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ORIGINAL RESEARCH

Having a baby in the new land: a qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia

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ABSTRACT

Introduction: Australia is a land of cultural diversity. Cultural differences in maternity care may result in conflict between migrants and healthcare providers, especially when migrants have minimal English language knowledge. The aim of the study was to investigate Asian migrant women's child-birth experiences in a rural Australian context.

Method: The study consisted of semi-structured interviews conducted with 10 Asian migrant women living in rural Tasmania to explore their childbirth experiences and the barriers they faced in accessing maternal care in the new land. The data were analysed using grounded theory and three main categories were identified: 'migrants with traditional practices in the new land', 'support and postnatal experiences' and 'barriers to accessing maternal care'.

Results: The findings revealed that Asian migrants in Tasmania faced language and cultural barriers when dealing with the new healthcare system. Because some Asian migrants retain traditional views and practices for maternity care, confusion and conflicting expectations may occur. Family and community play an important role in supporting migrant women through their maternity care.

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Conclusions: Providing interpreting services, social support for migrant women and improving the cross-cultural training for healthcare providers were recommended to improve available maternal care services.

Key words: acculturation, Asian women, Australia, child birth, cultural diversity, health services for migrants, maternity care, reproductive health, rural health context

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Introduction

While cultural diversity undoubtedly contributes to the quality of life in Australia, there are also problems caused by lack of intercultural awareness. Migrants bring their own 'cultural lenses' to Australia that may affect their view of the new cultural environment.

For many migrant women, pregnancy and childbirth comprise one of the most important life events. Although childbirth is a universal biological event and similar for everyone, birth experience is not. Birth experience occurs in a cultural context and is shaped by the views and practices of that culture[1-4].

Culture refers to the way of living, distinctive knowledge, habits, ideas, norms and values, and language shared by a group of people[5], and differs from one society to another. Reproductive health has a strong connection with culture. Notions of human reproduction, care of the expectant mother and the unborn child, methods of giving birth and post-natal care all vary considerably according to cultural beliefs and traditional practices, although the common aim is to maintain the wellbeing and safety of mother and child.

Cultural beliefs and practices surrounding childbirth have attracted much research interest[6-11]. Liamputtong et al provided detailed descriptions of traditional childbirth beliefs and practices relating to dietary and behavioural precautions and preparation for an easy birth among women in Thailand[11]. Kaewsarn et al conducted a survey of the traditional postpartum practices of 500 Thai women in Thailand[7]. They found the most popular practices after childbirth are sexual abstinence, restricted activity, taking hot drinks, hot baths, food restriction and practices to maintain body heat such as 'lying by fire'[7]. These studies focused on the role culture plays in pregnancy, birth and after birth in a particular country. Their findings provide insights for health professionals and assist them to better understand women from differing cultures.

Cross-cultural studies in human reproduction provide another aspect of childbirth research, and the work of Jordan is a significant contribution to this field[1]. Jordan focused on childbirth systems in Yucatan, Holland, Sweden and the USA as an anthropologist, and investigated a range of biosocial childbirth practices across different systems. Chu conducted one of the most comprehensive studies on cross-cultural childbirth in China (Taiwan) and Australia, emphasising that reproductive beliefs and behaviour are shaped by cultural, social and individual factors[12]. Her work has the potential to improve the services provided for Chinese clients in Australia by raising health providers' awareness of traditional Chinese models of illness.

A more recent cross-cultural study took a different approach. By exploring 'childbirth as a system operating within a specific cultural context', researchers studied the childbirth experiences of some minority ethnic groups living in Western countries[13]. It was found that the women's traditional birth beliefs and practices are very different from those found in the migrants' new land. Such cultural differences contribute to misunderstandings between healthcare providers in the host country and migrant patients, and this can affect the quality and efficacy of the care provided. It has also been determined that a lack of understanding of cultural diversities[14], racism and racial

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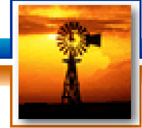

stereotyping[15] and lack of knowledge of health beliefs[16] affected health professionals' ability to meet the needs of ethnic minorities. Research in this area has been aimed at helping the health system and healthcare providers bridge the gap between themselves and migrant women by promoting an understanding of migrant women's cultural beliefs and practices.

According to the 2006 Australian Census of Population and Housing, Asian women in rural Tasmania account for only 0.3% of the Tasmanian population[17]. It is therefore unlikely that healthcare providers are familiar with specific Asian cultural practices. This article focused on Asian migrant women's traditional childbirth practices and barriers to accessing maternal care in rural Tasmania in order to provide insights to Tasmanian policy-makers and healthcare professionals, and so improve the quality of available care.

