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Mst Khadija Mitu
University of South Florida

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Giving Birth in a Different Country: Bangladeshi Immigrant
Women's Childbirth Experiences in the U.S.

by

Mst Khadija Mitu

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Anthropology
College of Arts and Sciences
University of South Florida

Major Professor: Heide Castañeda, Ph.D.
Linda M. Whiteford, Ph.D.,
Nancy Romero-Daza, Ph.D.

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Dedication

This thesis is dedicated to my father, Md. Alijan Mia, and my mother, Rashida Begum, who inspired me the most to achieve my goals.

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Experiences in the US**

Mst Khadija Mitu

ABSTRACT

Immigrant women often lack the social support and help from extended family and other social relationships, which is very significant during the pregnancy, delivery, and postnatal period. This research was conducted among Bangladeshi immigrant women living in the United States, in order to understand their experiences during pregnancy and childbirth: how they coped with the settings of a different country during that period, and how they felt about this situation. While there are several studies on immigrant women and maternal health issues in anthropology, to my knowledge, there have been none that focused specifically on the childbirth experiences of Bangladeshi immigrant women in the US. These women have very specific culturally-based perceptions about the US health care system around issues such as communication with service providers, dealing with the hospital system, the role of health insurance, and so on. This research was conducted among Bangladeshi women in Tampa, Florida, and sought to understand their experiences during pregnancy and childbirth and perceptions of access and quality in the health care system. Fifteen women were selected through purposive and snowball sampling. Data was collected using in-depth interviews. This study examines the experiences of these Bangladeshi immigrant women within their socioeconomic context and immigration status.

Chapter One

Introduction

Introduction

People who migrate to a foreign country experience social, emotional, and economic transitions and it is often women who are the most vulnerable in these situations. Migration and immigrant health have been important issues of anthropological study. While there are several studies on immigrant women and maternal health issues, no studies have specifically focused on the experiences of Bangladeshi immigrant women in the US. There are a range of migrants from Bangladesh with varied socioeconomic backgrounds, including some who are undocumented. This thesis aims to document Bangladeshi immigrant women's experiences related to pregnancy and childbirth based on a sample of women living in Tampa, Florida.

Women who migrate from Bangladesh to the United States undergo a major transition, which has various effects on their reproductive health experiences. These migrants may have very specific culturally-based perceptions about the US health care system around issues such as communication with service providers, dealing with the hospital system, and the role of health insurance. When it comes to maternity health care, women's experiences are related to gender norms and are influenced by different social settings. Many of them struggle with an unfamiliar situation and are hesitant to voice their complaints and dissatisfaction due to their gender role within the family and in broader social system. As Castaneda (2008) says, "Women's

experiences of migration, and their relationship to a host country, vary significantly from those of migrant men simply because pregnancy is a possibility” (2008: 340). Immigrant women often face much more complications than men under certain circumstances, especially with their pregnancy, and childbirth situations.

The perception and practices related to childbirth and pregnancy are widely diverse among societies of the world, and have been the focus of several studies by medical anthropologists (Boddy 1998, Jordan 1997, Sargent 2006, 1996). In many societies, pregnancy and childbirth are considered a natural event and are related to their perceived cosmology, while in other societies these are considered clinical experiences that require special bio-medical attention. Birth practices in Bangladesh fall primarily into the first category. Although most women in Bangladesh deliver their children at home with relatives or traditional birth attendants (Afsana and Rashid 2001), we cannot generalize these practices for all women. There are significant differences regarding childbirth practices between rural and urban women as well as for women from different classes. Despite these differences, family relationships, social networks, and socio-cultural values and norms are important for birth practices in Bangladesh.

By contrast, in the United States, health care facilities and infrastructure are much more developed and well-equipped than those in Bangladesh. Maternal health services are highly comprehensive in nature; however, immigrant women often lack the support from extended family during the pregnancy, delivery, and the postnatal period (Harley and Eskenazi 2006, Reitmanova and Gustafson 2008). In addition, access to health care facilities is not always comparable for immigrant women as it is for local woman (Harley and Eskenazi 2006).

Significance of the Research

Social scientists have explored the many different perspectives through which health and illness are perceived in different societies. Peoples' understanding of life, death, health, disease, illness, healing, and medicine are informed not only by biomedical perspectives, but cultural beliefs and practices as well. Contemporary medical anthropology deals with the nuances of health and illness and synthesizes biological and cultural notions of human experience regarding life stages and health. Medical anthropology views body, health, disease and healing from a very different perspective than the biomedical perspective. It is a great challenge for contemporary medical anthropology to situate health and body in a broader frame of socio-cultural context, social organizations and political economy (Whiteford and Bennett 2005). Health and disease are not only physical or biological phenomena; rather, they are shaped by society and culture. Medical anthropologists conduct empirical research to understand the process of shaping health issues and problems by society and culture and offer suggestions for changes in health care policies and programs to make them more effective.

Several anthropological studies have examined childbirth and maternity health experiences of immigrant women. For example, Manderson and Allotey (2003a) have studied African immigrant communities' experiences regarding utilization of health care services in Australia. Harley and Eskenazi (2006) have discussed the importance of social support for Mexican immigrant women during their pregnancy, which they lack in the US. Of particular interest for this thesis are studies that have focused specifically on Muslim immigrant populations. Carolyn Sargent (2006) has explored the discourses of Islam, biomedical practices and women's rights among Malian migrant population living in Paris, France. Reitmanova and

Gustafson (2008), working with Muslim immigrant women living in Canada, have argued that maternal health care information and practices designed to meet the needs of Canadian-born women lack the flexibility to meet the needs of immigrant Muslim women. Manderson and Allotey (2003b), in their study of immigrant women and refugees from the Middle East and the Sahel living in Melbourne, Australia, analyzed the limitations of conventional models of communication between patients and healthcare providers.

These studies, among others, point to several different issues for immigrant women's health. For instance, studies illustrate that women's gender role within the household and in broader social system has a great impact on their childbirth experiences (Sargent 2006). Some researchers have specifically examined social support during the maternity period. No matter whether women are immigrants or local, the support from their family and friends during their pregnancy, delivery, and post-partum periods is of great importance. However, most immigrant women are too distant from their extended family and lack this support. They may try to alternatively build social networks within the immigrant community in order to receive social support (Reitmanova and Gustafson 2008).

In most studies of maternal health practices in Bangladesh, researchers have set their focus on the experiences of rural or urban poor women and their reasons for not using health facilities. Non-compliance with health care facilities is the main focus of many studies. There are very few studies conducted among urban middle class women in Bangladesh, who are generally compliant with bio-medical services and are regular users of health facilities for maternity care. The research presented in this thesis helps to fill this gap by focusing on a population residing in an urban setting and who are regular users of health care facilities in the United States. Statistics

show that 99% of births in the United States are attended by skilled health personnel (WHO 2006). By contrast, in Bangladesh, doctors, trained nurses, or midwives assist in 13% of births, and other trained health providers assist in another 14% (BDHS report, 2009). Thus, the difference between these two countries is very significant. This research seeks to understand the experiences of immigrant women, in transition between these two settings.

This thesis represents a descriptive study that explores the childbirth experiences of Bangladeshi immigrant women living in a city in the United States. This research contextualizes immigrant Bangladeshi women's childbirth experiences within their socioeconomic conditions and immigration status, attempting to understand how socioeconomic conditions shape perceptions toward the maternity experiences in the US. Their socioeconomic condition impacts their experiences and the way in which they become acculturated to the host society. However, the concept of acculturation needs critical consideration when studying the health issues of immigrant communities (Hunt et al 2004). Finally, individuals' choices are also highly influenced by biomedical hegemony. As Margaret Lock (2002) states, "Biomedicine is usually taken as the gold standard against which other types of medical practice are measured" (2002:191). Therefore, this thesis also explores how Western biomedicine shapes these immigrant women's reproduction and maternity experiences.

This study establishes its position in the research arena of medical anthropology by applying relevant theoretical frameworks and utilizing uniquely anthropological methods. The researcher's academic and professional training in cultural anthropology greatly shaped this research, and is reflected in the study's theoretical understanding and methodological application, making it an important study in the field of anthropological research. The relevant

literatures that are reviewed and shaped the study objectives and analyses are selected from different theoretical frameworks within medical anthropology. This study also utilizes the tools and techniques of qualitative research that are very important in anthropological study.

Goals and Objectives

The ultimate goal of this study is to improve the reproductive health situation for Bangladeshi immigrant women by understanding their childbirth experiences and the challenges they face. Hopefully, this study will prove to have significance within applied anthropology through recommendations for more responsive maternal health care services for immigrant women in the United States. The objectives of this study are:

- To provide an in-depth documentation of the pregnancy and childbirth experiences of 15 Bangladeshi immigrant women in the United States;
- To understand how they perceive these experiences as a part of an immigrant community;
- To contextualize their perception within their socioeconomic conditions and immigration status.

Thesis Outline

This thesis contains five chapters. Following this introduction, the second chapter discusses the literature relevant to the study in order to situate it within the academic context. The chapter reviews previous anthropological studies as well as studies from other related disciplines to explore how maternal health and immigrant women's health are significant in anthropology, especially in medical anthropology. It also provides brief overviews of the maternal service system of the United States and that of Bangladesh, so that the reader can better understand the

context of the study. Finally, the chapter discusses previous literature on the influence of Western bio-medicine in maternal health services.

The third chapter elaborates the methods that were used to carry out the research. It provides an exploration of the field site, the data collection procedures and the process of data analysis. The field research was carried out in Tampa, Florida with Bangladeshi immigrant women. Fifteen in-depth interviews were conducted in order to collect primary data from participants. This chapter provides also information about the ethical considerations for the study.

The fourth chapter discusses the main findings of the field research. It details the experiences and perceptions of these women regarding their experience(s) in the US during their pregnancy, child delivery, and the post-partum period. A discussion of perceptions about cost of care, the role of social support, challenges of receiving care and maternity practices in Bangladesh are also presented.

The fifth chapter concludes with a discussion of the research findings and how this study adds to the anthropological scholarship on immigrant women's reproductive experiences. It also provides recommendations for how this study could be used to improve maternity experiences for the study population.

Chapter Two

Background Literature

Introduction

In order to develop a framework with which to explore this topic, a clear understanding of the existing literature is necessary. This includes literature from anthropology as well as other social sciences. This chapter presents an overview of relevant literature on a) maternal health and women's reproductive health issues in medical anthropology; b) studies on immigrant women's health, especially reproductive health; c) maternal health studies in Bangladesh; d) a brief comparison of the maternal health care systems in Bangladesh and in the United States; and e) the impact of Western bio-medicine in maternal health practices and care seeking behaviors.

Maternal Health in Medical Anthropology

Women's reproductive and maternal health issues have been discussed in medical anthropology in multiple waves. Women and their reproduction are subjugated through modernism in many different ways, but it took time for the study of reproduction and motherhood to find a significant place within anthropological scholarship. Ginsburg and Rapp (1991) assert that "perhaps because it was a "woman's topic," the study of reproduction by anthropologists has never been central to the field" (1991:311). As they mention, since the 1970s the analysis of reproduction has been greatly enriched by the encounter between second-wave feminism and anthropology, in which women's reproductive experiences were analyzed as sources of power as well as subordination.

Brigitte Jordan (1978) examines the different cultural perspectives related to childbirth using comparative research from four cultures. In *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*, Jordan describes the impact of different ideologies and practices regarding childbirth. She presents childbirth as “an intimate and complex transaction whose topic is physiological and whose language is cultural” (1978: 1). The central issue of her analysis is the relationship between universal, biological features of childbirth and the diverse social and cultural characteristics of birth in particular societies. Jordan introduced a biosocial framework for studying childbirth and viewed birth as a social production in which many people act. She notes that these acts vary widely from country to country. For example, in the United States, the woman in labor is described as not being part of the social interaction of birth in hospitals: "The sterile barrier over her knees separates her from the lower part of her body, and she has no visual access to either the birth area or the obstetrician standing scrubbed and ready.... women are still drugged when they get into the delivery room, unable to cooperate, and frequently quite unaware of what is going on” (1978:44). The contrast between this and the friendly to intense social interaction between mother-to-be and her specialist and non-specialist assistants in the other cultures shows convincingly the dramatic ways in which the birth event is shaped by social values and itself becomes a social production. Jordan also illustrates how the use of technology in this social event critically shapes it and the values associated with it. Based on cross-cultural comparison, she describes how technological and social forces interact with one another in cultural settings, especially in the context of childbirth. She concludes that the childbirth practices in the United States are very dependent on biomedical technology and medication, which is not the case in other three societies she examines. Following this point, she states that there is a demand for

change in the medical system in the United States, in which the medicalized way of doing birth is under attack “because it has been shown inferior to other systems by its own evaluation standards” (1978: 88- 89). She mentions that the American system is capable of change under pressure; it is thus neither a radical critical assessment nor of the production of alternate methods because “the standardization of practices within the system does not expose practitioners to other that system-specific routines” (1978: 89). Nevertheless, Jordan presents a holistic view of culture, and does not view variations and contestations in beliefs and practices as problematic within a given culture.

Robbie Davis-Floyd (1992) differs with Jordan on the topic of culture and childbirth practices. While Jordan examines the ideologies and practices of childbirth, she does not question the process of the construction of these ideologies. In contrast, Davis-Floyd is concerned to how ideologies related to birth are constructed within the dominant power structure. Specifically, she links birth practices in the United States with the dominance of biotechnology in medicine and identifies American birth practices as “technocratic”. Davis-Floyd also emphasizes that childbirth in the United States is dominated by medically trained obstetricians and that mothers have lost control over their own birthing process. Wagner (2006) and Cheyney (2008) echo Davis-Floyd and associate mainstream childbirth practices with the domination of biomedical practices and consider them to be overmedicalized.

In *Birthing in the Pacific: Beyond Tradition and Modernity*, Vicki and Jolly (2001) compile several chapters that focus on past and present childbirth practices in the Pacific region. Throughout the book, authors question how birth practices get mapped onto opposing constructs of “tradition” and “modernity”. Missionaries, governments, and international agencies have

advocated a “modern” biomedical model of birth and disparage “traditional” birth as dangerous and victimizing women. On the contrary, advocates of “natural” or “traditional” childbirth, emerging from feminist, ecological movements, have criticized the biomedical model of birth for being interventionist, culturally imperialistic and denying women autonomy. It is apparent in the texts how viewpoints from both perspectives are too simplistic. Advocates of the biomedical model have often failed to recognize the benefits of some “traditional” approaches (such as upright birthing positions, herbal medicines, and psychosocial support). Moreover, the characteristics that are relegated to the realm of “tradition” (such as large families with closely spaced children, or women’s shyness about their bodies) are shown to be a result of modern trends brought about through colonialism and missionary activity. As the authors note, many advocates of “traditional” births often hold romanticized images of the “poetics of Pacific motherland” (2001: 25) and incorrectly assume a direct correspondence among traditional/natural/non-interventionist/value for women’s reproductive capabilities.

Discussions on reproduction, maternity and motherhood within the discourse of modernity have had a significant impact upon anthropological scholarship. Cecilia Van- Hollen (1994) makes the point that birth is no longer reflective of ‘largely uncontested cultural patterns’; instead, there is growing conceptualization of birth as “an arena within which culture is produced, reproduced, and resisted,” of culture as situated historically “within the context of particular political and economic relations” (1994:501). In this context, Ram (1998) notes that, “despite the marginal status it has been allocated by masculinist presumptions, the anthropology of maternity reflects the impact of the contestory paradigms within the larger disciplinary field” (1998: 278).

Immigrant Women's Health

Migrant health and reproduction has been an important topic in recent anthropological studies. In the following section, I discuss the existing anthropological literature on the reproductive health experiences of immigrant women with a particular emphasis on gender roles and social support. Women's gender role within the household and in broader social system impacts upon their childbirth experiences. Regardless of whether the women are immigrants or local, "native" populations, support from family and friends appears to be of great importance during pregnancy, delivery and the post-partum period.

Reitmanova and Gustafson (2008) argued that maternal health care information and practices designed to meet the needs of mainstream Canadian-born women lack the flexibility to meet the needs of immigrant Muslim women. To document and explore the maternity health care needs and barriers to accessing maternity health services from the perspective of immigrant Muslim, Reitmanova and Gustafson carried out a qualitative study among Muslim immigrant women living in St. John's, Canada. They selected six women with purposive sampling and conducted in-depth semi-structured interviews to collect data. The maternal health care system, they argue, should be more culturally and linguistically appropriate for the immigrant women. It is very important to address the needs of immigrant women to develop the responsiveness of health care system.

Manderson and Allotey (2003b) conducted their study among immigrant women and refugees from Middle Eastern and Sahel African backgrounds living in Melbourne, Australia. With an aim to investigate reproductive health issues and indicators that affect the general well-being of migrant and refugee women from the Sahel and the Middle East, the researchers used a

combination of quantitative instruments (survey) and qualitative methods (in-depth interviews, focus group discussions, and clinical observations) in this study. They analyzed the limitations of conventional models of communication between patients and healthcare providers. The authors illustrate the need for health providers to appreciate the possible barriers of education, ethnicity, religion and gender that can impede communication, and the need to be mindful of broader structural, institutional and inter-cultural factors that affect the quality of the clinical encounter.

Most immigrant women are far away from their extended family and lack this support during their childbirth period. They often try to build social networks within the immigrant community so that they can receive some social support however fail to establish a strong social network in the host country (Reitmanova and Gustafson 2008). The authors recognized that many immigrant women have “weaker social support networks” than they require during their maternity experiences (2008: 104). Immigrant women, they note, often struggle with low socio-economic status and weak social networks, which can contribute to “stress and changes in women’s hormonal and immune responses, making some immigrant women more vulnerable to pre-term labor and low birth weight” (2008:104).

Harley and Eskenazi (2006) also describe the importance of social support for Mexican immigrant women during their pregnancy, which they lack in the US. They note that immigrant women undergo social stress, which has a negative impact on their health. Harley and Eskenazi (2006) conducted a longitudinal birth cohort study of the health of pregnant women and their children living in the Salinas Valley in California. The study examined a population of low-income women of Mexican descent in an agricultural

community to determine whether social support patterns were associated with age at arrival in the US; whether it is associated with pregnancy behaviors; and whether increased social support could prevent some of the negative pregnancy behaviors. The study was conducted among 568 pregnant women enrolled in prenatal care in the Salinas Valley. The authors found that high parity, low education, and low income were also associated with low social support. On the other hand, higher social support was associated with better quality of diet, increased likelihood of using prenatal vitamins, and decreased likelihood of smoking during pregnancy. It was also evident in the study that high social support prevents the negative impact of life in the U.S. on diet quality. Women with intermediate or low levels of social support who had spent their childhoods in the U.S. had significantly poorer diet quality than women who had spent their childhoods in Mexico. However, among women with high social support, there was no difference in diet quality according to country of childhood. Thus, in the case of diet quality, increased social support appears to prevent some of the negative pregnancy behaviors that accompany time in the US among women of Mexican descent.

