This lack of support can create conflicts between what is traditionally expected and what may actually happen. While

a large family is valued (many children), Betty questioned how many children she and her husband could afford to support. She said that it was much easier (and cheaper) to have a large family back in the Sudan. This also provides another potential area of conflict with Betty anticipating fulfilling the traditional role of mother by staying home to care for her infant against the reality of needing to go to work to supplement the family's income while leaving her infant with someone other than a family member.

Economic Factors

Betty's husband works, but does not have health insurance for himself or Betty. Betty was covered by state funded medical coverage until 6-8 weeks postpartum. An unexpected illness could be a hardship for this family. Because the family still values traditional gender roles, Betty wants to stay home with her baby and not go out and look for work to supplement the family's income. They live in low-income housing, buy food and some household items, but have little left over for other necessities. Paris and Bronson (2006) found that while many refugees come to America to improve their economic standing, most experience impoverished conditions and lack access to resources that may improve their resettlement.

The information provided in the three previous factors is an example of what kind of cultural information may need to be included when planning client care. Leininger's three modes of nursing care actions will be discussed as a guide to help nurses to provide congruent, meaningful nursing care.

Discussion of Transcultural Care Decisions and Actions

Leininger's three modes of nursing care actions or decisions help the nurse provide appropriate, congruent and meaningful nursing care that is decided jointly by the nurse and

client. In Betty's case, Culture Care Preservation and/or Maintenance refers to what traditional lifeways the nurse can continue to support that will help the client maintain a sense of cultural connectedness. When Betty was asked by this author, "if you were in Africa with your family, how would you learn about pregnancy and childbirth?" This author was looking for a way to acknowledge that it was understood that Betty had knowledge and different ways of being other than what this author knew and have experienced. By demonstrating a desire to learn what was important to her, a safe place was made for dialog and learning that was reciprocal. We were able to negotiate that she would still ask for support and information form her mother and other relatives (via phone conversations) but that the nurse was now going to be the "elder woman" from another village who would give advice and pass on knowledge.

Culture Care Accommodation and/or Negotiation refers to provider care actions or decisions that help one adapt or negotiate with others for culturally congruent care. This was demonstrated by this author by acknowledging and accepting that gender roles need to be respected. While labor and delivery teaching is (in this country) traditionally done with men and women present, Betty was not comfortable attending classes with or without her husband. She and this author watched videos, and with the help of the interpreter, were able to provide her with an overview of labor and delivery. Also it was not assumed that the husband would participate in labor and delivery at the hospital. Plans were discussed with Betty that she needed to ask for an interpreter at the hospital and that a nurse (female) would be able to provide some comfort and support with the husband participating as he was able.

Culture Care Repatterning and/or Restructuring refers to helping the client change or modify their lifeways for beneficial health care outcomes. Betty had little opportunity for

preventative health care in the Sudan. While the Sudanese culture values Western medicine, medical care is not thought necessary unless there is a problem or complication (Kridli, 2000). Her culture values pregnancy as a natural time in woman's life that reflects her good health and fertility. The need for medical care during pregnancy is hard to justify when a woman is healthy (Kridli, 2000). Betty needed reassurance that her pregnancy was going along smoothly, even though she was seeing the doctor monthly. Betty understands that someone went to the doctor when they were sick. How did going to the doctor monthly preserve the health of her and her baby?

Even though it appears that some accommodation was made on the part of the client and the nurse, that benefited the client, the resources did not seem to fit the reality of the client's situation.

Reflections, Conclusion, and Recommendations

Reflections

Many factors related to cultural traditions and lifeways can influence the effectiveness of nursing care. Language and communication are examples of the barriers that need to be overcome; whether that communication is spoken, written, listened to or viewed. Even with the use of an interpreter, there can still be miscommunication and a lack of meaningful dialog between the nurse and the client.

In providing teaching to pregnant Sudanese women, this author was always mindful of the lack of appropriate cultural resources available to Sudanese women. The videos available were generally of Caucasian women and few women of color. None of the videos were in Arabic. All printed information was in English. The small number of Sudanese women served here in southeastern Minnesota makes finding and purchasing appropriate

materials hard to justify with funding sources continuing to be stretched. This author located some free printed material from on the internet. An example of the material was from the U.S. Committee for Refugees and Immigrants (www.refugees.org) on pregnancy. The handout is one page, front and back and pertains to going to the doctor for prenatal care, eating right and avoiding harmful substances. The handout is printed in Arabic, with further internet sources printed in English. This resource was welcomed, but lacking in information about labor and delivery, breastfeeding, and postpartum care. If the Sudanese woman is illiterate, this printed information is not helpful.