Yin and yang

In Chinese and many Asian cultures, following childbirth women are considered to be in a weakened and vulnerable condition and in need of special care for at least a month in order to regain their health[4,18] and be protected from illness. This postnatal care month consists of a set of cultural practices that provide support and special care to the new mother. The cultural perceptions and postnatal healthcare measures are derived from beliefs about the 'yin–yang' or hot–cold principle[19]. This principle holds that everything in the universe contains two aspects: yin and yang, which are in opposition but also in unison[20]. If yin and yang are in balance, one will be in good health; however, if energy is moved in either direction, one becomes ill. In this tradition, during labour and delivery, a woman is considered to be in a 'cold state'. In order to restore the balance she should keep warm by not having a bath or washing her hair. Special dietary restrictions assist recovery of the heat and energy. Women should have as much rest as possible and observe certain physical restrictions. The new mother should not leave the house for a period of time after childbirth.

Methods

A qualitative approach using semi-structured interviews was employed to investigate the childbirth experiences of Asian migrants living in rural Tasmania. The study used grounded theory methodology for its data analysis, as described by Strauss and Corbin[21].

Research questions

Two research questions were formulated:

1. How do migrants' views on maternity care vary after having moved to Australia?
2. What are the barriers to them accessing health care?

Sampling and data collection

The selection criteria for interviews were that the participants were:

- female
- living in rural Tasmania
- of Asian background (ie born in Asia and still sharing Asian cultural beliefs and practices
- experienced in birth-giving in Australia, or in her original country and Australia.

Participants were recruited through referral by ethnic community members in Tasmania. Eleven Asian women who met the criteria were invited to participate in the interviews and 10 accepted the invitation. Two participants spoke limited English and their interviews were by teleconference with interpreters from outside their own rural communities in order to assure confidentiality. The remainder could communicate in English, although some women made the point that at the time they experienced childbirth in Australia they did not speak English well or at all. The interviews took approximately 40 min to complete and consisted of 20 questions concerning the background of participants, their maternal care experiences in Australia,

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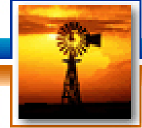

cultural beliefs and practices and how they adapted these in a new environment, and barriers to accessing health care. Some participant characteristics are presented (Table 1).

Table 1: Selected participant characteristics

Characteristic	***N***
Country of origin	
Vietnam	4
China	2
Japan	2
Korea	1
Philippines	1
One to 2 children born in Australia	10

Data analysis

The data were analysed using grounded theory. The grounded theory system requires the researcher to constantly analyse and compare newly gathered information before going back to new participants[21]. All transcribed material was analysed sentence by sentence and coded for the participant's meanings. Initial open coding of the data used differing codes, which were then organised into categories. The data were then repeatedly re-analysed to reassess the content and confirm the findings. Three main categories and 6 subcategories were identified.

During the analysis NVivo v8.0 (QSR International; Melbourne, VIC, Australia) software was used to organize transcripts and codes. Quotes were referenced according to the nationality of the informant and given a number if there was more than one participant of that nationality.

In this study the word 'confinement' refers to the period of 30 days after birth.

Ethical clearance

An ethics application was submitted to and approved by the Tasmanian Social Sciences Human Research Ethics Network prior to the interviews.

Results

The three main categories that emerged were labeled (i) 'migrants with traditional practices in the new land'; (ii) 'support and postnatal experiences'; and (iii) 'barriers to accessing maternal care'. The first category was explained by its 6 subcategories: 'keeping warm after birth', 'diet in confinement', 'good rest and physical precautions', 'social restrictions', 'no husband present at birth' and 'adaptation to the new culture'.

Migrants with traditional practices in the new land

The Vietnamese, Chinese and Korean women in the study shared similar maternity care cultural practices. In their tradition, the confinement is seen as the most important period for a new mother.

Keeping warm after birth: Traditionally, a woman is not allowed to shower or wash her hair for at least a week after delivery, and in some cases for a month, in order to keep warm.

> *My first child was born in Vietnam so I did go through all the traditional practices. I did not have a shower and* [or] *washed my hair for a week after childbirth. I washed myself with a warm cloth and steamed the body with a lot of herbs.* (Vietnamese participant 3)

> *I had to follow a set of dietary and behavioural rules during confinement period. I had to keep warm and avoid exposure to wind and could not have showers and wash my hair.* (Chinese participant 2)

Diet in confinement: It is believed that because the mother has lost heat, blood and vital energy during labour, dietary measures help recover the heat and energy.