The authors also found that many immigrant women face language barriers, discrimination and separation from family, friends, and social resources. They urged that, “interventions to increase social support to Mexican immigrant women may help prevent some of the negative behaviors that are associated with becoming more acculturated in the US” (2006: 3059).

Gender issues also play an important role in the study of migrant women’s reproduction. In Bangladesh, most women depend on their husband or other male guardians to make decisions. As a result, men are considered the bread-earners of the family as well as the decision-makers. Regardless of whether the woman is employed or not, earns money or not, she is expected to

depend on the man for making decisions (Kabeer 1997). Even in most cases of migration, the husband makes the decision to migrate and the woman follows his decision as a spouse. In the case of using health care services, the scenario is generally the same. Men play the vital role in deciding which services and facilities to use, however little attention has been devoted to the influence of male partners on women's reproductive activities (Browner 2000; Dudgeon and Inhorn 2004; Sargent 2006).

Dudgeon and Inhorn (2004) discuss men's influence on women's reproductive health from a medical anthropological perspective. They analyze this issue from many different aspects of women's reproductive health. The authors discuss about how men's roles have significant influence on contraception, sexually transmitted infections, infertility, abortion, fetal harm, and pregnancy and childbirth. For example, in the case of pregnancy and childbirth experiences, the authors mention that women often define pregnancy intention as influenced by their relationship to their partners and their partners' desires, and in a similar fashion, decision making for obstetric care often times depend on the male partners' choice (2004: 1386-87). The authors mentioned that anthropologists have primarily addressed men's influences on prenatal care in developing countries in only the broadest sense, examining how male-dominated biomedical services interact with existing pregnancy practices. However, Sargent (1989) has argued that the encouragement of hospital-based birth by public health programs can limit women's reproductive choices by enhancing the power of male heads of households to make decisions about obstetric care. She provides examples from Benin, where men's educational and occupational status affected women's prenatal and obstetric care choices because of the importance of emerging status distinctions within the community. These authors urge for more studies in medical anthropology on the issue on men's influence on decision making process in

women's reproductive health. This study answers the call and will also focus on how gender roles influence the decision making process of receiving health care.

Of particular interest to this project are studies that focus on Muslim migrant women in healthcare settings very different from those they may be used to. For instance, anthropologist Carolyn Sargent (2006) conducted research among the Malian migrant population living in Paris, France and examined discourses of Islam, bio-medical practices and women's rights. She identifies that biomedical policies generate marital conflicts and pose health dilemmas for women who face family and community pressures to reproduce, but who simultaneously face biomedical encouragement to limit childbearing. She also asserts that French social workers play a particularly controversial role by introducing women to a discourse of women's rights that questions the authority of their husbands and of religious doctrine. She argues that women and men frame decisions in diverse interpretations of Islam as they seek to manage the contradictions of everyday life and assert individual agency in the context of immigration and health politics.

Sargent (2006) emphasizes that further exploration is required to understand how women negotiate diverse structural and cultural constraints and exert agency in the face of conjugal, community and institutional pressures; she particularly calls attention to "individual and collective reproductive relations and practices take shape in the context of transnational migration and ensuing reconfigurations of identity" (2006:32).

The only study located which relates specifically to Bangladeshi immigrant women's reproductive health in the United States is an MA thesis conducted by Syeda Sarah Jesmin (2001). Jesmin conducted the research as a part of her Master's study in the Sociology Department at the University of Texas, Arlington. The focus of her study is to locate "how the

Bangladeshi immigrant women do respond to illness during their pregnancies” (2001:1). She carried out a qualitative research among the Bangladeshi immigrant women living in Dallas-Fort Worth Metroplex area. With an aim at viewing the prevailing situation in their health-seeking patterns, the researcher recruited 12 women via snowball sampling and collected data using in-depth interviews for a period of 12 months. Jesmin notes that, while the Bangladeshi immigrant women are satisfied with the quality of care they received in the U.S, they do not depend totally on it and seek “traditional” forms of care from their own country. She also mentions that traditional beliefs and practices do not act as barriers to access to Western medical care or to utilization of preventive services. Jesmin concludes by saying that the immigrant women’s health seeking behavior remains, to a large extent, based in their country of origin. Even if they access the Western health care system, that does not ensure appropriate utilization or better health outcomes for them. She thus views cultural beliefs and practices from their country of origin to have a great influence on these women’s health seeking behavior.

Jesmin’s study focused only on the experiences of Bangladeshi immigrant women during their pregnancy period. The current thesis sets its focus on understanding the overall childbirth experiences of Bangladeshi immigrant women, including their pregnancy period, child delivery and postpartum period. The primary difference between this study and Jesmin’s is that this study did not set out to identify the influence of cultural beliefs and practices from the women’s country of origin. In her research, Jesmin identified the immigrant women to be ‘skeptical’ of medical systems different from than their own cultural practices, while this research viewed immigrant women as primarily compliant with the Western biomedical system. This research does also discuss the perceptions of immigrant women in regard to the cultural practices of their own country of origin; however, it emphasizes that not all immigrant women are reluctant to give

up those practices. Rather, they appeared to be more convinced by the practices of the host country and thus tried to adopt those as a sign of modernity.

Maternal Health Studies in Bangladesh

To study maternal health practices in Bangladesh, many researchers have focused on the experiences of rural/urban poor women and their childbirth practices, along with reasons for not using health facilities. Thus, the main focus of many studies done in Bangladesh is the issue of non-compliance for maternity health care. For example, Afsana and Rashid (2001) present factors to explain why rural women in Bangladesh do not utilize the health facilities available to them for delivery, pointing out the challenges to meeting the needs of rural women. They mention the reasons behind not using hospital care by the rural women for delivery and the constraints these women encounter. In this study, the researchers conducted in-depth interviews and focus group discussions among two groups of women aged 20-40 years, who had had at least one live birth. One group included women who experienced childbirth both at a health center and at home, while the other group consisted of women who had experienced only a home birth. Most of the participant women reported poor health quality of district hospitals where emergency obstetric care is provided. The authors found that financial constraints, fear of hospitals and surgical instruments, and the stigma of being seen to be 'sick,' with an 'abnormal birth' were important barriers for restricting women to utilize hospital care for childbirth. They also mentioned that female paramedics in birth centers who perform vaginal delivery made women deliver lying down, did not always use aseptic procedures, and were too busy to give information, making birth a passive experience for women. Overall, the women perceived hospitals to be place for treating 'pathological phenomena,' thus receiving treatment from the

hospital implied that ‘something abnormal’ had happened to their bodies (2001: 82). Afsana and Rashid further indicated that “most women felt intimidated when interacting with health providers at the health center and were often afraid of expressing their feelings; however well they were treated, underlying hierarchical and class distinctions remained” (2001: 83). The researchers observed that hospital staffs often overlook some crucial behavioral issues; e.g., privacy was not well maintained due to a lack of cultural understanding and dismissive attitudes towards poorer women.

Bhatia (1981) conducted sociological research in the villages of the Matlab district in Bangladesh. She argues that a better utilization of biomedical facilities will occur if they are village-based and incorporate prevailing cultural practices and beliefs regarding childbirth practices. Goodburn et al (1995) also focus on the ‘traditional’ beliefs and practices regarding childbirth and the postpartum period in rural Bangladesh and note the impacts of these practices on the high maternal mortality rate in Bangladesh. The researchers carried out qualitative research in three *unions* (smallest level of local government in rural) in Bangladesh. They conducted focus group discussions with the younger mothers, older mothers and trained and non-trained traditional birth attendants. The authors argue that programs regarding delivery and post partum care should take into consideration not only the cultural constraints on women but also the existing beliefs and wealth of knowledge of the women themselves. In contrast to other researchers who generalized traditional birth practices and considered these ‘harmful;’ Goodburn et al. urged separation of ‘harmful’ and ‘useful’ practices in context of home birth practices in rural Bangladesh. While the authors listed some harmful practices performed in home birth such as internal manipulations and massage, introduction of oils into vagina, and pulling on the umbilical cord, they also listed some useful practices e.g., adopting an upright positions and

walking during labor, adopting the squatting position for delivery, noninterference with the membranes, having psychological support from attendants and being in familiar surroundings.

Finally, Nahar and Costello (1998) conducted a questionnaire survey and in-depth interviews among 220 postpartum mothers and their husbands selected from four government maternity facilities in Dhaka. The researchers examine the non-utilization of the health facilities by poor women and identify the “hidden costs” of free maternity care provided by the government of Bangladesh. They assert that these hidden costs may be a major contributor to low utilization of maternity services, especially among low-income groups. The authors recommended that policy-makers might consider introducing fixed user charges with clear exemption guidelines, or greater subsidies for existing services to increase utilization of safer motherhood services.

As this brief summary shows, most of the literature focuses on compliance and access barriers among poor women in both rural and urban settings. One population which remains understudied are urban middle class women in Bangladesh who are compliant to bio-medical services and are regular users of health facilities for maternity care. While set outside of Bangladesh, this study fills a gap in that literature to a certain degree, since it examine middle-class women residing in an urban setting who are regular users of health care facilities.

Overview of Maternal Health Service System in Bangladesh

At this point, it is useful to provide a brief overview of the health care system in Bangladesh, with a specific focus on maternal health services. Bangladesh is a developing country in South Asia with an area of 147,570 sq. kilometer and a highly dense population of 153 million. The gross national income (GNI) is per capita 470 US\$. Nearly half the population lives below the

poverty line, and 36% live on an income of less than one US dollar per day. The crude birth rate is 25 (per thousand) with an estimated 4 million annual births. Total fertility rate (TFR) in Bangladesh is 2.9 per woman. Most of the women still give birth at home with female relatives and traditional birth attendants. Institutional delivery is recorded in only 15% births and the rate of skilled attendants at birth is only 18% (UNICEF 2008). The government of Bangladesh and its development partners has strengthened emergency obstetric care (EmOC) services at various levels during the past decades. Although MMR has been declining (from 574/100,000 live births in 1991 to 290 in 2006), it is still one of the highest in the world. The government of Bangladesh has committed to meet the MDGs (millennium development goals) of United Nations, and under MDG-4 and 5, it targets to reduce MMR by 75% by the year 2015. Bangladesh's current challenge is to improve effective service delivery, health sector governance (especially in primary, and maternal health services), and increase the number of trained birth attendants.

The health care system in Bangladesh is very pluralistic, and both the public and private sectors are actively involved in providing health care to people. Maternal and child health (MCH) services have been given highest priority in the government of Bangladesh's health policy in recent years. The public services are provided through a nationwide network of facilities. In addition, there are private practitioners who provide health care in practices and clinics, which represent the most common source of care for the urban middle and upper class population.

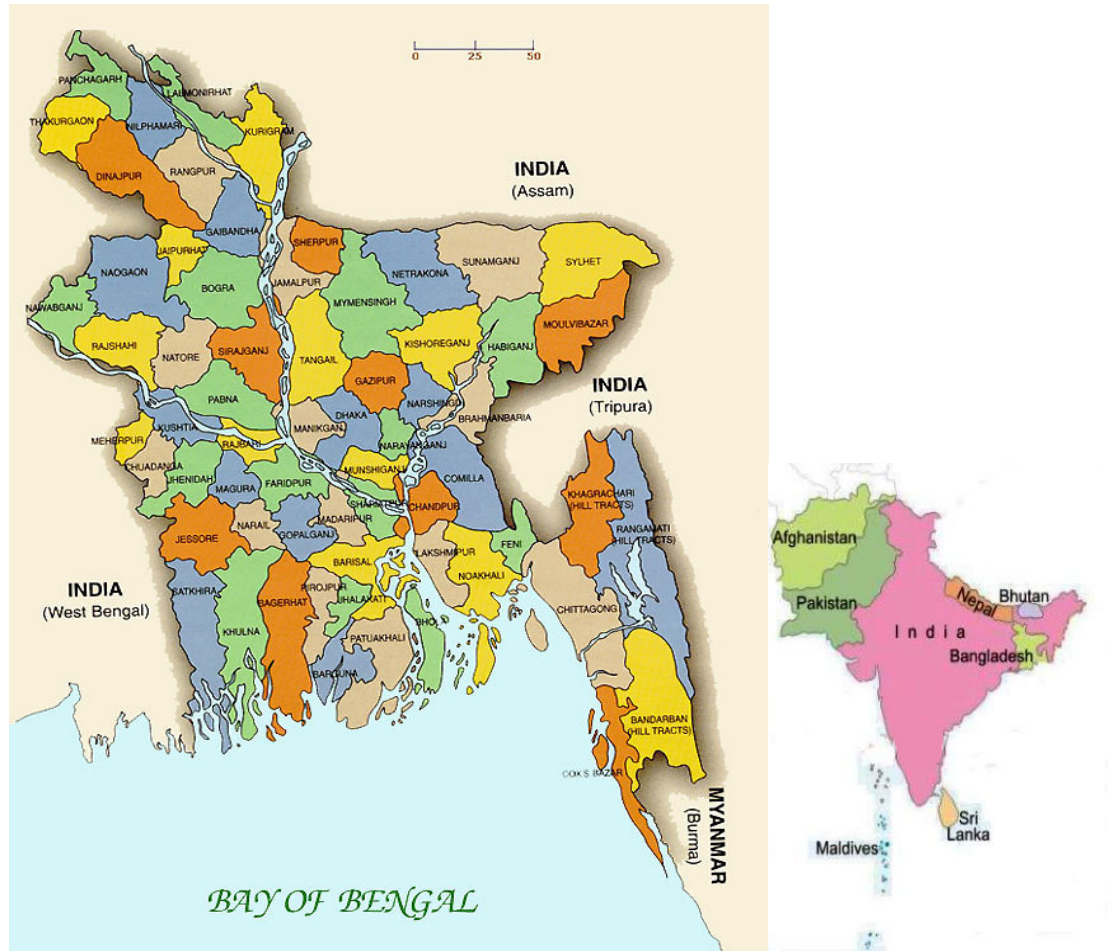


Figure 1: Map of Bangladesh . Source: <http://www.sasnet.lu.se/bilder/bangmap.jpg>

Bangladesh has a well-designed, grassroots-based service delivery infrastructure across the country. The government committed to achieving the following goals: to increase the rate of deliveries assisted by skilled attendants from 13% to 50% by 2010, and to reduce maternal mortality by 75% between 1990 and 2015, in adherence to the Millennium Development Goals (MDGs) 4 and 5. At the national level, there is one Institute of Post Graduate Medicine and Research, one Maternal and Child Health Institute (MCHTI), one Institute of Child & Mother Health (ICMH) and thirteen Government Medical College Hospitals in the country. The services available are antenatal care and delivery services including comprehensive EOC (Emergency

Obstetric Care) services and postnatal care for mother and child. At the community level, the Family Welfare Assistants and Health Assistants provide services from the Community Clinics (CC). At the *Union*¹ (collection of villages, smallest unit of local government in rural parts of Bangladesh) level, a Family Welfare Visitor (FWV) and a Sub-Assistant Community Medical Officer or medical assistants are mainly responsible for providing the services. There are also 250 Graduate Medical Officers posted in 3,275 UHFWCs to provide MCH services. At the *Upazila* (sub-district) level, the MCH unit of the *Upazila* Health Complex (UHC) headed by a Graduate Medical Officer is responsible for providing MCH services. Trained support personnel such as FWV and *Ayas* (female ward assistants) assist as well. There is also a position of Junior Consultant (Gynecological) who provides services in case of emergencies, attending all deliveries at the UHC and all referred maternal patients. The district hospitals (DHs) in the district headquarters provide maternal services through an outpatient consultation center and a labor ward. Between 25-40% of beds are reserved for maternal patients in every hospital.

NGOs and the private sector are also involved in providing reproductive health services. Like the public hospitals, the NGOs working with safe motherhood initiatives have extensive service networks at the community level, including special programs and facilities for providing antenatal care and safe deliveries. The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), Bangladesh Rural Advancement Committee (BRAC), Corporation for American Relief Everywhere (CARE), and many more national and international NGOs are active in this area. They have their own service models through which they run safe motherhood programs. These programs have been conducting research in critical and priority areas of reproductive health in various parts of Bangladesh to identify determinants and consequences of reproductive ill health, followed by appropriate interventions with the ultimate aim of improving

reproductive health. They provide safe motherhood interventions as a means of reducing maternal mortality and morbidity. They work on projects aiming to promote utilization of basic EOC services at union level and comprehensive EOC services at the *Upazila* level by women in need of those services, particularly those with obstetric complications. These organizations have community level workers who visit door-to-door and provide safe motherhood messages and services to the people.

The government organizations and NGOs collaborate on issues of maternal health at many different levels of providing care. Non-governmental organizations often run joint programs in collaboration with the government to develop the maternal health status by using the government's infrastructure at community, *Union* and *Upazila* levels. The government UHCs (*Upazila* Health Complex) is sometimes used for referrals to comprehensive EOC services in case of obstetric emergency by the community level health centers.

Despite this well-organized infrastructure and public-private collaborations, the overall utilization rate of the health care facilities for maternal health is not satisfactory in Bangladesh. There is a very unequal distribution among rural and urban women as well as in different social classes regarding the utilization of health care facilities (BDHS report, 2009).

Overview of Maternal Health Service System in the United States

In the United States, maternity care is defined primarily by modern biomedicine, with 99% of births occurring in hospitals. Wagner (2006) notes that, in the United States and in Canada, highly trained surgical specialists (obstetricians) still regularly attend normal, healthy, low-risk mothers in delivery. Anthropologists who have studied childbirth issues in the United States report that pregnancy and childbirth are considered pathological conditions and technological

interventions, such as episiotomies, pain medication, and fetal monitoring, are standard procedures (Davis-Floyd 1987, Jordan 1978). In many cases, even Caesarean sections are considered a standard procedure to avoid the “risks” of child delivery.