Another area of concern is the lack of cultural information about working with Sudanese families. Leininger (2006) discussed many issues pertaining to a refugee family that she recently sponsored in Nebraska. The issues such as safe housing, income and connecting to resources could pertain to any immigrant or refugee family. The information she was able to gather over a period of time while working with the family revealed issues such as trauma, hunger and safety that were continuing to impact this family. Using Leininger's theory and Sunrise model to discover what may remain hidden demonstrates that the practice of gathering cultural information and using it to direct the nursing process is essential.

According to Mercer (1985), "mothering behaviors reflect the common beliefs about what mothers should do" (p. 203). What are the common beliefs and behaviors for Sudanese women and how do they influence becoming a mother?

This author visited another pregnant Sudanese woman over a period of 10 months, starting early in her pregnancy and following her until several months after the birth of twins. This woman spoke English, had only been in the United States for a few months, was

married, and experiencing her first pregnancy. On one of my home visits, this author decided to use a tool that is meant to provide anticipatory guidance for the pregnant woman. The tool allows for discussion on the expectations of motherhood and to reflect on the kind of mother she wants to be. Its use with diverse cultures has not been studied. Two of the questions we reviewed were, "mothers should be with their babies 24 hours a day for the first three months" and "mothers have to pick up their crying babies immediately". The answers to both those questions from this author's perspective (and the developer of the tool) are false. But from my client's cultural perspective, she expressed that mothers are responsible for their children and it is up to them to be with their children to care for them and protect them at all times. She already had an idea about what a mother looks and acts like (role expectations and responsibilities) which is a component of maternal role attainment.

Conclusion

The research on MRA is largely based on white middle class women, which becomes the "prevailing measuring stick by which all mothers are measured" (Koniak-Griffin, Logsdon, Hines-Martin & Turner, 2006, p. 672). Koniak-Griffin et al., proposes that the role of mother is learned and influenced by both her cultural environment and her culture of origin. Cultural displacement has an impact on maternal role attainment and the many transitions that she may need to work through. The pregnant woman may struggle to integrate both cultures while taking on the role of mother. Because cultural care assessments have a different emphasis from traditional physical and mental health nursing assessments, this author proposes that a cultural assessment be completed with every pregnant woman along with the traditional assessment (Leininger and McFarland, 2002). Asking the following questions on a cultural assessment would be helpful in learning more about how culture may

affect becoming a mother. (1) If you were with your family now, how would you learn about pregnancy and preparing for birth? (2) What kinds of things would you need to learn about? (3) What kind of activities do mothers do? (4) What kind of activities do fathers do? (5) Are there any traditional foods or medicines that you are using now? (6) How can the nurse support you through your pregnancy?

Recommendations

Further research needs to be conducted to improve the understanding of MRA across diverse cultural groups and how concurrent role transitions may put a woman at risk for role strain. Also insight into what nursing interventions facilitate role transitions would be helpful. This research will also add to the body of transcultural nursing knowledge and may ultimately guide practice.

In an early study by Mercer (1984) she proposed that parenting support groups would be a valuable tool to support women who find themselves isolated and lacking support during pregnancy and the first year postpartum. The group would be especially helpful with routine information about normal growth and development and every day concerns of new mothers. Ideally, this group would be culture specific and targeted to woman who lack family and community support.

Home visitation by public health nurses to provide support and education during the prenatal and postpartum period may be an effective means of support. In a culturally congruent way, PHNs can help women identify the role expectations and responsibilities of becoming a mother that also supports the transition process and is specific to a woman's needs.

As nurses, we need to be aware of our own cultural beliefs and values and make sure our client's needs are not overshadowed by our own needs and professional care practices. We also need to remember not to generalize information about cultural groups. What may be true for one person may not be true for another person from the same culture.

Making nursing care actions or decisions based on the cultural (emic) knowledge and the needs of the client in partnership with the nurses' (etic) knowledge and resources will guide the nurse away from what is inappropriate or non-therapeutic, benefiting the nurse and the client.

Additionally, having an understanding of a cultural group provides the nurse with a knowledge base upon which she can become an advocate to guide nursing practice and possibly affect change in public policy related to health and reimbursement issues of the immigrant and refugee families our state serves. Providing services that include helping a woman become confident in her role as a mother has the potential to affect a secure mother-infant attachment, produce a confident, secure child, who then has the potential to become a well adjusted human being.