The Childbearing Haitian Refugee—Cultural Applications to Clinical Nursing

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SYNOPSIS

As a result of the recent influx of Haitian refugees, referred to as the "boat people," the large county-owned hospital in Miami, Fla., reported that, of the 8,000 births for 1980, approximately 1 in 5 deliveries was of a Haitian woman. One hundred fourteen Haitians gave birth at that institution during July 1980, and this pattern continues to date. Although some research investigations have been conducted in relation to Haitians, none have had the specific focus of this study which used an assessment tool to develop a cultural profile of the refugee Haitian childbearing client as a basis for deriving culturally appropriate nursing goals and interventions.

Ten pregnant refugee women, born in Haiti and residing in Miami, were interviewed in their homes by a Haitian (Creole-speaking) interviewer. Areas of respondent consensus and individual responses of interest are discussed in this paper. The authors have compiled a list of care givers' goals and interventions directed toward specific beliefs, values, and practices.

Assumptions held by nursing personnel that all Haitian childbearing clients who have recently arrived in south Florida are so different as to have few characteristics in common with the American culture are not supported by the findings of this investigation. Rather, the findings suggest that the 10 Haitian women who were interviewed generally perceived pregnancy and its particular needs and characteristics in much the same way and with similar concerns as their American counterparts. The variations in their responses reemphasized the need for accurate culture-specific assessment of each client in order to provide appropriate health care. Replicating the study among the other cultures in the Miami area would extend the interpretations of this study and be an exciting challenge.

More than 14,000 Haitian refugees, referred to as the "boat people," landed on the shores of south Florida during 1980. As many as 5,000 landed during the 6-month period from September 1980 to March 1981. During the second week of March 1981 alone, five boatloads arrived, an estimated 500 refugees. This influx of Haitian refugees added to the 30,000 Haitians already estimated to be residing in South Florida (*1*).

As a result of this influx of refugees, the maternity unit at University of Miami—Jackson Memorial Medical Center, the large county-owned hospital in Miami, reported that 114 Haitians gave birth at that institution during July 1980 alone. Of the 8,000 births for the year 1980, approximately 1 in 5 deliveries was of a Haitian. This pattern continues to date. Nursing professionals, including nurse-midwives who care for a large segment of this population, have identified the need to support the culture-specific beliefs, values, and practices of their Haitian clients. The American College of Nurse-Midwives has published a statement of philosophy: "every childbearing family has a right to a safe, satisfying experience with respect for human dignity and worth; for variety in cultural forms; and for the parents' right to self-determination" (*2*).

There presently exists no identifiable culture-specific body of knowledge that could provide the basis for formulating culturally appropriate nursing goals and interventions applicable to the childbearing experiences of the Haitian refugee mother.

The most extensive ethnic investigation in the Miami area is the University of Miami–Health Ecology Project, conducted by staff of the Department of Psychiatry, School of Medicine. This research was supported from 1971 to 1976 by the Commonwealth Fund. A major goal was to describe the health conditions, beliefs, and behaviors of the five

ethnic groups in an inner-city area of Miami: Cubans, Haitians, Puerto Ricans, Bahamians, and southern United States blacks. The project's 1978 report (*3*) contains data related to use of health services, morbidity levels, ethnicity and health profiles, health practices, traditional health organizations, and value orientation profiles. In a preliminary report of the findings, Scott (*4*) observed that the pattern of health care among Haitians was to treat illness first with herbs and home remedies and then to rely heavily on the emergency room at the Jackson Memorial Medical Center, the only public hospital in the area that did not demand immediate payment. This finding is not unlike that of Leininger's studies of folk and professional health systems (*5*). She has defined the dominant contrasts of these two health systems and believes they both exist in the United States and in practically all cultures in the world. She further believes that failing to recognize and respect these often divergent systems creates conflict and gaps in professional health services.

Several studies specific to certain aspects of childbearing of Haitians have been conducted. Wiese investigated maternal and infant nutrition and traditional food beliefs in Haiti during 1969 and 1970. She discussed various behavioral demands upon post partum women in rural southern Haiti, the cultural rationale behind such behavior, the effect on nutrition of lactating mothers and nursing infants, as well as a proposed program for altering such behavior (*6*).

Scott's paper (*7*), based upon data from the Miami Health Ecology Project, reported beliefs about menstruation among Haitians, a majority of whom believed the function of menstruation to be that of ridding the body of "unclean," "waste," or "unnecessary" blood. Many Haitians also described menstruation as "it means you are a woman," "woman" meaning that the "individual has sexual feelings and needs and is not sterile" (*7*). Scott also discussed beliefs relating to blood and its function, as well as family planning attitudes and methods. Finally, Johnston (*8*) discussed cultural variations in parental and professional parenting patterns. Her paper concluded with a cognitive method for examining culturally divergent health beliefs and practices to determine if these are likely to be beneficial or harmful.