Although Caesarean section is an emergency procedure “to prevent or treat life-threatening maternal or perinatal complications” (Althabe 2006: 1472), researchers have observed an inappropriate rise of Caesarean sections in many countries of the world (Beckett, 2005; Faundes & Cecatti 1993; Hopkins 2000; Leone et al. 2008; Liamputtong 2005; Wagner 2000). The World Health Organization states that 15% should be the maximum and that no region in the world is justified in having a Caesarean rate greater than 10–15% (WHO, 1985). However, in the United States, the rate is almost 25% (Betran et al. 2007). As Wendland (2007) notes, “critics suggested that cesareans were being performed because they were more lucrative and more convenient for physicians, not because women really needed them” (2007: 220). Wendland cited Corea (1985) and mentions that, “although many in and out of the medical field had expressed concern over cesarean rates in the past, now the entire ideology of U.S. obstetrics was attacked as a system in which male physicians saw women’s bodies as inherently dysfunctional” (2007: 220).

Sargent and Stark (1989) note that during prenatal classes, pregnant women are informed about the pain and risks associated with child delivery. Thus, they may be more likely to accept pain management medication like epidurals. Women are also influenced by the experiences of their family members and friends who have used these medications for their deliveries. The natural process of childbirth is represented as a horrible and traumatic experience through the

information provided for the women during their pregnancies. Overall, the maternal health system is overmedicalized and highly technocratic.

Some women in the United States choose home births or give birth in a birthing center with a midwife. Davis-Floyd (2004) introduces us to the different wave of women's choice and agency when the conversation increasingly came to include women's right to choose to give birth at home. Across the nation throughout the 1970s, women began to choose to give birth at home reacting to the massive overmedicalization of birth (Davis-Floyd 2004). There is a more recent trend of using birthing centers and giving birth with specialized and trained midwives which has gain popularity among women in this country.

Cheyney (2008) conducted research among women who decided to choose home birth with direct entry midwives (DEMs), challenging the authority of obstetricians, the public narratives of the medical model of childbirth, and the powerful and widely accepted metanarratives of hospital birth. The author also presents evidence that the 'homebirther' acquires alternative birthing knowledge from multiple sources, e.g. books on midwife-attended birth, internet, informal knowledge sharing networks, as well as bodily and experiential knowledge of intuition or 'body knowledge.' Cheyney notes that the 'homebirther' women refuse the "gaze of medical surveillance" (the concept coined by Foucault), undermine the authority of medical establishment, reject the docile body, live the empowered body, and enhance democratization of the birthplace. However, it is important to identify the socio-economic conditions of those women who are able to practice their agency and choose alternative birthing methods.

Influence of Western Bio-Medicine in Maternal Health Services

This thesis explores how Western biomedicine shapes women's reproductive experiences and thus also draws upon the literature regarding authoritative knowledge of Western bio-medicine and technological interventions within the domain of maternal health care. To discuss the subjugation process of women's reproduction and motherhood by modernity, it is important to identify the role of Western bio-medicine as a vital catalyst of this process. Biomedicine is a powerful knowledge industry which defines body, health, and disease. These medical ideas are not separate from the global political arena. Global politics and market forces are operated and dominated by certain groups of people. The biomedical system is part of that domination. Lock (2002) presents case studies of constructed ideas in biomedicine. For example, notions of aging vary in North America and Japan. She describes how menopause is constructed as an abnormal state by biomedicine in North America. It is assumed that menopause requires special medication to meet estrogen deficiency, which is disease-like state of the female body. Thus, the aging female body has become an investment site for pharmaceutical industries. Lock argues that, although the life cycle is simultaneously a social and a biological process, the focus of attention in medical circles is confined to physical changes. Complications caused by menopause are propagated as universal. Lock presents the case study of Japan in contrast, where menopause is not considered to require any special intervention. Instead of menopause, social values affect aging in Japanese society, and Japanese women do not worry about menopause as a symbol of the loss of youth. Lock notes that, recently, some physicians are seeking to medicalize menopause and to treat it much more aggressively as a disease of aging. She views them as directly influenced by the trends of North America.

Jordan (1997) conducted fieldwork on the birthing processes in several cultures. She writes that when multiple knowledge paradigms exist, one tends to dominate. A frequent result is the loss of authority and even denigration of local ways of knowing; further subordinating these populations in relation to exogenous biomedical practices. In her view, the biomedical physicians' unquestioned authority and status is a type of performance of ritualized deference paid to the high status of biomedical knowledge. This elevated status serves as a barrier to establishing dialogical relationships between biomedical practitioners and clients.

In her book, *Birthing the Nation: Strategies of Palestinian Women in Israel*, Kannaneh (2002) details how the notion of the "modern mother" is constructed in the Galilee through different tools of modernity. She discusses and analyzes the connection of reproduction with politics and policies of the nation state, modernization, medicalization of the Western bio-medicine, economic development and local dynamics. Kannaneh focuses on the increasing medicalization of the body, its commoditization, and its penetration by "science" which has led to new conceptualizations of reproduction and sexuality.

Lazarus (1994) studied the influence of technological care over choice and control and its intersection with social relationships. She conducted several studies among diverse groups of women from different socio-economic classes. She interviewed women about their pregnancy and childbirth experiences and obstetricians, midwives, residents, medical students, and nurses about their views on childbirth, and observed interactions between women and physicians. She found women to have unequal access to knowledge and differing degrees of desire for such knowledge. She reported that her study examined three groups: working middle class women, women health professionals that are also middle-class, and poor women. When comparing the

experiences of the three divergent groups, she found that knowledge about childbirth and care in hospitals was inextricably linked to social class. Depending on one's social class, patients received unequal levels of care. Poor women received separate and unequal levels of care; they were seen in different waiting rooms and examination rooms. Middle class women were influenced by the feminist movement to assert control over reproduction and fertility treatment options however their decisions are also influenced by their acceptance of, or ambivalence toward, the increasingly routine use of advanced technology and obstetrician control of the birthing process. Lazarus viewed the authority of medical system very prominent which is similar to what Jordan indicates as 'authoritative knowledge' – the knowledge on the basis of which decisions are made and actions are taken (Jordan 1993). Lazarus hence states that, "The medical establishment "creates" birth as a "natural" family event, not as a crisis, right in the hospital. At the same time, an increasing reliance on technological innovations in childbirth continues to keep knowledge of the workings of the system in authoritative hands" (1994: 41).

Lisa Handwerker (1998) explores how the broader cultural, economic and social system reproduces the politics of gender and new notions of infertility. Medical knowledge and practices frame the reproduction of infertile women, often resulting in social suffering. Women blame themselves for this "inability" to conceive. She asserts that, "challenges to gender norms, and specially the position of women in society, have resulted in an increased medicalization of social problems, impacting on the definition and treatment of infertility, and attitudes toward childless women" (1998:179). She elaborates the policy issues that shape this notion and explains the politico-economic factors that are active in problematizing infertility. Handwerker argues that "Chinese birth policy aimed at reducing births has ironically led to the further stigmatization of infertile women as *other*," and through the complex new reproductive technological expansion

“China has unwittingly encouraged the growth of a high-tech baby-making industry” (2002: 310). Handwerker discussed that, the expanding market of new reproductive technology uses women’s vulnerability to sell their products. Handwerker also points out the role of reproductive technology in promoting new eugenics in modern China, where male babies are precious and expected. The process is influenced by policy makers, global market forces and the importation of Western reproductive technologies which are disguised by medical knowledge and practices. She states, “Maoist social ideology, the one-child policy, post-1980 global market forces and the importation of Western reproductive technologies have played out in China in unique ways...high-tech baby making in this cultural setting has become potent signifier of Chinese “modernity,” even though modernity is also signaled by the country’s low birthrate” (2002: 310-311).

Some anthropologists have argued that maternity has become a commodity through biomedical practice. Whiteford and Gonzalez (1995) examine how infertility is reshaped within the biomedical industry and identified as a fault of the female body. They argue that, “popular culture media such as advertising, weekly and monthly magazines, movies and television augment the authoritative knowledge of biomedicine...stories about women who overcome great odds, and at terrifying costs to themselves succeed in producing a child, reproduce and legitimate the biomedical hegemony” (1995:35). Notions of maternity and infertility are used by producers of this market to run their trade, and the human body is commodified through these processes. It is generally propagated that the use of reproductive technology is a response to consumers’ demands. As Handwerker notes the high-tech baby making is driven by the consumers, that is, infertile women who desire a child. In the post-1980 global market, there is also a belief among infertile Chinese women that the best medicine is often the most technical and expensive. The

recent equation of “Western” medicine with modernity and prestige has led to the incorporation of more and more Western biomedical techniques into an increasingly competitive market (2002: 304-305). On a separate note, we can recall Appadurai (1996) in this context, where he argues that the “images of agency are increasingly distortions of a world of merchandising so subtle that the consumer is consistently helped to believe that he or she is an actor, where he or she is at best a chooser”(1996: 42). Hence, women’s choice of modern technology for fertility and childbirth is constructed upon the demand and expansion of a global market force which obtains its legacy from “modern” biomedicine.

As these studies show, being a “modern mother” is important for most women in the contemporary world since being a “traditional mother” is stigmatized (Ram and Jolly 1998). The dichotomy between “modern” and ‘traditional’ has been a long discussed in anthropology as well as in other social sciences. This dichotomy has been constructed under colonialism throughout many different parts of the world in the past. Western authorities attempted to modernize “traditional” non-Western people through colonialization and by constructing the West as modern. This “great responsibility” was carried out by developing pre-colonized societies. The scheme of modernizing “others” is still very much active in the world and being carried out though Western authorities and biomedical systems. Women and motherhood have been subjugated by the modernization scheme for a long time, regardless if women are Western or non-Western. However, the process of targeting non-Western women’s reproduction requires significant attention in anthropological scholarship. Western bio-medicine is a powerful operating sector to establish hegemonic relationship with non-Western world. Globalization plays a vital role in allowing the penetration of Western biomedical knowledge and practices to the rest of the world. Discussing motherhood and reproduction within the discourse of modernity

includes many different issues: the female body, birthing, fertility, abortion, childcare, reproductive technology, bio-medicine, women's agency, and so on. Through this research, we can also identify the relationship of modernity which is an important arena of anthropological investigation and scholarship.

Summary

The study of childbirth in anthropology calls for an amalgamation of different complex contexts related to women's reproduction. While it is important to understand cultural beliefs and practices regarding childbirth, structural factors that influence women's choices and decisions, as well as the hegemony of biomedical system are also important. In regard to immigrant women's childbirth experiences, the situation demands an even more in-depth investigation. Immigrant women are in vulnerable condition where they face acculturation to the host country as well as the adoption of ideologies and practices of a new society; simultaneously, they retain the cultural practices and social norms of their own countries.

This study aimed to explore the childbirth experiences of Bangladeshi immigrant women living in the US. Hence, the complex conditions of immigrant life, coping strategies within the host country, interactions with the biomedical system and perceptions towards modern medicine and technology used in childbirth become apparent. It is also important to identify the degree to which Bangladeshi cultural practices of childbirth are still retained by these.

While there is a literature on immigrant women and maternal health issues in anthropology; to my knowledge, there have been no studies specifically on Bangladeshi immigrant women's childbirth experiences in the US. They may have very specific culturally-based perceptions about the US health care system such as communication with service

providers, dealing with the hospital system, health insurance, and so on. When it comes to maternity health care, women's experiences are related to gender norms and influenced by different social settings as well. Furthermore, most studies on immigrant women's health focus on non/under-utilization of and/or barriers for access to health care services. This research uses childbirth narratives of Bangladeshi immigrant women to analyze their perceptions and experiences regarding prenatal and delivery in the US health system. For a better understanding, these experiences must be contextualized in relation to modernity and biomedicine.

Chapter Three

Methodology

Introduction

This chapter elaborates on the research process and the steps followed throughout the study. It discusses methods used for data collection and analysis, the setting, and the participants involved in the research. In addition, the ethical considerations of the study are discussed and a brief timeline of the research is provided.

Qualitative Research

The research objectives of this study required qualitative research methods. Qualitative approaches focus on “processes and meanings that are not rigorously examined, or measured (if measured at all) in terms of quantity, amount, intensity or frequency” (Denzin and Lincoln 1998:8). Qualitative methods help researchers to understand the nature of reality, which is shaped by society, through the close relationship between the researcher and the subject of study, and the environment around them.

Qualitative research depends on “systematic observation in the field by interviewing and carefully recording what is seen and heard, as well as how things are done, while learning the meanings that people attribute to what they make and do” (LeCompte and Schensul 1999: 2).

This approach is important to understanding the perceptions and experiences of the immigrant Bangladeshi immigrant women in this study and allowed for an investigation and

analysis of those experiences. This study utilized sampling and data collection methods that are typical of qualitative research. The participants of this study were recruited by purposive and snowball sampling, and primary data were collected through in-depth interviews (Bernard 2006).

Research Setting

This study was conducted in Tampa, Florida. The city of Tampa is the third most populous in Florida. It is located on the west coast of the state, approximately 200 miles northwest of Miami, 180 southwest of Jacksonville, and 20 miles northeast of St. Petersburg. The total population of the city is 301,863, with 1,687 persons living per square mile. Tampa's economy is founded on a diverse base that includes tourism, agriculture, construction, finance, health care, government, technology, and the Port of Tampa. According to the US Census report of 2000, the racial composition of the city was 46.22% White (51.0% White Non-Hispanic), 26.07% Black or African American, 0.38% American Indian and Alaska-Native, 2.15% Asian, 0.09% Native Hawaiian and Other Pacific Islander, 4.17% from other races, and 2.92% from two or more races. Hispanic or Latino of any race was 19.29% of the population. The most prominent ancestries are German (9.2%), Irish (8.4%), English (7.7%), Italian (5.6%), and French (2.4%)(United States Census Bureau).

Many Bangladeshi families come and decide to settle down in Tampa because of the weather, which they perceive to be similar to the weather in Bangladesh. While there are no official statistics about the number of Bangladeshi residents in the area, key informants estimated that there are approximately 80-90 Bangladeshi families living in Tampa

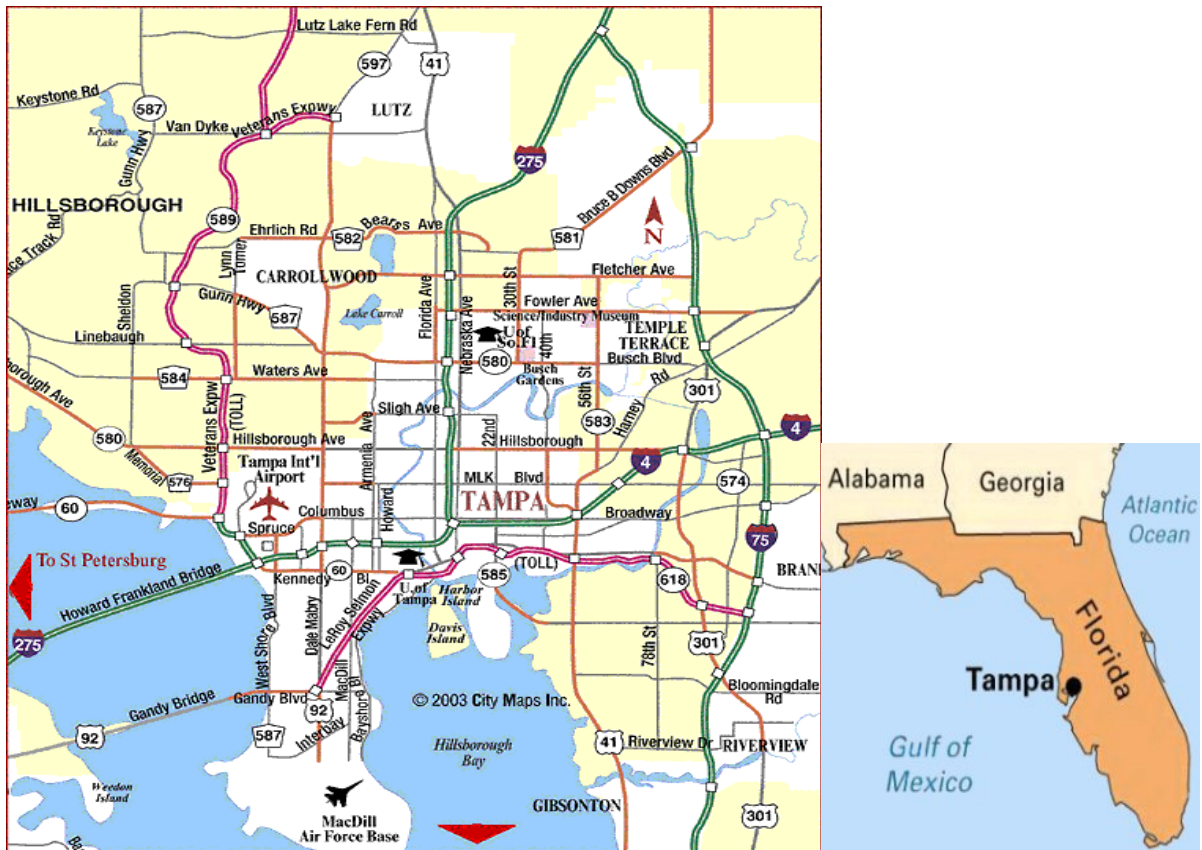


Figure 2: Map of Tampa

Source: http://www.aaccessmaps.com/show/map/us/fl/tampa_bay_north

Data Collection

Primary data were collected using in-depth interview methods. Participants were recruited from the Bangladeshi immigrant community living in Tampa using purposive sampling and snowball sampling, which is discussed in greater detail below. The interview sessions were based on the following research questions:

- *How did the participant women experience their pregnancy and childbirth in the United States?*

- *What differences do they identify between the health care systems of Bangladesh and the US in this regard?*
- *How do they perceive these different situations from a socio-cultural perspective*
In terms of:
 - a) *Cultural beliefs and practices regarding pregnancy and childbirth*
 - b) *Social networks of support*
- *How do they perceive these different situations from a structural perspective?*
In terms of:
 - a) *Hospital infrastructure and facilities*
 - b) *Cost of care*
 - c) *Prenatal, delivery and postpartum care.*
- *How does their gender role in the household impact on their experiences?*

Participant Recruitment

The population size of this community is not large enough to apply random sampling methods or other sampling strategies. Therefore, purposive sampling (Bernard 2006) was used to select the respondents. In purposive sampling, the researchers decide the purpose of the study and locate participants to serve those purposes. Purposive sampling is usually used in the cases of a) pilot studies, b) intensive case studies, c) critical case studies, and d) studies of hard-to-find population (Bernard 2006: 189-190). In this study, no official record of Bangladeshi immigrant

women living in Tampa, Florida could be located. Hence, it was hard to find women of this community, which as a result demanded the use of purposive sampling.