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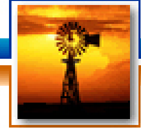

One should eat nutritious meals like chicken soup, chicken with ginger and sesame oil and eat many meals a day to help one recover and produce a lot of milk. (Chinese participant 1)

Vietnamese women should not be served cold food and cold drink when they have a baby. Hot food and warm or hot drink are always good for women after childbirth because they feel so cold after losing blood from birth. (Vietnamese participant 1)

Good rest and physical precautions: During the confinement period, the new mother should have good rest. She should not stand for long or lift heavy objects to avoid vaginal prolapse.

One is exempted from housework within a month [after childbirth] *so one can rest in bed. One should not walk around much because that will cause the stomach to sag. The new mother also should not keep standing for a long time and lift heavy things to avoid vaginal prolapse because her body is very 'new' after giving birth to the baby.* (Vietnamese participant 2)

Extended reading is not suggested because it is believed this will cause poor eyesight in the mother.

My mother knew that I was studying at the time I had the baby so she tried to tell me that I should not read books or work on the computer for at least a few months after childbirth. She warned me that if I did not follow it, I would have bad eyesight in my old age and this would come early too. (Vietnamese participant 1)

Social restrictions: A woman is advised not to go out for 30 days after giving birth. The ability of the woman to 'pollute' after childbirth is one of the reasons she should not leave the house.

According to village tradition, after giving birth a woman is not 'allowed' [if living with the in-laws] *to stay in the main part of the house as she is still 'not clean'.* (Vietnamese participant 4)

Another reason for not leaving the house during confinement is that the woman is highly vulnerable to a variety of illnesses due to the loss of vital energies and her cold state.

My mother-in-law advised me not to go out for a month [after birth] *because I was very weak and easy to catch cold if I let wind enter my body after birth.* (Chinese participant 2)

No husband present at birth: In Vietnamese and Chinese cultures, women would not have their husbands present at childbirth.

Vietnamese husbands do not take a great part in caring for their wives during pregnancy, birth giving and postnatal care. They think these are jobs of women. In this case, they may easily take for granted the suffering that women have during birth giving. (Vietnamese participant 4)

In Vietnam, a husband is not allowed to be with his wife during labour and delivery so he does not know how painful his wife has to go through when she is in labour. Actually in Vietnam a woman is with only doctors and nurses in the labour ward. She might feel very lonely because no one can be there to support her when she needs it most. (Vietnamese participant 2)

Adaptation to the new culture: As relatively recent migrants, seven out of the 10 participating women did not strictly abide by their own cultures practices and adopted practices other than their own.

I found that having a shower and washing my hair after birth was OK for me because I had a warm shower and dried my hair by hairdryer. However, I followed the practices after birth such as having a good rest to recover, eating nutritious meals and hot

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> *drink. I found it good for myself when I followed it.* (Vietnamese participant 2)

The majority of women strictly observed and followed the physical precautions advised by their mothers and mothers-in-law, such as not lifting heavy objects, because they also believed that they were still weak after birth and that lifting could cause uterine prolapse. However, most women found it impossible not to go out for the whole month because they had to shop and do other things. One woman explained her reason for not following the restriction on leaving home:

> *I saw no reason for doing that* [not going out] *as the environment here is very fresh and clean.* (Vietnamese participant 2)

Most women in the study said that they had their husband/partner present at the birth of their child despite this not being the practice in their original country.

> *My husband stayed with me during my labour and I felt to be supported and especially when my English was not good enough to communicate with midwives and doctors. I felt that now my husband has a great sympathy for women when they are in labour because he witnessed what his wife went through.* (Vietnamese participant 1)

Three out of 10 women in the study followed the Australian way of childbirth completely, although they knew about traditional practices:

> *Although I am aware of the differences, I followed the Australian ways of giving birth and doing baby things.* (Japanese participant 1)

> *If I was in my country, I would follow that because I would not want to offend my Mum. Now I am here in Australia, I do not want to follow my traditional ways. I want to do what Australians do.* (Korean participant)

Support and postnatal experiences

Four women who had a great deal of support from their extended family, husbands, friends and community nurses recovered very well in the month following the birth:

> *I felt very good and recovered well in the first few months following birth because I had support from my parents-in-law.* (Chinese participant 1)

In families where the husband was the only source of help but could only give a little support due to their work or study commitments, six women in this study described their postnatal experience as a contrast to that of the women who received plenty of support:

> *I was exhausted, teary. I cannot describe it clearly but I felt miserable and isolated. Though I still looked after my baby but I was not happy and did not enjoy it.* (Vietnamese participant 1)

Two other women who experienced childbirth in both their original countries and Australia lacked support from extended family in the new country and that made them feel tired and isolated. One woman said:

> *I felt lonely, isolated because I did not have many friends and my family is not here. I had only two friends to come to see me when I came back from hospital. It was very different with what I experienced in Vietnam. I did not get any support from anyone. I did all house work and looked after my two children by myself.* (Vietnamese participant 3)

Although the sample is small, it appears that support plays an important role in the wellbeing and maternal health of Asian women.