To be included, participants had to be women who migrated to Tampa from Bangladesh and have had at least one child born in the United States. For a better understanding of their immigration status, women were selected who have been living in the US for at least five years. Fifteen women (Table 1) who fulfilled these eligibility criteria were selected using purposive sampling (Bernard 2006). The age range of the participants was 28 to 46 years. All of the participant women except two came to the US as a spouse, and they all had legal permanent residence status in the US at the time of the interview. All the women maintained a heterosexual married life and lived with their husbands.

Table 1: Demographic Information of the Participants

Participants' Name (Pseudonym)	Age	Education (degree obtained)	Duration of living in the U.S. (in years)	Duration of living in Tampa (in years)	Number of Children	Childbirth Experience (location)
Dilara	38	Master	8	8	2	Bangladesh and United States
Tahmina	42	Bachelor	12	10	2	Bangladesh and United States
Maliha	46	Master	18	14	2	Bangladesh and United States
Afreen	38	Master	11	9	2	United States
Lamiha	31	High School	10	7	2	United States
Sakiba	39	Master	13	10	2	United States
Sharmin	36	Bachelor	11	11	2	United States
Shirin	43	High School	20	11	2	United States
Munia	37	Medical degree	7	5	1	United States

Hena	41	Master	20	17	2	Bangladesh and United States
Laila	40	High School	21	8	2	United States
Nasrin	36	High School	9	5	3	Bangladesh and United States
Bina	44	Master	21	17	2	United States
Rabeya	37	Master	11	10	2	United States
Shormi	28	Master	10	9	2	United States

The researcher used her contacts with Bangladeshi families to reach participants. Most Bangladeshi families maintain some sort of social relationship and connection with other compatriots although these networks are not as strong as practiced in Bangladesh. The researchers utilized these networks to select the participants. After finalizing the proposal of this study, the researcher contacted some Bangladeshi acquaintances living in Tampa, and attended several social gatherings to meet others. She then talked to some of the women about the research project and asked them if they would be interested in participating. After meeting some women who have childbirth experiences in the US, the researcher maintained continued contact with them and eventually asked if they would allow her some time to interview them. Snowball sampling (Bernard 2006) was also used to select additional participants. In snowball sampling researchers use key informants to locate one or two informants who can help to recommend others in the community whom the researcher might interview (Bernard 2006: 192-193). The researcher moves from informant to informant and the sampling frame grows with each interview. In this study, the researcher primarily received help from Shamin and Sakiba (Table 1) to locate other women from the community. Later, she received additional contact information

from participants about women in their social network, and then used the referrals from the previous participant to select others.

In-depth Interview

This study used in-depth interviewing (Bernard 2006) as the primary method of data collection in order to explore the perceptions and experiences of the participants. In-depth interviews allow the researcher to better gather information on such sensitive issues. As it is a one-on-one interview method, participants may feel more comfortable in sharing their experiences. In this study the participant women are a part of immigrant community and might have had issues related to immigration status that they might not have been comfortable sharing. Moreover, the study aimed to understand the experienced-based perceptions of the participant women, which required in-depth conversations with the researcher. It was also easier for the researcher to gain access to participants because of her own position as a Bangladeshi woman. Since snowball sampling was used to select the participants, this also aided the researcher in gaining the trust of these women.

The interview sessions were held at the convenience of the participants. The researcher contacted the women via telephone to set a time and place for the interviews to be conducted. Eight interviews took place at the participants' home, while five women came to the researcher's house for the interview sessions. One interview took place in a coffee shop, and another was held at the participant's sister's house. When the interviews were held at the participants' house, the women continued their household tasks (cooking, taking care of children, etc) while talking to the interviewer. The women who came to the researcher's house brought their children with

them. The interview sessions were fairly flexible and pleasant. The interview sessions were 1 to 2 hours long.

The interviews were conducted in Bengali, the native language of the participants as well as the researcher's. Most of the women who participated in the study could converse in English but not all were sufficiently fluent to talk about their personal issues in depth. The researcher read and explained a verbal consent script to the participants and obtained verbal agreement of consent to participate in the study. Verbal consents were tape recorded. An unstructured questionnaire was used for the interviews that guided the women to share their experiences related to hospital care, service providers' behavior, their husbands' role, the labor room experience, pre- and post-natal care, family and social support, their migration situation, among others. The women were also asked to talk about their feelings and impressions by contrasting the two settings of Bangladesh and the United States in relation to pregnancy, delivery and the postpartum period. The participant women who had had childbirth experiences both in Bangladesh and in the United States discussed these issues based on their own experiences. By contrast, the women who had their childbirth experiences only in the United States reflected their opinions and comments about Bangladeshi practices based on the knowledge from the experiences their friends and relatives in Bangladesh. The questionnaire design allowed for these reflections. Notes were taken during the sessions. Interviews were audio-taped with the permission of the participant. A sample question guide is included as an appendix.

Data Recording and Transcription

All interviews were tape recorded. Permissions were obtained from the participants for the recording. The interviewer also took notes during the interviews to supplement the recordings.

Most of the interviews were transcribed thoroughly however, not all interviews were transcribed thoroughly. In cases of those interviews the researcher transcribed specific parts of the interviews based on the themes of the study. As the interviews were conducted in Bengali, some parts of the interviews were translated into English to use as direct quotes in this thesis.

Data Analysis

Analyzing the collected data started shortly after the data collection began. Since the research methods in this study focused on qualitative data collection, the largest part of data was analyzed primarily by reviewing field notes and interview transcripts. There are several issues that were discussed very frequently during the interview sessions. Topics like doctors' behavior, well equipped service facilities, lacking social support, and missing family member are very common in almost all the interviews. The researcher extracted some quotes from the interviews in relation to the common issues discussed. This allowed the researcher to identify major themes and issues related to the research objectives. The themes were primarily selected from the interview guide. Later, these were supplemented by the responses of the participants. Some frequent and common responses were received on several issues almost in all the interviews. Those themes were examined within the context of the goals and objectives of the research as well as within the discourse of maternity health care and biomedical practices.

Field Experiences

The field experience included a number of small challenges. After selecting the participants, it was often difficult to arrange actual interviews due to scheduling conflicts, requiring adjustments to the planned timeline. Although women were contacted several times and appeared very enthusiastic, it was hard for some of them to schedule time for an interview. This is not

uncommon in qualitative research, especially with marginal populations who may have busy family and working schedules. Some women were very busy with their young children, while others had to work. In addition, some appeared doubtful about the research, since they were not used to being asked to participate in a study. Even during the interviews, some women asked repeatedly what will happen with the information. In these cases, the researcher detailed the research objectives to the participants and informed them that this research had the goal of understanding immigrant women's experiences with the U.S. health care system in order to improve the health care system for them.

The positionality of the researcher presented a challenge as well. Specifically, because the interviewer was from Bangladesh, participants took for granted that she already knew about the Bangladeshi health care system and social practices related to childbirth. Thus, it was often difficult getting enough information from women when it came to talking about their perceptions and experiences in Bangladesh, requiring repetition of the same or similar questions throughout the interview. Participants tended to discuss their experiences in the US more frequently than those in Bangladesh.

At the same time, there were some advantages to the researcher being a part of the participants' culture. One major benefit was the ability to conduct the interview sessions in the participants' first language. It was also relatively easy to contact the women and build rapport with them, gaining access to their homes to talk to them for long hours. Many of the women specifically expressed a desire to help a student from their home country complete their educational degree abroad, which they viewed as positive. Furthermore, the researcher faced some transportation challenges because she does not drive a car; however, some participants

arranged transportation to their homes, another gesture of solidarity. Finally, the participants felt sympathetic towards a compatriot living abroad without family, and often the interview sessions were followed by an elaborate dinner in the participant's home in which the women cooked a typical Bangladeshi meal.

Ethical Considerations

Before carrying out the fieldwork, the research proposal was submitted to the thesis committee for approval. The committee consisted of three faculty members of the Department of Anthropology at the University of South Florida. Once the proposal was approved by the thesis committee, a detailed application was submitted to the Institutional Review Board (IRB) at the University of South Florida for official approval. IRB approval is required for any kind of research that deals with human subjects. The IRB officially approved the research project and data collection tools (interview questionnaire and verbal consent form) on July 14, 2008. Following approval, the interviews were conducted using those tools.

This study was conducted among adults who do not constitute a "risk group". Verbal consent was used instead of a written consent form, in order to avoid getting signatures from the participants. Based on my experiences, it was assumed that many immigrant Bangladeshi people do not feel comfortable signing a piece of paper. I read and explained a verbal consent script to the participants and obtained verbal agreement of consent to participate in the study. Verbal consents were tape recorded. The research study was explained in Bengali. As I am a native speaker of Bengali, there were no communication problems. This study did not produce any harm or discomfort to the participants' daily lives. The participants were not forced to talk about

anything that they do not want to. Their names are not included in the notes or recordings of the interviews. All information provided by them was kept confidential.

Chapter Four

Results

Introduction

This chapter presents the results of the study. The structure of the sections is based on the questionnaire used for the in-depth interviews. Participants' experiences and perceptions are discussed, including those related to their pregnancy and childbirth; the quality of health care services and cost of care; and finally, how the migration experiences of the participants affected their childbirth experiences.

Maternity Experiences of the Participants

The participants' maternity experiences were the most important part of this study, through which it aimed to understand the distinctive features of this particular group of people, if any. It was important to understand the significance of these experiences in the context of immigrant women's health. The interviews explored the unique experiences of the participants in regard to their experiences with and perceptions of the quality of care, the health care facilities, and, more significantly, access to care. To explain these experiences more constructively, maternity experiences are discussed in several different sections that follow.

The participants were 15 Bangladeshi women who are part of an immigrant population living in Tampa, Florida in the United States. The age range of these women was 28-46 years.

The duration range of living in the United States was between 7 and 21 years, while the range of

living in Tampa was 5 to 17 years. Of these participants, two women had their bachelor's and master's degrees from universities in the United States. The other 13 participants completed their education in Bangladesh. Including the two previously mentioned participants, eight women held a master's degree; four women had completed high school, and two held bachelor's degrees. In addition, one participant had completed a professional degree in medicine in the United States, following completion of her bachelor's studies in Bangladesh. All of the participant women except two came to the US as a spouse, and all had legal permanent residence status in the US at the time of the interview. Five of the participants had their childbirth experiences both in Bangladesh and in the United States; ten participants had their childbirth experiences only in the United States. One woman had three children and one woman had one child; all other participants have two children each.

Pregnancy

Pregnancy is an important period for most women because they face many physical, mental, and social transitions during this relatively long period of time (around forty weeks). This section will discuss the participants' experiences during their pregnancies. These experiences also yielded information about their perceptions towards the maternal health care system in the United States, especially regarding prenatal care and preparation for child delivery.

In their discussions, most participants considered pregnancy to be a natural process rather than an illness. Participants reported that pregnancy is a "normal" process of women's life cycle; a woman has to go through the situation if she wants to have a baby. At the same time, most of the women mentioned various illnesses they had during their pregnancies that are common during that period of time. Most commonly mentioned were gestational diabetes, high blood

pressure, nausea and vomiting, severe tiredness and fatigue, and anemia. In addition to these, three participants faced serious physical complications during their pregnancies, which will be discussed later in this chapter.

While talking about pregnancy, most women discussed it as a nine to ten-month period, which is very common way to express this time frame in Bangladesh. For antenatal routine visits, most of them talked about them in terms of months, even though they followed the standard US routine of using weeks (as it is followed in the clinics). This expression reflects the common perception of being comfortable calculating the pregnancy period according to their Bangladeshi understanding of reproductive timing.

As mentioned before, some participants in this study had pregnancy experiences both in Bangladesh and in the United States, while others had only been pregnant in the US. There were noticeable differences in pregnancy experiences between these two groups of women. Participants who experienced pregnancy in Bangladesh enjoyed the support and care from immediate family and friends, while most of those in the US did not. Regardless of experiencing pregnancy period in Bangladesh or not, all the participants mentioned that in Bangladesh they would have their mother or sister or other relatives with them during the pregnancy period. If not, they said, at least a maid would be there to help them with the household work. Some women mentioned that it is very common to feel sick during pregnancy, to feel tired and not want to eat anything. If they were in Bangladesh, they said, family members or friends could offer them different options of food to encourage them to eat. Participants mentioned that it is important to have someone around who is caring and trying to help, since they consider

pregnancy to be a very sensitive period for women. Most of the women mentioned that they missed their close family members and friends during pregnancy more than at other times.

On the contrary, some of them said that one should not be pampered so much during pregnancy, as is common in Bangladesh; after all, pregnancy is not an illness. They also expressed their understanding of self-reliance in this situation. Six participants reported that the experiences in the US, that is, the lack of help from family and friends, made them feel self-sufficient. For example, they did not depend on anyone for household work, to accompany them to doctors, or to do other activities, whereas in Bangladesh there are always others present to help. For example, Maliha said that she did not do any household work when she was living with her mother in Bangladesh during her first pregnancy and the post-partum period that followed. Whenever she visited her doctor, someone from the family accompanied her. When she was pregnant with her second child in the U.S., her son was only four years old; she managed to do all the household work, including taking care of her son. She used to go to the health center for antenatal visits by herself. She believed the situation made her strong and taught her to manage everything on her own. While she commented that it was very hard to manage everything, whenever she looks back she thinks those experiences gave her courage to face other difficult times in life. Dilara, another participant, echoed Maliha's experiences. She said,

When I was pregnant with my son, my husband was abroad doing his PhD studies, and I was staying at my parent's house. My mother, sisters, and brothers did not let me do anything. They treated me like a princess and were always concern about my wishes. Let aside household work, my food was always served to me. My mother and sisters used to take care of me a lot. They were very happy that I was having a baby, and it was a matter of great joy to them. But see, when I had my daughter in America, no one was with me, my husband was very busy with his work, and I managed to do everything..... everything ! The thing is, I had learned to do everything by that time. That is how this country makes you independent. - Dilara

Another significant aspect of the pregnancy experiences of the participants was related to their jobs/employment. Five of the participants had never worked since they had been in the US, outside of being a housewife. Three of the participants resigned their jobs when they became pregnant and never got their jobs back. Three others reported that they did not work during their first pregnancy, but were working during the second pregnancy and that they preferred working over being at home during pregnancy. According to them, staying home made them depressed and lonely. Afreen did not work during her first pregnancy; she found that staying home made her days longer. As she said,

I used to wait for my husband the entire day. I had negative thoughts at that time, sometimes I felt, if I fall down, if I get seriously sick, or if something bad happens to me, who would come to save me? And sometimes the clock seemed to me as if it stopped working - Afreen

There were different perceptions about working while pregnant. The participants who continued working reported that it was very helpful in coping with pregnancy. They said that going to work and spending time outside the home interacting with many people helped them to overcome the morose loneliness. Afreen (38) had to resign her job during her first pregnancy, but worked during her second. She reported that she felt much better when she was working, because she said she had felt very lonely at home during her first pregnancy. In another example, Sakiba (39) reported that it can be difficult to continue with a job during pregnancy, depending on what kind of job someone has. According to her perception, very few immigrant women have 'official jobs' but rely on informal types of employment; some women are involved in temporary and 'odd jobs,' which are not always easy to continue while pregnant. Shormi (28) was working in a company and doing very well, by her own account, before her first pregnancy. When she became pregnant, she had to quit her job because she was not able to concentrate on her work properly

and found herself to be inefficient. However, she did not return after delivering the baby. She and her husband started a business with other partners running a gas station. Shormi was working there when she became pregnant for the second time. After 22 weeks, her doctor suggested she should go on bed rest and discontinue working in the gas station. Eventually Shormi and her husband faced many problems with their business partners, as Shormi's husband was working full-time at another job and not able to devote enough time to the business. They eventually lost the business. Shormi's experience is a good example of how a pregnancy can interrupt regular sources of income. Her work was very important for her family, but she could not continue working because of her pregnancy.

The participants' experiences reflect different strategies to cope with their situations as immigrants. Some had to quit their jobs when they became pregnant as they did not have any other options. It was hard for many women to return to their jobs after pregnancy. Others considered themselves self-sufficient in terms of taking care of themselves, and did not miss the support from their family members and friends in Bangladesh. They were successfully able to cope with their situation, and felt proud to not be dependent on others. On the contrary, other participants complained about the very same situation, wishing they could have received that kind of support in the US.

Child Delivery

The next significant stage is labor and the delivery of the baby. In this study, this stage was particularly significant, with participants reflecting upon their perceptions of quality of care and the health facilities in relation to their delivery experiences. All the participants in this study had

their children delivered in a hospital or health center, regardless of whether the delivery took place in Bangladesh or in the United States.

Some of the participants faced complications during labor, and some reported going through very difficult and long labor. Five of the participants who delivered their babies in both Bangladesh and in the U.S. compared their delivery experiences in the two countries. They reported to be satisfied with the care they received from the facilities in both countries. Some participants focused on comparing the attitudes and behaviors of the health care providers in the labor room. For example, Maliha (43) liked the behavior of the doctors in the US more than those in Bangladesh. In her opinion, doctors and nurses in the U.S. are more tolerant. She thinks that a nurse or doctor should provide plenty of time and attention to the women in labor. Based on her experiences, she found the doctors and nurses in Bangladesh were not tolerant enough to soothe the laboring mother.

Dilara opined much differently than Maliha. She thought her doctor in Bangladesh was more tolerant than the doctor who attended to her in the US. She also mentioned, however, that not all doctors are nice in Bangladesh, and emphasized that she was lucky to have had a very nice doctor during her pregnancy and child delivery.

The participants who had delivery experiences only in the United States also expressed opinions about their doctors and nurses. Sakiba (39) felt that the doctors and nurses were not very enthusiastic or attentive. In her case, the doctor came at the very last moment of delivery and the nurses were not always present either. Instead, the nurses watched her condition over the monitor. Sakiba did not complain about the situation, though; she explained that situation as simply part of “their” system. She also added that the service providers have their own way of

performing their job, and that they know well what to do and when. Laila (40), on the other hand, explained the same situation in a very different way. She said, “It is not necessary for the nurses and the doctor to be there at the labor room all the time. It depends on your health condition. If you are having a long labor they should not be with you all the time. They can watch your condition over the monitor; they will not know better when to come to you.” She also mentioned that some Bangladeshi women are not tolerant enough to wait for the nurses and doctors; they want to have the nurses and doctors to be there all the time, which she considered “ridiculous.”

A very significant issue in the interviews, mentioned by almost all participants, was the presence of their husbands in the delivery room. In Bangladesh, it is very rare to have the husband in the delivery room. For cultural reasons, husbands are not allowed or expected to be in the labor and delivery room, be it a home or hospital delivery. At home deliveries, only female relatives attend, along with the midwife. At the hospital facilities, only a female attendant is allowed to be at the labor and/or delivery room besides the doctor and/or nurses. There was one exception, however, with Maliha reporting that her husband was present during her first delivery in Bangladesh.

Only three participants in this study did not have their husbands present at the labor and delivery room in the United States, and in each case it was because their husbands had to work. All the participants reported that they felt it was very important to have their husbands in the labor and delivery room. They expressed that husbands can provide the best emotional support during that ‘difficult’ time, since they are closest to the woman. As Sakiba said,

My husband was standing by the delivery bed holding my hand. I was very terrified and felt that I am dying. But the presence of my husband provided me a lot of courage at that time. – Sakiba

Shormi mentioned that husbands share the baby, since they are the father; therefore, it is important for them to at least watch the birthing process and know the pain, even if they cannot experience it themselves. Some participants also mentioned that they wanted to have their husbands watch how much suffering they had to go through in order for the child to be born. Laila (40) said, “Our husbands should know how much suffering we have to get their (husbands’) babies born. Then they will know our importance and will take care of us more. In Bangladesh, husbands do not take care of their wives that much, because they do not know the degree of suffering.”

Shirin (43) said, “Our husbands do not have any idea about the process of child delivery. They never watched a delivery. Even some husbands here do not want to be present in the delivery room, they feel shy or afraid, but they should -- otherwise how would they know how much pain we bear, how difficult the process is?”

The participants also reported that the labor rooms in the United States are much more modern, clean, and well-equipped than those in Bangladesh. Laila (40) said that even if she were not in the US, she would try to go to some other developed country to give birth. She said she would not dare to give birth in Bangladeshi facilities. On the other hand, Hena (41) reported that the facility she used for her first delivery in Bangladesh was very nice and clean. She said she did not see much differences between the US and Bangladeshi facilities. She also mentioned that she had used one of the best facilities in Bangladesh, which is not very different than a US hospital.

To summarize, participants had mixed perceptions regarding their delivery experiences in the United States. They all used hospital facilities to deliver their babies, and most were impressed with the quality of care they received in the hospitals. Overall, the well-equipped and clean labor and delivery rooms in the United States was appreciated. In addition, they looked favorably on the behavior and attention of the hospital staff. They liked the fact that their husbands were allowed to be present at the delivery room. While most participants did not report any challenges during their delivery experiences, a few expressed their feelings of insecurity in the delivery room since they were not sure what to expect in terms of treatment and they could not ask anything of the doctors.

The participant women also talked about the social support they received from friends and neighbors in America. Four women left their young children at a neighbor's or friend's house when they went to hospital to deliver the baby. Most participants reported that their Bangladeshi friends visited them and brought cooked food while they were in the hospital.

The Post-partum Period

The participants found the postpartum period to be the most challenging part of their childbirth experiences in the United States, especially because of the lack of assistance and care they would have received in Bangladesh. All mentioned that if they were in Bangladesh, for example, they would not do any household work after childbirth because there would always be someone to help the new mother. This was not always the case in the United States.

Five of the participants had childbirth experiences in Bangladesh. They all recalled the care they received from their extended family members, reporting that they did not have to do anything (mostly referring to household work, e.g., cooking, cleaning, etc.) after their birth.

Dilara, Maliha, Hena and Nasrin all stayed at their parents' houses for a month after childbirth. They compared that time with their postpartum period they spent in the US, and glorified the care they received in Bangladesh. Maliha (43) said,

when you have your first child you don't know anything, how to take care of the baby, how to take care of yourself; it's your mother or sister or other relatives who teach you these things; however, I did not face any problems with my second childbirth as I knew everything from my first experience.

Tahmina's first child was born in Bangladesh; she did not go to her parent's house after her delivery, since her in-laws resided in Dhaka (the capital city of Bangladesh), where health care facilities are better than those in the city where her parents lived. Tahmina had some medical complications during her pregnancy and child delivery, and she was under the close supervision of an obstetrician. Her doctor suggested she take complete rest during and after her pregnancy. She now believes that she could only follow those suggestions because she was in Bangladesh with her family members. She also mentioned that in Bangladesh, people could at least hire a maid to assist them if their own family members were not available.

Three of the participants had their mothers travel to the United States before or after their delivery. They mentioned that having their mothers there during the postpartum period made them feel more comforted and relaxed. Their mothers' presence helped them to rest more, as well as to take care of the newborn. They also mentioned that they received mental and emotional support from their mothers when they were around. As Shormi said,

I was very sick during my second pregnancy; the doctors suggested I go on bed rest. I was at risk of having a miscarriage. At that time, my first child was only two years old and he was really a hyper baby. I had to leave him with a baby-sitter even though I wasn't working at the time. But my son always wanted to come to me and I was not able to take care of him. I asked my parents to come, and so they did when I was six months pregnant. At that time, I got a relief from everything. I felt that they saved me by being

with me. My mother let me rest and took care of my son and the housework. I don't know what would have happened if they had not come at that time.- Shormi

One participant had her grandmother come from New York to help her during the postpartum period, and two participants, who are sisters, received support from each other during their pregnancy and postpartum period. Shirin thinks that her older sister's presence helped her to cope with serious sickness during her pregnancies. Another two women reported that they had their mother-in-law living with them; however they did not receive as much support and care from their mother-in-laws.

Laila felt that it would not have been possible for her to take care of her baby if her mother were not there with her, since she did not have any idea how to care for a baby. She went to Lamaze classes during her pregnancy and read a lot; however she felt that, in practice, it was much harder than what she understood from the classes and the books. Her mother helped her to cope with that situation. She said,

It was even very surprising for me that the baby was waking up so many times at night. I thought I would feed him and he would sleep through the whole night. I went crazy to find that I had to wake up and nurse him a couple of times at night. During the days I used to be dead tired; my mother allowed me to sleep while she was taking care of the baby. - Laila

Lamiha and Rabeya had their first children in New York, where their extended family members live. They therefore received good care after childbirth. In their words,

My aunt and my grandmother took care of me and the baby in New York. They did not allow me to do any household work. They cooked all good meals for me. They know what food I needed at that time, what type of care the baby needed. They made some special food so that I have good flow of breast milk. – Lamiha

When I had my first child born in New York, I did not even feel like the baby had been born. My sister-in-law and my nieces were always taking care of the baby. They asked me to rest. The baby used to wake up at night and I had to nurse her, so I used to have less sleep at night and be very tired. During daytime, my family members would keep the baby so that I could get enough sleep. When my second baby was born in Tampa, I missed that care badly. - Rabeya

Lamiha had her grandmother come from New York to Tampa to help her after the second delivery. She felt blessed to have relatives living in the United States who could help her during the postpartum period. Similarly, Tahmina and Shirin are sisters and living nearby one another, which meant that they could get help from each other during their pregnancy and postpartum period.

On the other hand, Afreen faced many challenges after her childbirth. She had a Caesarean section for her second child. At that time, her first child was only two years old. This meant that she had to take care of her older son as well as the newborn, and she herself was recovering from the surgery. She felt that it was a very hard time for her; however, she did not complain about the situation. As she noted, every situation brings a solution with it, and people learn how to cope. She said that she learned how to manage the situation.

Many participants, including Shormi, Hena and Bina, noted that their husbands helped them and took care of them during their postpartum period. Their husbands even cooked food for them, which is something that would not have happened if they were in Bangladesh. Other women reported that their husbands were the same, whether they are in Bangladesh or in the United States. In these cases, no matter how bad the wife's physical condition, they are supposed to cook for the family members and do the household work.

Finally, some participants felt that it would have been better for them if they could have stayed at the hospital longer after delivery, since it would have helped them to rest a little more. Most of the women mentioned that they had to start doing work around the household in addition to taking care of the newborn right after returning from the hospital. During their stay at the hospital, they could rest. These participants indicated that they would be better taken care of at the hospital, since the nurses were very caring and they were exempted from household work and care for the newborn. However, a few other participants mentioned that they did not want to stay longer at the hospital, since they were more comfortable at home. This was especially the case for women who had their mothers with them; most came home after one day. The five participants who had their babies born in Bangladesh also did not want to stay in the hospital longer than necessary . They felt that the home environment was much comfortable than the hospital environment in Bangladesh.

Selection of a Doctor

The participants in this study had very specific strategies regarding the selection of a doctor. These preferences were based on the gender and cultural background of the doctor, distance of the doctor's clinic from the participants' home, and friends' recommendation through community networking. Although the women had preferences, those were not always easy to meet because of various circumstances. Constraints related to health insurance played a major role in the selection of a doctor. The respondents mentioned that they would have had many choices of doctors in Bangladesh; in the U.S., however, they had to depend on the list of doctors provided by the insurance company. Of course, this situation applies only for the women who

had health insurance. The scenario was very different for the five women who did not. Their choices were even more limited.

All of the women except two preferred a female doctor for their antenatal check-up and child delivery. There are multiple reasons the women mentioned for preferring a female doctor. Most commonly they said that it was a matter of their own comfort. Some women reported that they would see a male doctor for other diseases, but medical care related to pregnancy was a different matter. They did not want to allow a male doctor to do the check-up or deliver the child, since it requires examination of the body. Seven women mentioned that they visit male doctors for other illnesses, but they preferred female doctors for pregnancy check-up and especially for child delivery. In Bangladesh, most ob-gyn doctors are female, because women prefer to visit female doctors for reproductive health matters. They said that the physical examinations during pregnancy and child delivery are related to women's privacy regarding their bodies. While discussing seeing a female doctor, most of the women mentioned that they do not feel comfortable to show their "body" to a male. They indicated that they were referring to "intimate body parts" (Ivry and Teman 2008:370) through the word "body." According to their social and cultural norms, it is not common to utter the terms of female genitals in discussion. Therefore, they used the more generic term "body" instead of naming the parts of the body that are related to childbirth.

Three women specifically said that their preference for a female doctor was linked to being a Muslim. In their words:

When I went to the hospital for my first child's delivery, a male doctor came and I denied letting him do the delivery. I said 'we are Muslim, we feel better with a female doctor for delivery.' Then the hospital people called in a female doctor. I had to wait one hour for a female doctor. - Lamiha

As we are Muslim we should see a female doctor during pregnancy and delivery. – Laila
One other participant said,

It's obvious that we would want to see a female doctor. We cannot really feel comfortable if a male doctor does the physical examination during pregnancy. It's very common to see a female doctor for pregnancy in Bangladesh. – Sharmin

Two women saw male doctors during their pregnancy even though they wanted to have female doctors. One woman said that she did not want to visit a male doctor and expressed this to her husband, but he ignored her, saying that they did not have many choices in a foreign country. She says,

In Bangladesh, when I had [my] first child, I told the doctor on duty in the hospital that I want a female doctor to deliver my baby. When I asked to visit a female doctor here, my husband told me that this is *bidesh* (foreign country); therefore, I don't have that much choice here. Anyway, I didn't feel that bad with the male doctor, because he was very old, a bearded man, was like a father to me. I had some hesitation but as he was very gentle, I felt better afterwards. – Maliha

In this case, the respondent did not want to visit a male doctor but when she had to, she tried to accept the situation by considering that the doctor's age and appearance helped her feel at ease. From her perspective, she equated the male doctor with a father figure, which provided her comfort as she could asexualize the doctor's actions. During another interview, a participant said, "That male doctor checked me from outside. The female nurses checked me internally. But my baby was delivered by the female doctor." In this case, the respondent emphasized that the male doctor did not examine her intimate body parts and her "body" was exposed to female service providers only.

There were two women who did not specifically request or prefer a female doctor, and both were very sick during their pregnancies. They did not feel that the gender of the doctor was important for them to receive good care for their sickness. As Hena (41) stated,

When you have options, why don't you choose a female doctor? If there's no female doctor available, you can see a male doctor. After all, saving a life comes first.

Munia (41) reflected almost the same comment as Hena did. She wanted to have a female doctor to deliver her baby. But while discussing the preference of a female doctor, she says,

I preferred a female doctor that time to deliver my child, but I really believe that it doesn't matter what the sex of the doctor is. Doctors are doctors, they don't see a female body in that way, and they treat that as a body. – Munia

Munia did not have health insurance, nor did she receive Medicaid for her pregnancy. She visited a male doctor during her pregnancy. The doctor was her neighbor, and he gave her a discount, so she did not have to pay much for the visits. She said there were no better options, as she did not have health insurance. Munia also emphasized that the doctor was Muslim and she thinks that he might have helped her out of charitable obligation and a sense of shared background. Similarly, Lamiha denied allowing a male doctor to deliver her first baby in New York. She requested a female doctor, and her request was granted there. However, she went to see a male doctor during her second pregnancy. She did not have health insurance or Medicaid, so she went to see a doctor in her neighborhood who has a private practice at his home. She paid \$50 dollars for each appointment. She said that she thinks it is a blessing to have an arrangement like that; otherwise, it is too expensive to see a doctor without health insurance.

While discussing their preference for a female doctor, most of the women mentioned that if there were no female doctors on the list provided by the insurance company, they would go to

a male doctor. Female doctors were preferred, but there were also no cases when this preference was not honored and resulted in the women refusing maternal health care.

Some of the participants reported that they tried to select someone with whom they share a cultural background, e.g. a Muslim person or a person from India, Pakistan, or other parts of Asia. They felt that it is easier for a doctor from a similar cultural background to understand their condition. The following quotes illustrate this point:

It was good that I had a Pakistani doctor during my pregnancy. She could understand how I was feeling, as we are from similar cultural backgrounds. She knows how we could get some comfort during this time period. – Laila

American doctors would tell me not to eat spicy food, but an Indian doctor knows that during that time I need food of my taste. Having food is important during pregnancy. Therefore, it's important to consider what kind of food I can eat. – Sharmin

My doctor was very nice here. She was a Chinese lady. It was a plus for me. As she was from our side (Asia), she could understand our cultural practices more. - Dilara

These comments suggest that respondents were trying to associate themselves with the doctors of somehow similar cultural background. It is interesting to notice that someone is associating her cultural background with China, which is quite far away from Bangladesh, both geographically and culturally. It appears that, while the respondents are in a different country, they create their own strategies to cope with the different setting.

However, some women also reported that American doctors behaved very favorably to them and were very efficient. Sakiba liked her doctor, who was an American, as he asked her many questions regarding her health. She felt that there were many things that she could mention while answering the doctor that she would not have mentioned on her own. Interestingly, all the women expressed confidence in their doctors, regardless of whether they had an American doctor or if they chose a doctor based on cultural background.

Communication with the doctor during pregnancy and the delivery period was a significant part of each interview. Along with equipment and technology, participants emphasized doctors' behavior as a measure of quality of care. All the participant women's native language is Bengali, and some said that when they received health care during pregnancy they were not very fluent in English. Their husbands helped them to understand the doctors' suggestions and prescriptions. It is interesting that the women thought that the doctors were smart and skilled enough to understand their health condition, even though they (the women themselves) were not able to talk directly to the doctor. They felt that language was a barrier in communication with the doctor; however they relied on the doctors to understand their physical condition. For example, some participants stated:

Here, doctors know what to check. You don't have to say that much. Sometimes I felt that I am not being able to say what I wanted to, but they understand their duty well. – Tahmina

To be honest, American doctors are very nice. They know everything. You don't have to say anything. They are smart enough to understand your condition. - Sakiba

American doctors saved my life. I was so badly sick that Bangladeshi doctors wouldn't be able to save my life. – Shirin

Some women preferred a doctor whose clinic was closer to their homes. They wanted to make sure that they could reach the doctor if any complications arose. Seven of the participants mentioned that their husband selected the doctor for them, and that they did not know what criteria their husband had used. When Nasrin was asked about this matter, she said, "I do not know anything about that, it's my husband who selected a doctor and took me to the doctor's office." The other eight participants mentioned that they had a discussion with their husbands about selecting a doctor. As Afreen (38) said, "We wanted to find a female doctor, but especially it was my husband who looked for a female doctor for me. I was not that adamant about that. My

husband doesn't even go to a female doctor. However, I feel comfortable with a female doctor. It's really a matter of personal comfort.”

Finally, community networks also influenced the selection of a doctor. Three women said that they selected a doctor because they knew about them from Bangladeshi friends. They consulted with other Bangladeshi people and asked about their experiences. They asked for recommendations from their friends before selecting a doctor. Two women were pregnant at the same time, and neither of them had health insurance; they visited the same doctor who was recommended by another mutual Bangladeshi friend.

Health Care Facilities

In this section I will discuss the experiences of the participants regarding the health care facilities from which they received care. All the participants reported that the health care facilities were very good. They said that the hospitals are very comfortable in the United States, very systematic and well-organized. They particularly liked the clean and quiet environment of the facilities. They also liked the fact that the hospitals had modern equipment needed for their prenatal checkup and child delivery. For example, Laila was impressed by the monitors used in the nursing station. She felt it was a nice system, so that even if the nurses were not with her, they could still check on her condition.

Afreen compared the two different health centers where she was a patient for her two deliveries. She was very impressed with the health center where she had her first child, because the labor room was large with a big window facing a lake. The view was very soothing for her while she was coping with the labor. She thinks that the environment of the labor and delivery room can help a mother to cope with the pain. In her words,

I especially liked the labor room where I stayed during my first labor. It was a spacious room with a big window facing to a lake. I liked the view as it was scenic, and the whole environment of that room. I think, the health facilities should consider that the environment of a labor room can help a woman to cope with her pain. – Afreen.

Five women reported that they had been very well cared for at their hospitals following delivery. The nurses were very helpful and guided them about how to care for themselves. They mentioned the behavior of the nursing staff of the hospital, in particular, who they viewed as very enthusiastic towards the patients, which aided the patients' comfort. One woman, however, felt that the nurses in the United States lack emotion and do not show the kind of interpersonal communication that is common in Bangladesh.

Family and Social Support

It was very interesting to notice during the interviews that the participant women were always very cautious to not complain about anything regarding their experiences in the United States. They repeatedly stated that were very impressed with the care they received. When they were asked if they had faced any challenges, almost everyone negated. However, interestingly, this changed as the interviews progressed. Participants often talked about the family and social support they missed during the different stages of their childbirth experiences (e.g., pregnancy, delivery, postpartum) because they lived in the US. They all mentioned that it is very common in Bangladesh to get extra care during pregnancy and the postpartum period. The women who had their childbirth experiences in Bangladesh emphasized and described in detail the amount of care they received while they were in their own country. For example, Hena said,

During my first pregnancy, my mother was with me most of the time. I was very young at that time, did not know anything about how to take care of myself. My mother took care of me as if I was a baby again. She cooked all good food for me. She was always concerned about making me feel better.