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Barriers to accessing maternal care

Lack of English language skills is the reason the new mothers had difficulty in accessing services and information.

> *I did not go to antenatal classes because my English was not good. When I came to see the midwives, they could not understand me and I could not understand them.* (Chinese participant 2)

All participants reported that they received many booklets and brochures from hospitals and healthcare providers; however, most of these were written in English:

> *I went to hospital to find out the information about health care. They gave me few booklets to read. I did not understand well because my English was not good. I could not read the booklets because they were all in English*. (Chinese participant 2)

Language is not the only barrier that prevents migrants from accessing services and the information that should be available to them. Most Asian cultures teach people to be unassertive and inhibited from childhood. Thus, Asian women were often too reluctant or embarrassed to express their needs or enquire about services. As one woman commented:

> *Because we are Asian we are very reluctant to ask someone for more information.* (Filipino participant)

One woman expressed regret when she later found that the hospital had information in Vietnamese and she had not asked about it.

> *When my husband came to hospital…, he brought home a lot of brochures and booklets in English that I could not read… Later we discovered that the hospital had all the booklets in Vietnamese but because we did not ask, they did not offer us. What a pity! If I had them in Vietnamese I would be able to read them and get a lot of information from it.* (Vietnamese participant 3)

Lack of assertiveness also prevents women from expressing their preferences. They did whatever the health professionals asked them to do, even when this went against their accustomed practices. One woman wanted to follow her mother's advice by not having a shower immediately after childbirth and she was reluctant to follow the nurse's instruction:

> *After my baby was delivered, the nurse asked me to have a shower immediately. I knew I was not supposed to do it but I was reluctant not to do it because I did not want to be against what they told me.* (Vietnamese participant 2)

Lack of English skills and reticence in speaking out affected the communication between healthcare providers and migrants and limited their access to resources. Consequently, these migrant women had fewer opportunities to receive the services they were entitled to. They were also less able to access health information and services available to the general population.

Discussion

Many traditional Asian maternity care practices seem unnecessary in modern times and in a developed environment such as Australia. However, these practices have functional purposes, given their historical and social contexts. Further, many Western-trained professionals believe some Chinese cultural practices actually protect and maintain the health of women to some extent[18].

The practice of not washing hair or bathing seems unhygienic today but it was meaningful in certain social contexts, recalling the yin–yang principle discussed earlier. In addition, in the past the water supply may have been contaminated, increasing the risk of vaginal infection if used for washing postpartum[18]. However this is obviously not the

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case in modern Australia and many of the women studied recognised this.

Most of the interviewed women followed the practice of having hot food and drink, although they may not have known about traditional hot and cold therapy. Many of the traditional foods prescribed for the new mother enhance the production of red blood cells, according to Western dietary analysis[22]. In addition, once poor families in the countryside lived without refrigeration, so it was safer to prescribe that foods be cooked before consumption to destroy pathogens and so prevent diarrhoea in breastfed infants. In terms of hot drinks, herbal teas can be useful to control menstrual and postpartum bleeding and discomfort, and the traditional teas given to a woman after childbirth may actually have medicinal value[18].

The traditional practice of not leaving a house for the first 30 days after childbirth, and the belief that the new mother is 'polluted' and in a socially dangerous state sound unreasonable today in Australia. However, the historical and social context of the practices offer another meaning. These practices are believed to have offered protection against infection for both mother (eg mastitis) and newborn[23]. And even today, the majority of Chinese and Vietnamese people live in rural areas where housing and sanitary conditions may present a risk. In these circumstances, the practice of isolating the newborn, the mother and those who come in contact with them may reduce the incidence of infections. However, in contemporary Australia such precautions do not seem practical or feasible and the majority women in this study found they were not necessary in their new environment.

In contrast to disregarding the practice of not leaving house, the interviewed women in the study still strongly believed in having a profound rest in order to regain their strength. However, new mothers can only observe and follow this practice with the support of family and society. Traditionally, Asian women commonly lived with extended family, such as parents-in-law and siblings, and this enabled their rest after childbirth. However, when they left their kin and moved to Australia support from extended family was often absent. In some cases, even the partner or husband was unable to assist due to his work or study commitments.