Some women reported feeling very lonely during their pregnancy. Even if they had Bangladeshi friends living nearby, most reported that they did not ask them for help because they would be busy with their own issues. This is not the same as it would be in Bangladesh, many commented. Nasrin said,

In our country, people are more helping and supportive. You have your own family and relatives there; even the friendships are of long term and have a different meaning there. Here, you get some support from the Bangladeshi community, but it's not the same. The people who have their own family members living in the United States have better support than we who do not have anyone.

Afreen and Sharmin reported different experiences than Nasrin. They had family members living in other states in the U.S. (for Afreen, in-laws' family members and for Sharmin, her brothers and sisters); however these relatives could not visit the participants during any portion of their pregnancy and childbirth. These two respondents stated, again, that people are busier in the US than in Bangladesh. Sharmin also mentioned that it would not be very convenient for her sister to come, even if she had time. She said, "I used to live in a smaller house at that time, how I could accommodate my sister for [a] couple of weeks?"

Some of the women mentioned receiving care from their Bangladeshi friends. For example, they were invited to their friends' houses, or friends brought cooked food over for them. Friends called them or visited with them and inquired about their health. When asked about any social support they received in the U.S., many mentioned that while they receive some social support it was not comparable with what they would have received in Bangladesh. They also mentioned that whatever support they received from the other Bangladeshi people was had to suffice because they did not have their own family members and close relatives around to provide that care. For instance, Sharmin reported that one Bangladeshi woman used to give her

rides to the health center for the prenatal visits during her first pregnancy, which was a great help for her. At that time, Sharmin did not know how to drive. She also mentioned that when she started driving she tried to help other Bangladeshi people who do not drive.

However, in general there seemed to be a tendency among the women not to ask for any help from other Bangladeshis. Some of the women commented that they did not want to depend on anybody else. While they missed their family's support, these women were not willing to ask for help from compatriots living in the area because they are not relatives. They also reported that everyone is busy with their own households and jobs, and that it did not seem appropriate to bother them.

Overall, the lack of family and social support appeared to be the most important complaint among the participant women. At many points in the interviews, women returned to a discussion of the support they missed. Sometimes these discussions seemed to be vague and romanticized, since many women could not really define or describe anything in particular that they missed.

Challenges

During their interviews, participants were asked to talk about challenges during their childbirth experiences in the United States. Interestingly, as noted earlier, most of the women replied promptly that they did not face any challenges. However, through the course of the conversation, they brought up several issues. It appeared that they were conscious about not complaining in regards to the US health care system. Hena (41) said,

I am very much adapted to this country. After coming here, I started school, I was working here. I am very much adapted to this culture. That's why I didn't feel any problem. I am from another country. I was culturally shocked, but I adapted here very

quickly. Only problem I see here is the language barrier. Even if we speak English we have [an] accent. There are nurses in the hospital; they wouldn't understand what I am saying. When I am sick it's hard to explain everything as they don't know much about our experiences. I didn't have that much problem, some people do face though. I overcame somehow.

The participants generally liked the health services they received in the US. The women who also had had childbirth experiences in Bangladesh were satisfied with Bangladeshi health system as well. They reported that they received good care in Bangladesh. Interestingly, the women who had childbirth experiences only in the US had a negative opinion about the Bangladeshi health system. Shirin (43) said that, "if I were in Bangladesh at that time, I wouldn't have survived. They wouldn't have provided the advanced health services that I got here." Shirin was not physically well during her entire pregnancy. She reported that she was very sick during both pregnancies. She could not eat anything and became very weak, tired and anemic. She used to vomit whatever she would eat. She had to be hospitalized several times, and doctors supplemented her nutrition through an IV. She thinks her situation was managed very well by her doctors. Therefore, she had a favorable opinion about American doctors.

Loneliness, a lack of desired food, missing close family members, and not having a helping hand for household activities and for childcare were the challenges reported by the participants. Consider the following examples:

The first thing I did when I came back home from hospital is feed my son. The doctor told me that I should not do any household work, I should be like a queen, and I should rest. But how? Who would take care of my household, who would feed my son? Who would hold the newborn? Let alone my own health. At that time, I missed my family a lot. But everything is adjustable; we are to cope with every situation. Afreen

I had to cook rice on the day I came back to home from the hospital and that was only one day after my baby was born. I had to do all household work here, whereas I didn't do anything in Bangladesh for almost a month. Dilara

Some women said that they did not experience any problems at all. They felt that as newcomers to the US; they should not expect everything they would have had in their own country. They stated that they were happy especially with having better health care in the US, which was the most important thing at that time.

Cost of Care

The first response when asked about the cost of care was the same from all the participants: they all reported that the cost of care in the United States is too high. However, the responses varied when they discussed payment. Most of the participants' maternity care cost were paid by their husbands' insurance, be it a professional insurance (insurance provided by their employer) or a private insurance (purchased themselves). Only one woman had health insurance covered by her own employer; seven women had their health insurance covered by their husbands' employer. Two women had their health insurance purchased by their husbands only during their pregnancy and delivery; and after delivery they cancelled the health insurance. Five women did not have any health insurance. Four of them received Medicaid, and one woman received a subsidized service package covered by Planned Parenthood. Participants who were covered by either form of health insurance had different experiences compared to those who were uninsured.

Experiences with Medicaid

Medicaid is a state and federal partnership that provides health coverage for selected categories of people with low incomes to improve the health of people who might otherwise go without

medical care for themselves and their children; and policies of Medicaid is different in every state. According to Florida Department of Children and Families, Medicaid provides Medical coverage to low income individuals and families. The state and federal government share the costs of the Medicaid program. Medicaid services in Florida are administered by the Agency for Health Care Administration (AHCA). Medicaid eligibility in Florida is determined either by the Department of Children and Families (DCF) or the Social Security Administration (for SSI recipients). Three basic groups are eligible for Medicaid: SSI beneficiaries, children and families; aged, blind and disabled people, including people needing institutional care. However these programs also refer that, an individual must meet specific eligibility requirement; each program has specific income and asset limits that must be met; and Persons may be eligible for full or limited benefits, depending on the program. There are some basics of Medicaid that are mentioned in the AHCS's report: a) not all providers accept Medicaid, b) not all services are covered by Medicaid, c) some limitations may apply to covered services, and d) Medicaid has a set fee for each individual type of service and procedure. In Florida, Medicaid serves 27% of children, 44% of pregnant women, 66% of nursing home days, 885,000 adults (parents, aged and disabled), 52% of people with AIDS (AHCA 2004).

For maternity care, different services are offered through many different programs; and the most common services are: 8-12 prenatal visits during pregnancy, 1-2 ultrasounds per pregnancy, 0-2 postpartum visits (which include an examination of both mother and baby), 1 or 2 newborn assessment, and the post delivery recovery service for 24 hours. However, not all women are eligible for all these services. Some women receive only limited Medicaid services for maternity care through the programs called Emergency Medicaid for Aliens (EMA) and Presumptively Eligible Pregnant Women (PEPW) programs. EMA serves the women who are

aliens (do not meet citizenship or permanent residency requirements), and are only eligible for emergency services only. EMA does not include prenatal and postpartum services; it covers only the delivery service for the women. In PEPW service package, temporary eligibility is established for low-income pregnant women where only outpatient and office services are covered during pregnancy. PEPW does not cover services associated with labor, delivery, postpartum, and inpatient hospitalization (AHCA 2004).

As mentioned before five participants of this study did not have any health insurance. Four of them received Medicaid however two of them received only emergency/limited Medicaid. All these four women reported that their experiences with maternity care were not smooth. They faced different challenges to receive Medicaid services. The two women, who did not receive emergency Medicaid only, mentioned that their immigration status was the main reason for not receiving Medicaid during pregnancy. In their words,

I conceived my second baby right after we moved to Florida. We applied for Medicaid but we got rejected (Lamiha)

I did not receive Medicaid for my pregnancy because we just came to the U.S. at that time (Munia)

These two women who were legal immigrants in the country did not receive Medicaid due to the short length of their stay. And, they faced challenges for receiving pre and post natal care.

I used to visit a private practitioner and had to pay him for every visit, therefore, I missed some visits if I felt better health wise. My doctor suggested me to get an ultrasound when I was at the advanced stage of pregnancy. But I did not do that as I had to pay a lot of money for that - (Lamiha)

I was very sick during my pregnancy. I had *placenta praevia*, and I was hospitalized for seven days. I did neither have insurance nor a Medicaid. I got a bill of \$10,000. In that hospital, my husband knew a doctor and he sought help from that doctor. The doctor was very nice and he helped us to get a fund from the hospital's social services that paid the major portion of the bill; otherwise it would not possible for us to pay that amount and we would be under debt for long time. During my pregnancy, I used to visit a doctor who was our neighbor; he was very nice and exempted me from the fees of prenatal care. As I had had a complicated pregnancy, several times I had to get some lab tests done. Without that doctor's help it would be difficult for us to pay for all these services as it is very expensive to pay the fees without having Medicaid. - (Munia)

Munia further reported that she suffered from post partum complications however the emergency Medicaid she received did not cover her post partum treatments.

My Medicaid was emergency Medicaid and it was valid only for childbirth. I had a cesarean section and I had post-partum complications. For those I had to pay the treatments from own pocket – (Munia)

The other two women who received Medicaid during their pregnancy also reported same challenges for receiving pre and post natal care.

I received Medicaid when I was seven-months pregnant. I used to visit a doctor for my prenatal care. I had to pay in cash, and it was very expensive. Hence, I did not go every month. Moreover, I had some complications during pregnancy and the doctor prescribed an ultrasound for me, but it would cost me \$700, and this amount was very high for me at that time, and I could not afford it - (Sharmin)

I wish I could stay longer at the hospital after my delivery. Medicaid covers only one day stay for post delivery recovery unless you are very sick – (Nasrin)

These women also reported that they faced delay to get the approval for Medicaid. In their words,

The paper work was too confusing for us to understand. We sought support from other Bangladeshi friends for that, but the people who have health insurance could not help us. All these paper work delayed Medicaid to receive - (Nasrin)

I received Medicaid and it helped me a lot to use health services for my childbirth. But it was a difficult process. My application was rejected when I applied first time. I had to reapply, and that made a delay” – (Sharmin)

All these participants however were satisfied with the child delivery services they received that were covered by Medicaid no matter it was regular Medicaid or emergency Medicaid.

Cost of delivery care is very high and would be unaffordable for us without emergency Medicaid. Besides, I had had a caesarean section and that would cost me us a lot. In this country it is very nice that the government takes care of delivery services for all women. - Munia

At least we got our delivery services covered by the state; otherwise it would be impossible for us to pay the cost - (Lamiha)

Although Medicaid is very helpful for immigrant women who do not have other health insurance, the procedure and provision of providing Medicaid services may restrict immigrant women to receive necessary health services e.g. prenatal check-up and post partum treatments. Moreover, women can endure severe health complications during pregnancy while the cost of care is very high without health insurance or Medicaid.

Comparison between Maternal Care Services of Bangladesh and of the United States

Five participants in this study had childbirth experiences in both Bangladesh and the United States. They compared their experiences between their own and the host country. However, other participants, who did not have any childbirth experiences in Bangladesh, also compared some aspects of maternity care and childbirth between the two countries, sometimes relying on examples of relatives or friends who had childbirth experiences in Bangladesh. One participant spent 32 weeks of her pregnancy in Bangladesh before migrating to the US.

The comparisons they made about these two settings were mainly based on three aspects of maternity care: a) medical care services b) care from extended family and friends, and c) cultural practices. The women who had childbirth experiences in both settings compared the hospital settings, prenatal visits, and labor room experiences they had. Mostly, they commented on the fact that the equipment and medicine used in the hospitals in Bangladesh are not as advanced as those in the United States. They all mentioned that, these days, modern equipment and medicines are available in Bangladesh, but not at the time when their children were born. They also mentioned that modern equipment is not readily accessible for women of lower economic status, since it is too expensive.

Maliha said, “When my first child was born in Bangladesh, it was 19 years ago. Now, things have totally changed there. They have all modern equipment there in Bangladesh.” Dilara echoed Maliha and mentioned that she had her son was born in Bangladesh 13 years ago, and she received very good care at that time. She also thinks that Bangladeshi health service systems have become much better now. Hena reported a different opinion. Although her first child was born in Bangladesh 25 years ago, she says she received very good hospital care, in terms of equipment and medicines even at that time.

On the contrary, women who did not have childbirth experiences in Bangladesh had doubts about the hospital services there. Afreen said,

“I am very afraid of Bangladeshi hospital services. They don’t have the necessary equipment for emergency management. Here you will see everything around you while in the labor room. You know that you will be treated perfectly if any emergency arises.”

Some women talked about the negligence of doctors. They considered Bangladeshi doctors to be less caring, for example. Lamiha said,

“The doctors are careless [in Bangladesh]. They can kill you or your baby. I heard from my sister the other day that a woman had a stillbirth, just because of negligence of the doctors in a private clinic.”

These women hear many rumors about the bad care in the hospitals and negligence of doctors and nurses in Bangladesh, which made them fearful to have a child there. Affording good care was also a matter of concern when they were commenting on Bangladeshi medical care. Some of them agreed about the existence of good care in Bangladesh, although it is very expensive. One woman considered the situation in a very different way. She said she would fly to Thailand or Singapore to have her child if she were in Bangladesh at that time. She said,

“If you can afford the cost, then why in Bangladesh? Why should you put your baby in risk? It’s good that I was here, otherwise I would think of different options, but not to deliver my baby in Bangladesh.”

Overall, there were many different viewpoints. Two women preferred to have their children born in Bangladesh. They liked the hospital care and services in the United States, but they found the hospital environment to be very unfamiliar. They felt that in Bangladesh, at least they would be in a familiar setting. One participant is herself a doctor. She felt that Bangladeshi doctors are very competent and caring to the patients. The problem is, she noted, that they face many infrastructural problems, which hampers their ability to provide services. She also mentioned that the doctors and nurses in Bangladesh must attend to many more patients than their US counterparts. She said, “It is hard for them to spend much time with each patient; however that doesn’t mean that they are not caring enough. I would like to have my childbirth in Bangladesh.”

The participant women also talked about the social support they received in the United States as compared with that in Bangladesh. They all reported that they would receive better support from their extended family and friends if they were in Bangladesh during their maternity period. The women who had their childbirth experiences in Bangladesh said that they always felt surrounded by family members during their maternity period. The family members and friends were always concerned about their well-being. They never felt lonely there. On the other hand, they often felt very lonely in the United States during the maternity period. The women who did not have their childbirth experiences in Bangladesh reported that they would have received extensive care from family members and friends if they were there.

While the participants compared the two settings of Bangladesh and the United States, they talked about cultural practices that are usually followed by women in Bangladesh. They commented on whether they felt the practices were good or bad, scientific or superstitious, and/or whether or not they followed them while in the U.S. The women mostly discussed the instructions that are provided by elderly people ,especially elderly women (mother and mother-in-law were mentioned frequently) in Bangladesh. Participants said that they still received those instructions from their relatives over phone.

Five women talked about following the instructions of elders regarding the period of solar eclipse and lunar eclipse. They mentioned that, in Bangladesh, elders suggest the pregnant women not eat anything, or look at the sun or moon, during the solar and lunar eclipse. They indicated that these practices are meant to avoid birth defects in the baby. These women also mentioned that pregnant women should not cut anything during that time. If someone cuts

something, it is understood that the baby could be born with a cut in its body, such as cleft lip.

Sharmin, one these women, said,

I know I am in America and I did not follow all the instructions our *murubbi* (elderly people) say, but there are some issues that are very important for the baby. My mother called me before *chondrogrohon* (lunar eclipse) and asked me not to eat or sleep at that time. She told me I can drink some juice or eat some light food though. She especially asked me not to look at the moon at that time. She asked me to stay at home, and keep walking rather than lying down. I followed her instructions. I do not know these are really scientific or not, but I did not want to take any risk.

Nasrin, Laila, Shirin and Tahmina also talked about eclipse period and followed the restrictions. Sharmin also mentioned that it is not good to look at cats during pregnancy, since it might cause the baby to be born with cat's eyes. Nasrin also mentioned this practice, but said that she does not believe in this.

Most of the women believed and followed the custom of doing good deeds and being in good state of mind during the pregnancy. They especially mentioned the importance of saying prayers and reading the Quran (the Muslim holy book) regularly. They indicated that these activities bring about peace in mind and that it is good for the baby's mental and physical growth. They also talked about reading good books, in general. A few of them also mentioned listening to good music and avoiding violent movies during pregnancy.

They participants also talked about rituals related to childbirth that are usually performed in Bangladesh. They mentioned specific rituals associated with the postpartum resting period that are very common in Bangladesh. Seven participants mentioned that, in Bangladesh, there are celebrations for the neonates within the extended family which they could not arrange in the United States. Some of them discussed a celebration that takes place on the sixth or seventh day after the birth. There is a feast arranged for relatives and friends who come to see the baby and

offer their blessings. Six of the participants talked about *Akeekah*, which is a religious ceremony performed for the safety of the baby. Four of them said that they sent money to their family members back in Bangladesh to perform this ceremony for them. On the other hand, five participants reported that they had arranged these celebrations in the United States and had friends of Bangladeshi community come and bless their neonate.

Three women mentioned a belief that is exercised in Bangladesh, according to which people should not buy baby items (such as toys, furniture, or clothes) before the baby's birth. However, they felt that this practice is just superstitious, and appreciated the common practice in the United States to buy all necessary items beforehand (in baby showers) so that they can bring them to the hospital. They felt that this is a good practice as it helps them to organize everything nicely. Shirin said, "In Bangladesh, right after the baby's birth, your family members bring all the necessary stuff for the baby. Here, either you get babies' stuff during a baby-shower as presents, or you buy them yourself to bring with you to the hospital." She concluded by saying that things are different in the United States, because pregnant women have to prepare every single thing by themselves, and they have to be well organized before they go to the hospital for delivery

Some mentioned the mobility restrictions they followed during pregnancy and the postpartum period. Others talked about food taboos, including recommended food during pregnancy and the post partum period. Women are supposed to avoid certain foods that might cause abortion during pregnancy, and they mentioned pineapple as a specific example. Some said that one should really avoid food that might cause any kind of allergy. They mentioned that,

during the maternity period, women can become allergic to certain foods that they would have been able to eat during “normal” times. Therefore, women should make careful food choices.

Most of the participants mentioned the traditional 40-days of postpartum period that is maintained in Bangladesh and includes exemption from household work, restricted mobility, and a special diet. However, they did not express the desire of maintain that tradition in terms of mobility restriction. They even noted that women in Bangladesh do not always follow this tradition now-a-days, especially in urban areas. Some women said that, in Bangladesh, elderly women suggest that in the postpartum period women should avoid foods that cause colds. If the mother catches a cold, the baby will be also affected by that. Four women talked about having “hot” and dry foods that help to heal the wounds of the mother’s body resulting from child delivery. Some women also talked about avoiding spicy foods after birth, as that could cause stomach problems for the baby. They also mentioned recommended foods that produce a better milk flow to the breasts. For example, these include drinking a lot of milk themselves, and about the ingestion of a seed called *kaali zeera* (black cumin). Goodburn et al. (1995) also indicated about a similar food item in their study: a ground-up mixture of cumin, chili, and garlic (a “hot” food) is commonly eaten in the immediate postpartum period, because it is thought to help heal the birth passage” (1995:25). Most of the participant women of this study reported that it is very common in Bangladesh to make a special food item with *kaali zeera*, which is very helpful for producing milk flow to the breasts. The participant who is a medical doctor recalled that she used to recommend mothers of neonates to eat *kaali zeera* when she was a medical practitioner in Bangladesh; however she herself did not eat that in the United States. She also mentioned that she did not need it, as she had supplemented her diet with many other good foods. Two women mentioned the custom of eating pigeon, which is considered a good food for producing or

replenishing blood in the body. They indicated that women lose a lot of blood during the delivery, so they should have food that produces more blood.

Nine of the participants talked about different cultural practices that they considered harmful for babies. Four women talked about shaving the baby's hair after birth. They felt it is not necessary to shave baby's hair, which is a very common practice in Bangladesh within a week of birth. They also reported that doctors in the United States do not recommend that. On the other hand, in Bangladesh, people consider this hair to be unclean. One woman said that she did not want to shave her baby's head, however, she had to because she was living with her in-laws, whose instructions she had to follow.

Three women talked about the practice of feeding honey to newborns, which is again common in Bangladesh as a way for the baby to develop a beautiful voice. They said that American doctors consider it harmful for babies (based on a risk of botulism), and one woman gave a medical explanation of why honey is harmful for the baby.

The participants mentioned that in Bangladesh it is common for mothers to co-sleep with the baby, whereas in the United States it is not very common. Most participants did not co-sleep with the baby and indicated that they felt it is good to keep the baby in crib, while five women mentioned that they co-slept with their babies until they were six/seven months old. All the five women who had their babies born in Bangladesh co-slept with their baby; however three of them did not co-sleep in the United States. Thus, it is evident that these immigrant women treat certain practices differently than they would in their own country, and that the dominant practices of host country convince them to do so.

Participants' Recommendations for improving Health Care

Two participants in this study did not have any health insurance or Medicaid during pregnancy but were exempted from the costs of delivery through emergency Medicaid. After their delivery, they signed forms at the hospital which provided social services and as a result, they did not have to pay for the delivery. Two other participants had difficulties obtaining Medicaid. They had to reapply before they finally received it. Therefore, all of these participants wished they had had better Medicaid for them during their pregnancy and childbirth.

The women had a multitude of recommendations for improving care. One woman specifically recommended that health care in the US could be improved by having more female doctors available for child delivery. She herself had a female doctor when she delivered her first baby in Bangladesh, and thinks that other women should also have that opportunity. Sharmin said that the hospital food should include *halal* meals (permitted food for Muslim people). In addition, she noted that hospital food was not of their taste and that many women have friends who bring cooked food from home, but unfortunately not all women had friends like that.

Some women mentioned the long hours they spent waiting during their prenatal visits. They said that even if they had appointments with the doctors, they still had to wait for long time, which was very tiring. Especially during pregnancy, they said, it is hard to remain patient. They recommended improving this situation. One woman recommended making the labor and delivery room more comfortable, with a scenic view and relaxing interiors. Four women recommended extending the period of hospital stay after child delivery. They mentioned that the duration of stay in the hospital depends greatly on the type of health insurance one has. Insurance policies typically allow women to stay longer only if the doctor recommends this out

of concern for their health. Sharmin said that she requested this from her doctor since she needed some rest, even if she was not sick physically. The doctor agreed, and she reported that the extra rest was a great help.

Finally, not all women felt that the system needed improvement. Sakiba said that she believed the health system is good enough as it is. The doctors and nurses behaved well and provided necessary treatment, she stated, which is all anyone can need.

Migration Experiences of the Participants

All the participants except one came with spouse visa of different type (H4, B2, and J2, F2 etc.) to accompany their husbands to the United States. Only one woman came with her own visa, sponsored by her elder brother as a part of the family reunification policy. Some women accompanied their husbands soon after they arrived in the United States, and some came after their husbands were settled in for some time already. Some of the women's husbands came to pursue higher education and started professional jobs after finishing their education. On the contrary, some men came through the diversity lottery visa or with a business visa and therefore struggled for long time before finally getting settled financially and in terms of residency/immigration. These differences impacted on the experiences and perceptions of the women regarding their childbirth experiences.

Table 3: Immigration Information of the Participants

Participants' Name (Pseudonym)	Immigration Status	Year of arrival in the U.S.
Dilara	Permanent Resident	2000
Tahmina	Citizen	1996
Maliha	Citizen	1990

Afreen	Citizen	1997
Lamiha	Permanent Resident	1998
Sakiba	Citizen	1995
Sharmin	Citizen	1997
Shirin	Citizen	1988
Munia	Citizen	2001
Hena	Citizen	1988
Laila	Citizen	1987
Nasrin	Permanent Resident	1999
Bina	Citizen	1988
Rabeya	Citizen	1998
Shormi	Permanent Resident	1999

Immigration had different impacts on the participant women's lives, including on their childbirth experiences. This section present two women's experiences in order to reflect their suffering in relation to their migration experiences. Shirin (43) waited nine years to conceive a baby because she was waiting for her 'papers' (green card) to be issued and for an established immigrant status. She was married in an early age when her elder sister and brother were not yet married; this is unusual because in Bangladesh it is not common to marry before the elder siblings. She said it was a "love-marriage" (typically, most marriages in Bangladesh are arranged) and she got married without her family's permission. Her husband was trying to emigrate to the United States at the time and they got married so that they could apply together as a couple. They both received tourist visas to come to the United States, however, her in-laws did not allow her to leave because they thought if she accompanied her husband, he would not

send money for the family. After nine months, they permitted her to leave since her visa was almost ready to expire. When she traveled to the United States in 1988, she found that her husband could not save any money; he was struggling to earn money and would then send it all to the family back in Bangladesh. Shirin then started to do work to help her husband. She said, “We had been struggling a lot and we could not even think to have a child at that time. My husband was doing two/three jobs, I was doing a job, and he had to send money to family, how could we think of having a baby? We couldn’t afford it. We were always thinking to make the situation little better before having a baby. And it took us nine years.” They started to think about having a child once her husband received his papers and the couple had a stable economic situation.

Shirin’s husband had originally entered the U.S. on a tourist visa, but was later able to apply for a special visa for migrant farmworkers. Once he received that visa, he was easily able to obtain a permanent residency status. When Shirin arrived in the US, her husband and her in-laws made her apply for the same type of visa. However, that visa system was now closed and she was unable to get her papers in that manner. After waiting for ten years, they consulted with a lawyer and surrendered her previous immigration status. Her husband applied to get papers for her as his spouse, which she successfully received in 1999.

Shirin’s case shows us how the immigration experiences of her and her husband had an impact on their decision to have a child. Even if they wanted to have child, they could not afford it due to their unstable situation regarding their immigration status.

When Shirin (43) had her first child, she had complications during labor. She went to the hospital and the doctor told her that her water had broken; hence she had to be admitted on an

emergency basis. The doctors told her that she would have to have a Caesarean section. She was prepared for that, but the doctors did not begin with the surgery immediately. They appeared to be waiting for a normal delivery. Shirin struggled a lot during her labor, but neither she nor her husband or any other family member contested the doctor's actions. Shirin thinks that the doctors waited unnecessarily for the normal delivery and her child was injured because of it. She described the situation as follows:

“When I went they told me that I will have a Caesarean section and I lost my fluid. They induced my labor with an IV. I had severe pain and they broke my water by themselves. My son was in a dry place in my tummy. He was getting hurt. I was too sick to say anything to the doctor. My sister was waiting outside the delivery room. She wanted to say something but she could not. I and my sister were asking my husband to say something but he did not. We do not understand things very clearly here. We were afraid to say something about the doctor's activities. My sister was saying that it's not right; the baby should not be in dry for such a long time. But she could not dare to say that to the doctor. She was new in this country that time and was afraid to say something to the doctor. They waited 24 hours to deliver the baby. They induced IV again to increase my pain, and then they induced epidural to decrease my pain. Whatever they wanted to do we agreed as we do not understand things very clearly. When my son was born he was sick. He was almost ready to die. He had blood clotted around his eyes. The doctors took him away from me and he was under their close supervision for two weeks. Many medical students came to see my son and learn from his case study. The doctors almost killed my son. It was Allah's grace and all our elderly people's prayers that returned my son to me. Everyone I talked with about this situation after that told me that we should sue the doctor. They told that the doctors cannot do that, it's illegal. But we did not do anything because we were in a vulnerable situation in this country. We did not know how to handle those situations. Thanks to Allah, my son survived.” (Shirin)

Shirin's experience shows that she and her family members could not confront the health care providers even if they were suspicious about the procedures. They found themselves in a vulnerable position as immigrants and thus could not ask questions. They also did not even consider taking any legal action for their grief.

Rabeya (37) came to the US when she was eight months pregnant. She received immigration papers through her eldest brother, who had lived in the US for many years already. When he became a citizen, he applied for immigration papers for all of his family members. This was made possible through the US family reunification law. After ten years, all of his brothers and sisters received immigration papers. Rabeya was initially unwilling to come to the US. She was completing her MA studies in Bangladesh and dreamt of being independent and with her own career. When she got married, her husband knew about her plans and was willing to accept her wishes, especially since he also had a good job in Bangladesh.

However, when Rabeya became pregnant, her husband persuaded her to come to the United States by asking her to consider the future of their child. He said that they should emigrate so that she could give birth in the US and the child would be a US citizen. He also promised that they would return to Bangladesh after a couple of years. Rabeya agreed to leave for the child's sake. She said that it was very hard for her to fly at that time because she was eight months pregnant and not doing very well physically. She was very tired, she said, but that did not stop her from coming to the United States. She still thinks that it was a risky decision for her to fly at that time, but giving birth to the baby in the U.S. was important to gain citizenship status. Rabeya was not very happy when she emigrated here. She did not really want to leave her country. However she did so anyway, for the sake of her children's future. She took a physical risk to immigrate to the United States. She expressed worry about her own health but immigrating to the United States seemed more important to her because of gaining American nationality for the child.

These cases demonstrate that some immigrant women do suffer a lot during their maternity period and face insecurity and health problems. However, they did not complain and may accept the situation because of their vulnerable situation as immigrants. They can risk their own health to emigrate for the sake of their children's future, or delay childbearing due to a wait for secured immigrant status. They do not even feel confident to question the authority of medical professional since they think that they know little about the system.

Chapter Five

Conclusions and Recommendations

Introduction

This chapter presents a discussion of the research findings based on the results obtained from the qualitative data analysis and concludes the thesis. This chapter also includes recommendations for how this study could be applicable to better understanding the experiences of immigrant groups in the United States in order to make positive changes to health policy and improve maternity care for immigrant women.

Conclusion

This study attempted to understand the perceptions of the Bangladeshi immigrant women regarding their childbirth and maternal care experiences. The study objectives were to a) document the pregnancy and childbirth experiences of a sample of Bangladeshi immigrant women in the United States, b) understand how they perceive these experiences as a part of an immigrant community, and c) contextualize their perceptions within their socioeconomic condition and immigration status.

This research suggests some significant findings that both contrast with and underscore results from other studies on migrant women's health in the United States and other major migrant-receiving nations, as outlined in the literature review (Chapter Two). Specifically, results indicate that the participants in this study differ in the following six ways:

- 1) These women appear to have fairly consistent access to health care, and do not shy away from using services to which they are entitled;
- 2) They expressed overall satisfaction in regard to the health care system of the United States;
- 3) They appeared to look favorably upon Western biomedicine and the trend towards medicalized childbirth in the United States;
- 4) The women missed the support from extended family and friends that they would have received in their home country;
- 5) The participant women's experiences and perceptions were influenced by their situation as immigrants living in a country different from their own;
- 6) The specific experiences of these women varied based on their socio-economic status (although this was explored only briefly in the current study).

In the following sections, I elaborate on each of these points.

Studies on immigrant populations often focus on barriers to health care systems for immigrant women (Lopez-Gonzalez et al. 2005, Loue et al. 2005, Manderson and Allotey 2003a). In this study, the participant women did not report any specific barriers to accessing the health care system, and all received care from standard facilities during pregnancy and delivery. Most of the women were very satisfied with the care they received; however, a few reported challenges they faced during their treatment. One of the biggest complaints was that they did not feel they had control over the treatment process, and women who suffered complications

reported that they did not feel they could ask about or contest treatment because they considered themselves to be ignorant about the medical system.

Jesmin (2001) argues that immigrant Bangladeshi women find the high-tech medical services of the United States to be in conflict with their own cultural beliefs, values and practices. In her commentary, she states that “most of the Bangladeshi women are skeptical of outside medical care, and prefer to rely on their family members and traditional healers for help and support during illness” (2001:1). She views the health practices of Bangladeshi immigrant women during pregnancy to be heavily influenced by the cultural beliefs and health practices of their country of origin. However, in the study presented here, the results were very different. Participant women were not particularly skeptical of biomedical care and did not mention a preference for or reliance upon traditional healers, even in the cases where women experienced their pregnancies in Bangladesh. They all used “modern,” biomedical health care facilities for prenatal care and delivery and expressed being very satisfied with the U.S. health care system. The challenges they mentioned facing while in the care of the system did not seem to cause them complain to against system as a whole.

The women in this study expressed being impressed with hospitals’ high-tech equipment and mentioned this as a reason to positively evaluate the quality of care in the United States. Along with the equipment and modern technology, they emphasized doctors’ behavior as a measure of quality of care. Communication with the doctor during the pregnancy and delivery period was a significant part of the conversations throughout the interviews. The participant women’s native language is Bengali, and, as they stated, they were not very fluent in English when they were receiving health care. As a result, their husbands helped them to understand the

doctors' suggestions and prescriptions. It is interesting to note that the women thought that the doctors were "smart" and "skilled" enough to understand their health conditions, even though they could not speak directly to them. Some participants did feel that language was a barrier to communication with the doctors; however they simultaneously said that they felt they could rely upon the doctor's professional skills to understand their physical condition.

The participants also wanted to discuss the issue of visiting male doctors during pregnancy. In Bangladesh, most ob-gyn doctors are female because of patient demand. The participants noted that they had many choices among the female doctors in Bangladesh. In the U.S., however, they had to depend on the doctors' list provided by the insurance company. Although most of them preferred to visit a female doctor, they were also open to seeing a male doctor and generally stated that this would not prevent them from receiving health care, since, as they said, "Saving lives is the first priority".

When asked about their childbirth experiences, whether or not they were talking about their experiences in Bangladesh or in the US participants' understanding of quality of care was very much influenced by biomedical values. Lazarus (1994) argues that the "dominant ideology of medically controlled birth as 'normal' birth envelopes women's thoughts about their own births and the use of technological interventions" (1994: 27). In the United States, childbirth is highly "medicalized", with 99% of deliveries occurring at hospitals and with biomedical assistance. Women's choice of the place and attendant for childbirth is heavily influenced and structured by biomedical hegemony (Davis-Floyd 1994, Wagner 2006). In this study, the participant women's choices reflected this internalization of medicalization as well, which was particularly evident when talking about their childbirth experiences. Lazarus (1994) notes that in

the medical profession, being cautious means using all available birth technologies. Women's acceptance of and desire for advanced technology, then, sets the stage for the technological fix providing the “perfect” birth, including for women in this study. For example, one woman reported that she would have asked for an epidural² if she had been in the US during her first delivery, since she had a long and painful labor in Bangladesh.

The authority of biomedical professionals is evident in the US health system, and women reported feeling unable to resist authority figures. In one example, a participant stated that she was given an unnecessary epidural during her delivery in the US. In her account, two nurses were arguing with each other about whether or not she should be given the epidural. The senior nurse ignored the junior one and gave the patient the epidural anyway. This illustrates the hierarchy present in the clinical setting, both between patient and medical professionals as well as between different levels of professionals in the medical hierarchy.

Almost all the participants mentioned that they missed the support of their extended family and friends during their childbirth experiences. Most of the women missed their mothers' presence, in particular, during the prenatal period and in the labor and delivery room. However, even though they said that it would be good to have their mothers with them in the U.S. during this important period of their lives, they also emphasized that it was not a major setback in their overall experience. In Bangladesh, husbands do not get involved in prenatal care and childbirth, which is considered to be a women's issue, with mothers and other senior female relatives considered to be knowledgeable and experienced in these matters. However, participants reported that while in the US, their husbands became more involved in the reproductive health process. Their husbands helped them throughout the maternity period, and most were present in

the labor and delivery room. Furthermore, women mentioned that nurses' and doctors' behavior was important in making them feel comfortable in the absence of other family members. One woman explained that while her mother was not with her in the hospital in the U.S. (as she had been in Bangladesh), she was not unhappy or distraught because the nurses were very nice to her.

Some women have family members living in the United States, and they were fortunate to receive support from them. Most of the participant women also received some form of social support from the local immigrant community, although they mentioned that it was difficult for them to ask for help. Social support is very important in immigrant communities, since it helps compatriots avoid risk and to meet challenges (Harley and Eskineza 2006). The Bangladeshi immigrants living in Tampa receive various forms of social support from their community. While not all Bangladeshis are networked to each other, many try to arrange social events and get together to build relationships. Reitmanova and Gustafson (2008), in their study, indicate that Muslim immigrant women in Canada build social networks within their community, since they believe that this will help them in difficult situations. Jesmin (2001) reported that the immigrant Bangladeshi women in her study also sought recommendations from women in their community. When they faced minor health problems during pregnancy, they consulted with other women before they consulted with a doctor. In the present study, women also mentioned receiving support from local Bangladeshi compatriots, but that is nothing in comparison to the networks available back home. Some women reported that consulting with one another about their health problems, and especially sought advice when selecting a doctor. One woman mentioned that during her pregnancy, Bangladeshi friends would visit her and would bring food. The same friends also brought her food when she was in the hospital following delivery. However, the

women also mentioned that most people are simply too busy to lend a hand. Hence, if somebody wanted help, it may still be difficult to arrange, despite the existence of such networks.