In Australia, it has been estimated that up to 10% of mothers experience postnatal depression (PND)[24,25]. Stern and Kruckman noted that PND is rare in non-Western countries[26] and this could be related to the traditional practices and family support that allow the mother to rest, relieve her from housework and protect from injury and infection, all of which minimize the stresses of confinement. At the very least, traditional practices suggest it is important for postnatal women to have appropriate support for a healthy transition through this stressful period.

In the present study, the results of the interviews also indicate a potential relationship between PND and lack of support. The women studied experienced symptoms similar to those of PND, such as loneliness, isolation and exhaustion[24,25] due to a lack of support from their families and the community. When migrant women cannot obtain the support of distant family they must rely on the support of the community in their new country. However, being unfamiliar with the healthcare system, the women were unaware of the many services available to assist them.

Lack of English is seen as one barriers to migrants accessing health care and other services[27-29]. Language barriers also prevent knowledge of services in Australia that do not exist in their original country. Hospital-run antenatal education programs provide a range of information related to pregnancy and childbirth; however, these classes are usually offered in English and without an interpreter. For this reason, the Asian women avoided the classes, and therefore were uninformed about available services and their rights as consumers.

The women in the study received bundles of booklets and pamphlets about maternal care and services but most were in English which they could not read or had difficulty in understanding. Lack of a common language also presented many difficulties for the migrant women in communicating

with healthcare providers. The lack of interpreting services compounded this. In addition, cultural differences caused further difficulties and misunderstandings when dealing with the healthcare system.

Most of the interviewed women believed in the benefits and health value of their traditional postnatal practices and had observed them to varying degrees. Although they did not complain about different practices in Australian maternity hospitals, some expressed fear for their long-term health when they were, for instance, served cold food and drink or told to take a shower and walk about soon after the birth. Due to their socialized reticence, many were too shy to express their concerns and preferences, or to enquire about support services.

One participant from Vietnam suffered a long suturing procedure because the inexperienced doctor had not sutured previously. She reported that she cried quietly throughout the procedure without asking or complaining and described it as the most painful experience in her life. Apart from having an inexperienced doctor, her culture may have contributed to the trauma she experienced. Enduring pain in silence and maintaining self-control without complaint has been reported as a traditional value of the Vietnamese[30,31] and this may have prevented the participant from questioning the healthcare provider even though she knew something was wrong. Among Vietnamese, negative feelings are not usually expressed towards those considered superior, such as parents, physicians or teachers[30]. This cultural value may mean the experience of Vietnamese women in childbirth is misunderstood by healthcare professionals, even to the extent of believing that Vietnamese women do not suffer much pain and offering less pain relief.

Limitations

There were some limitations to our study. Although the researchers tried to select participants from diverse cultural backgrounds, only some Asian countries were represented. Because of this the study may not have encompassed all the traditional practices and issues of Asian women in maternity care. The small number of participants limits the generalizability of the findings. Although this research provides significant insights into the views and attitudes of Asian migrants in rural Tasmania towards maternity care, a larger study is indicated.

Conclusion and recommendations

The study findings suggest that language barriers are a key issue for women attempting to access the health care they need. It is vital that all migrant women are *offered* an interpreter, because few of these women are familiar enough with the Australian healthcare system to know about the existence of such services. Interpreters should be easy to access and require less waiting time than at present. Providing printed healthcare information in a range of languages may be another solution to the language difficulties experienced by migrants. Pamphlets or booklets about maternity care should be available in different languages, such as Chinese and Vietnamese. Healthcare professionals and hospital staff should be informed about these resources in order to provide them to migrant women in need.

Cultural barriers may be reduced by staff training in which staff develop a general understanding of and empathy for the issues migrant women deal with. Specific staff training to improve knowledge of cross-cultural beliefs and practices relating to childbirth will reduce misunderstanding and mismanagement in providing hospital care for many Asian migrant women.

Family and society's support play an important role in the childbirth experience of rural migrant women. In the absence of close family, migrant women may be assisted by: (i) increasing their awareness of healthcare services; (ii) employing bilingual health workers; and (iii) encouraging their participation in social groups.

Pregnancy and childbirth can be the most significant events in a woman's life. It is potentially a period of achievement,

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happiness and fulfilment, but also a time of dependence and vulnerability. This study provides some insights about the issues and problems facing Asian migrant women in their childbirth experiences in rural Tasmania. It is hoped that the findings will contribute to the enhancement of healthcare services for vulnerable migrant women in rural Australia.

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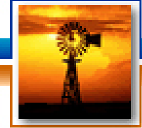

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