However, caution must be exercised when analyzing social networks in immigrant communities. First, homogenization should be avoided; social networking does not accommodate all people in a same way, and does not always reflect a harmonious community. This is because networks are often based on and maintained through social and economic status. For instance, professional people make friends with other professionals, and non-professionals create their own associations accordingly. Some women mentioned that one should “be careful” when making friends and keep social/class background in mind, since it is not possible to accommodate people from all statuses in one network.

At the beginning of this study, many of the women contacted and informed about the research said, “My experiences have been good; you should find someone who had problems.” For them, the concept of research is always translated into study of people who have “problems” in society, for example by not having access to health care. One woman said, “You should find some women who do not have any health insurance, then you will get the real stories.” In these ways, they referenced the many socioeconomic differences in the community and between different people.

Most participants had already adapted to life in a different country as well as being part of an immigrant community. The women used a variety of strategies to accept the changes that came with their situation. When they talked about their experiences in the US, they highlighted positive features of the US health care system. They said that they missed their family and friends’ support during their maternity period, but while narrating that situation, their overall

mood and expression was not negative. It was as if they were trying not to complain. One woman said, “When I left my country, from then to now, I knew that I will miss my family. I have to miss the people close to me. I know that nobody is *apon* (own people, close people) in *bidesh* (foreign place).” One respondent told me that because they are the first generation immigrants they miss the family support, social support. But when their children grow up in the US,, they will not face these same challenges.

It is also important to avoid conceptualizing Bangladeshi immigrants as a homogenous population. There are many differences within each immigrant community, and between communities living in different cities and states. Their experiences are also framed by their socio-economic status. For instance, as noted in this study, people who do not have professional jobs and health insurance have gone through very different struggles than the people who do. Although Medicaid covered the cost of maternity care, women described the process of applying for Medicaid as very difficult for them.

There were noticeable differences among the participants related to the emigration process and how it related to pregnancy. Those who came to the US to study at a university and found a professional career tended to live a better social life here in the US. Most of them had secured a job in which they received health insurance paid by their employers. Those who came on a visit visa or DV (diversity visa) and later converted their visa status suffered more from economic instability and insecurity of immigration status. They struggled much more because of their economic situation, which influenced the childbirth experiences of the women. They could not afford to buy regular insurance and later suffered through complex Medicaid procedures.

Some of them could not afford to bring their family members to stay with them during their maternity period.

This study aimed to understand how the immigrant Bangladeshi women experience and perceive their childbirth in a different country than their own. The research concludes that on many levels and on many issues, experiences are not very different for women who have immigrated to the US. In this era of globalization, expansion of Western biomedicine, and technological advancement around the world, it is often difficult to locate difference in terms of “cultural” experiences with the health care system. The difference is much deeper and often related to structural features and access to resources. People who have access to resources can afford high-tech modern treatment in their own country, even if it is a developing and technologically less advanced country like Bangladesh. On the other hand, those people who do not have sufficient access to resources may face obstacles to better care even if they are in a developed and technologically advanced country like the United States.

For the population of this study, perceptions regarding maternity experiences and the health care system are still shaped by their experience as immigrants. They do not expect much as newcomers to a different country. They immigrated to the United States for an economically better and socially more secured life. They expressed that they knew beforehand that they would miss their homeland, family, and friends; that they would suffer in some aspects; and that they would have to sacrifice some of the expectations that they might have in their own country. The women in this study reflected these perceptions in relation to maternity experiences; they said that they did not expect much because they are in a different country. If they have access to health care, can afford the cost or receive subsidized care, and if the doctors are nice, they

presented themselves as happy and grateful. If they have experienced otherwise, they did not feel that it was their place to complain. They did not want to mention the obstacles; rather they highlighted the strategies they applied to overcome them and were more likely to tell the successes they have achieved in the United States.

Recommendations

The information collected in this research project will be disseminated through presentations at professional meetings and will be submitted for publication in an academic journal. This academic engagement will link into current theoretical and methodological issues related to immigrant women's maternal health within medical anthropology to spark further debate by providing a unique case study. It will demonstrate the importance of anthropological involvement in the research of immigrant women's maternal health by shedding light on the conceptual and practical effects produced by prior professional abstention. It shows, in other words, that this immigrant group is diverse in their expectations and does not solely reject biomedicine and long for "traditional" cultural practices. Finally, this thesis will represent a valuable source of information for researchers from a wide variety of disciplines interested in the internal structure and dynamic of the public health system in the United States, and specifically, in the maternal care provided to the immigrant women. By disseminating the results of the study as widely as possible, clinicians and policy makers can learn about and from the perspectives of Bangladeshi immigrant women.

The results of this study could benefit not only Bangladeshi women, but also other immigrant women from similar socio-cultural backgrounds. This study can provide perspectives on these women's experiences with the US health care system and could be helpful in

developing more comprehensive services. Health care systems in the US are informed by biomedicine and focus on ensuring patient compliance. However, it is also important to consider the socio-cultural context of disease and illness for a better understanding of peoples' perception towards care. As this study emphasizes, people who are already convinced by the value of biomedical ideas and treatment and are highly compliant, may lack significant social and cultural support which must be considered by health policies and practitioners.

This study dealt with a group of people who have not been a focus of anthropological research in reproductive health issues. The findings of this study can be used to better understand the needs of Bangladeshi immigrant women, in particular, and other immigrant women of similar cultural background in general. Overall, this study recommends additional research on immigrant women's experiences. This study revealed, for example, the importance of the presence of a female doctor in prenatal services and child delivery. This issue was a culturally sensitive one for the women in this study. Therefore, this study recommends considering the appointment of female doctors for maternity care for women of this cultural and religious background.

The study also indicates a need for more research on equity for access to health care. Despite the availability of an established comprehensive health care system in the United States, immigrant women still appear to experience several complex situations when trying to gain access to maternity care. Thus, more research is needed on how to streamline Medicaid services as well as the cost of Maternal Health Services. This study suggests reforming Medicaid procedures and provisions to ensure immigrant women can access Medicaid for maternal health services regardless of their immigration status.

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Appendices

Appendix A: Questionnaire for In-depth Interview

PI: Mst. Khadija Mitu, Department of Anthropology, University of South Florida, USA.

Study Title: Giving Birth in a Different Country: Bangladeshi Immigrant Women's

Childbirth Experience in the US.

Open-ended interview questions (may not always be asked of participants in the same order)

1. What is your age?
2. How long have you been in the United States? How long have you lived in Tampa? (If applicable: Where else have you lived in the U.S.)?
3. Can you tell me about when your family first came to the US? What was the purpose?
4. What is your and your family members' current immigration status?
5. How many children do you have?
6. Next, I would like to learn more about your childbirth experience(s) in the US? Please tell me about each experience, starting with the oldest child.
7. What kind of health services did you receive here during your pregnancy, delivery and postpartum period?
8. How did you feel about the health services you received here in the US?
9. How did you feel about the service providers' attitude and the environment of health care facility?

10. Did you ever have any communication problem with your services providers? (If yes): would you please describe them to me? How were they resolved?
11. Did you ever felt any discomfort while receiving the care? (If yes): would you please describe them to me?
12. How did you find the cost of care?
13. In general, how would you characterize your experience with pregnancy and delivery here in the US?
14. Would you please describe your experiences you have had during delivery and postpartum period?
15. Did you face any challenges during your pregnancy, delivery and postpartum period?
16. What do you feel could have improved your experiences during your pregnancy, delivery and postpartum period?
17. Did you receive any support from your family members or friends during your childbirth experiences? If any, would you please describe?
18. Did you find anything missing here that you would have had in your own country during childbirth?
19. Is there anything else you would like to add?

Closing: Thank you for your time and helping with the study !

Appendix B: Verbal Consent Form



Verbal Informed Consent to Participate in Research Information to Consider Before Taking Part in this Research Study

Consent Script to be read to all participants prior to any research:

We are asking you to take part in a USF research study that is called:

“Giving Birth in a Different Country: Bangladeshi Immigrant Women’s Childbirth Experience in the US.”

The person who is in charge of this research study is *Mst. Khadija Mtiu, graduate student* of Anthropology at the University of South Florida, Tampa, Florida, USA (tel.: 813-507-3077; email: mmitu@mail.usf.edu)

The research will be done in Tampa, Florida, USA.
This research is being conducted as a part of an MA thesis.

Purpose of the study

“You are invited to participate in an interview about your experiences related to childbirth in the US. This will help us understand how immigrant women experience childbirth in the US as part of an immigrant community and how they perceive the experiences”.

Study Procedures

“If you take part in this study, you will be asked to talk with me (Mitu) one time for about an hour or two about your experiences related to childbirth in the US. I can interview you in your home or other place where you feel comfortable and only if you have time. If you agree that you do not mind, I will record what we say today so that I can be certain about exactly what your experience and perceptions are and go back and listen to them carefully again to make sure I have not missed anything. Your name will not be on the tape, and no one else will be able to figure out who you are after it is recorded. Only I will have access to that information, and no

one else. Later on, when the tapes are transcribed or results published, no one will be able to identify you.

“You can choose not to participate in this research study at any time.”

Benefits

“We do not know if you will receive any benefits by taking part in this study. But it is possible that by having this information, the community will be able to better explain their need to be included in any future decisions made about the maternity services for the immigrant women in the US. This has the potential to improve services for immigrant women.”

Risks or Discomfort

“There are no known risks to those who take part in this study.”

Compensation

“We will not pay you for the time you volunteer while being in this study.”

Confidentiality

“We will keep every part of our talk together confidential—that means I will not tell anyone else what you say or your identity. Recordings from the interviews and any notes will be written down, and stored in a safe place for 10 years, when they will be destroyed. You may receive a copy of your interview tape if you like. The only people who will be allowed to see these records are: the research team, including the Principal Investigator and all other research staff, or people who work for the University of South Florida Institutional Review Board (IRB) to make sure we are doing the study the right way. We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are.”

Voluntary Participation / Withdrawal

“You can stop the interview at any time, without any hesitation, and no one will get upset if you decide to withdraw from the interview.”

Questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, call Khadija Mitu at 813-507-3077, or via email: mmitu@mail.usf.edu

If you have questions about your rights, general questions, complaints, or issues as a person taking part in this study, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

If you have any further questions about the research, now or during the course of the project, you ask me at any time and you can contact me.

This research has been approved by the Institutional Review Board of the University of South Florida.

Do you agree to be in the study I have described?

Appendix C: Translated (in Bengali) Verbal Consent Form



ইউনিভার্সিটি অব সাউথ ফ্লোরিডা

গবেষণায় অংশগ্রহণের জন্য মৌখিক সম্মতি

এই গবেষণায় অংশগ্রহণের ক্ষেত্রে প্রয়োজনীয় তথ্যঃ

গবেষণায় অংশগ্রহণকারী সকলের জন্য পাঠিত সম্মতিপত্র

আমরা আপনাকে সাউথ ফ্লোরিডা ইউনিভার্সিটির একটি গবেষণায় অংশগ্রহণের জন্য অনুরোধ করছি, যার শিরোনাম:

“ভিনদেশে সন্তান জন্মদান: বাংলাদেশি অভিবাসী নারীদের আমেরিকায় সন্তান জন্মদানের অভিজ্ঞতা”

এই গবেষণার দায়িত্বে আছেন - মোসাম্মৎ খাদিজা মিতু, গ্র্যাজুয়েট স্টুডেন্ট, নৃবিজ্ঞান বিভাগ, ইউনিভার্সিটি অব সাউথ ফ্লোরিডা, ফোনঃ 813-507-3077 [৮১৩-৫০৭-৩০৭৭] ই-মেইলঃ mmitu@mail.usf.edu

এই গবেষণাটি আমেরিকার ফ্লোরিডার টামপায় পরিচালিত হবে।

এই গবেষণাটি একটি এম.এ. থিসিস-এর অংশ হিসেবে করা হচ্ছে।

গবেষণার উদ্দেশ্য

আপনাকে একটি সাক্ষাৎকার-এ অংশগ্রহণের জন্য অনুরোধ করা হচ্ছে যেখানে আমরা কথা বলবো আমেরিকায় থাকাকালীন আপনার সন্তান জন্মদানের অভিজ্ঞতা নিয়ে। এই সাক্ষাৎকার আমাদেরকে অভিবাসী নারীদের আমেরিকায় সন্তান জন্মদানের অভিজ্ঞতা বুঝতে এবং এই বিষয়টাকে ঐ নারীগণ কীভাবে গ্রহণ করে তা বুঝতে সাহায্য করবে।

গবেষণার কার্যপ্রণালী

আপনি যদি এই গবেষণায় অংশগ্রহণ করতে রাজি থাকেন, তাহলে আপনাকে আমার (খাদিজা মিতু) সাথে একবার এক বা দুই ঘন্টা আমেরিকায় আপনার সন্তান জন্মদানের অভিজ্ঞতা সম্পর্কে কথা বলার জন্য অনুরোধ করা হবে। আপনার বাসায় অথবা অন্য যে কোন জায়গায় যেখানে আপনি স্বাচ্ছন্দ্য বোধ করবেন এবং আপনার সুবিধামত সময়ে এই সাক্ষাৎকারটি নেওয়া হবে। আপনি যদি রাজি থাকেন এবং কিছু মনে না করেন, আমি আমাদের কথা রেকর্ড করবো যাতে আমি নিশ্চিত হতে পারি যে আমি আপনার অভিজ্ঞতা এবং ধারণাগুলো ঠিকমত বুঝতে পেরেছি এবং পরে আবার শুনে নিশ্চিত হব যে, কোন কিছু বাদ পড়েনি। এই রেকর্ডিং এ আপনার নাম ঠিকানা থাকবেনা এবং অন্য কেউ আপনার সম্পর্কে জানতে পারবেনা। আমি ছাড়া আর কেউ এই তথ্যগুলো জানতে পারবেনা। পরবর্তীতে যখন এই টেপ থেকে তথ্যগুলো লিখা হবে এবং গবেষণার ফলাফল প্রকাশিত হবে আপনার পরিচয় প্রকাশ করা হবেনা।

আপনি যে কোন সময় এই গবেষণায় অংশগ্রহণ না করার সিদ্ধান্ত নিতে পারেন।

উপকার:

আমরা জানি না আপনি এই গবেষণায় অংশগ্রহণের কারণে কোন উপকার পাবেন কিনা। কিন্তু এই তথ্যগুলোর মাধ্যমে অভিবাসীরা তাদের প্রয়োজনগুলো ভালভাবে উপস্থাপন করতে পারবে এবং পরবর্তীতে আমেরিকায় অভিবাসী নারীদের মাতৃস্বাস্থ্য সেবা আরও ভাল করার ক্ষেত্রে এই গবেষণাটি কাজে লাগার সম্ভাবনা রয়েছে।

ঝুঁকি বা অসুবিধা

যারা এই গবেষণায় অংশগ্রহণ করবেন তাদের কোন ঝুঁকি বা অসুবিধা হবে না।

পারিতোষিক

এই গবেষণায় সহযোগিতা বা সময় ব্যয় করার জন্য আমরা আপনাকে আর্থিকভাবে কোনরূপ সুবিধা দিতে পারবো না।

গোপনীয়তা

আমাদের কথার প্রতিটা অংশ গোপন রাখা হবে, অর্থাৎ আপনার কথা ও পরিচয় আমি কাউকে জানাবো না। এই সাক্ষাৎকারের রেকর্ডিং এবং নোট নিরাপদ স্থানে রাখা হবে এবং একটা নির্দিষ্ট সময় পর নষ্ট করে ফেলা হবে।

আপনি যদি চান, তাহলে এই স্বাক্ষাৎকারের টেপ এর একটা কপি পেতে পারেন। শুধুমাত্র যারা এই গবেষণার সাথে যুক্ত এবং সাউথ ফ্লোরিডা ইউনিভার্সিটি'র ইনস্টিটিউট অব রিসার্চ বোর্ড-এর সদস্যরা এই রেকর্ডগুলো দেখতে পারবেন যাতে গবেষণা ঠিকভাবে চলছে কিনা তা নিশ্চিত করা যায়। এই গবেষণা থেকে যা জানা যাবে, তা আমরা প্রকাশ করতে পারি। যদি তা করা হয় আমরা কাউকে আপনার নাম বা পরিচয় জানতে দেব না। আমরা এমন কিছু প্রকাশ করব না যাতে করে কেউ আপনার পরিচয় জানতে পারে।

স্বতঃঅংশগ্রহণ / প্রত্যাহার

আপনি যে কোন সময় কোন সঙ্কোচ ছাড়া এই স্বাক্ষাৎকার বন্ধ করতে পারেন। আপনি যদি এই স্বাক্ষাৎকার দেওয়া প্রত্যাহার করেন তাহলে কেউ নারাজ হবে না।

প্রশ্ন, আগ্রহ বা অভিযোগ

আপনার যদি এই গবেষণা নিয়ে কোন প্রশ্ন, আগ্রহ বা অভিযোগ থাকে তাহলে 813-507-3077 নাম্বারে আমাকে (খাদিজা মিতু) ফোন করতে পারেন অথবা mmitu@mail.usf.edu ঠিকানায় ই-মেইল করতে পারে।

এই গবেষণায় অংশগ্রহণকারী হিসেবে আপনার অধিকার, সাধারণ প্রশ্ন, অভিযোগ বা অন্য কোন বিষয় নিয়ে যদি আপনার কোন জিজ্ঞাস্য থাকে আপনি সাউথ ফ্লোরিডা ইউনিভার্সিটির রিসার্চ ইনটিগ্রিটি এন্ড কমপ্লিয়েন্স বিভাগে (813) 974-9343 নাম্বারে যোগাযোগ করতে পারেন।

এই গবেষণা চলাকালীন যদি গবেষণা সংক্রান্ত আর কোন প্রশ্ন থাকে, আপনি যে কোন সময় আমাকে জিজ্ঞেস করতে পারেন এবং আমার সাথে যোগাযোগ করতে পারেন।

এই গবেষণা সাউথ ফ্লোরিডা ইউনিভার্সিটি'র ইনস্টিটিউশনাল রিভিউ বোর্ড দ্বারা অনুমোদিত।

আপনি কি এই গবেষণায় অংশগ্রহণ করতে রাজি আছেন?