To sum up, the literature review revealed the need for cultural awareness and individuality in health care. Although some research investigations have been conducted in relation to Haitians, none have had the specific focus of our study. We propose to assess the beliefs, values, and practices related to childbearing of the Haitian refugee in Miami.

Conceptual Framework and Purpose

The relationship between culture-specific assessment and culture-specific nursing care provided the conceptual framework for this investigation. The perceptions held by a client concerning health and illness are culturally derived (*9*).

Culture is especially significant to the childbearing process because it defines the meaning of the experience and designates appropriate behaviors for reacting to and coping with events. All behavior is meaningful and should not be ridiculed, judged negatively, or ignored.

Of the published frameworks for cultural assessment related to childbearing, we chose the Kay-Galenic framework for this investigation because it provides the most complete assessment of cultural behavior patterns during the various phases of the childbearing experience. The framework uses the 1,800-year-old Galenic model of dietetics that focuses on the management of factors external to the body. Six categories of assessment are included: (*a*) air and water; (*b*) food and drink; (*c*) sleep and wakefulness; (*d*) movement, exercise, and rest; (*e*) evacuation and retention; and (*f*) passions of the spirit or emotions. In applying the Galenic model to childbearing, Margarita Kay, RN, PhD, a nurse anthropologist, proposed the acquiring of behavioral information to gain a better understanding of the client's response to childbearing; this knowledge should enable the nurse to provide care that supports the culture-specific beliefs, values, and attitudes of the childbearing client (*9*).

In this investigation we used an assessment tool to develop a cultural profile of the Haitian childbearing client. The profile served as a basis for deriving culturally appropriate nursing goals and interventions.

Method

Sample. The target population for the investigation consisted of pregnant Haitian refugee women receiving prenatal care at local health agencies in Miami. To provide a variety of respondent experiences with childbearing, we recruited a purposive sample of 10 pregnant Haitian refugee women with

the following characteristics: (*a*) women with children born in Haiti, (*b*) women with children born both in Haiti and the United States, (*c*) a balance between multigravid and primigravid women, (*d*) several women at high risk, and (*e*) a broad age range.

Research instrument. The structured assessment tool is an adaptation of the Kay-Galenic cultural assessment framework developed by Kay (*9*). The adapted assessment tool consists of 54 questions related to 4 areas of childbearing: (*a*) menstruation, conception, pregnancy (15 questions); (*b*) labor and birth (14 questions); (*c*) post partum (10 questions); (*d*) newborn (15 questions). Although the role of the father in childbearing and parenting is an important aspect and a component of the original assessment tool, it was not included in this study.

Content validity of the interview schedule was determined by a panel of three experts in the childbearing process. The interview schedule was translated into Creole by the interviewer for the investigation, who is a Haitian (Creole-speaking) registered nurse. The Creole interview schedule was then read back in English to the principal investigator by the interviewer to assure accuracy in translation. The interviewer pretested the schedule on two women. No revisions were made in the Creole interview schedule subsequent to pretesting. An interview face sheet was used to obtain pertinent background data.

Procedure. Nursing and nurse-midwifery staff members approached potential subjects during prenatal clinics at local health agencies and sought permission for the interviewer to visit the subject at home. All interviews were conducted by the Haitian interviewer during a 3-week period. The informed consent form, translated into Creole, was signed by the women before the interview (though three of the subjects signed with an X). The average interview lasted 2½ to 3 hours, and all women were interviewed in their homes.

Results

The sample consisted of 10 pregnant refugee women who had been born in Haiti and resided in Miami at the time of the investigation. Respondents ranged in age from 17 to 34 years, with a mean age of 24.9 years (see table). Length of time in the United States ranged from 5 to 30 months; the mean period was 10.3 months. All but one respondent had been in the United States 12 months or less. None of the women were legally married to the father of the child. All were receiving prenatal care at the time of the interview, and five were classified as "high risk" patients.

Characteristics of the study sample

Respondent's number	Age in years	Months in U.S.	Birthplace in Haiti	Number of children born in — Haiti	Number of children born in — U.S.
1	23	5	Deluge	0	0
2	34	9	LaGonave	8	0
3	17	9	LaGonave	0	0
4	33	30	Port-au-Prince	1	1
5	26	12	Port-au-Prince	5	0
6	24	7	Anse-a-Galet	2	0
7	17	5	LaGonave	0	0
8	34	9	Jean Rabel	2	0
9	19	7	Port-au-Prince	0	0
10	22	10	Port-de-Paix	1	0
Range	17–34	5–30	.....	0–8	0–1
Median	23.5	9	.....	1	0
Mean	24.9	10.3	.....	1.9	.10

Areas of consensus. Although there was much diversity in responses regarding childbearing beliefs, values, and practices, there was at least a 60 percent consensus among the 10 interviewees in the following areas.

Menstruation was identified as a sign of maturity in the female (one respondent added that menstruation tells that a girl can get pregnant). Most women did not identify anything a woman must do or not do during menstruation and believed that menstruation is associated with fertility.

Pregnancy was generally believed to be associated with sexual intercourse and the deposit of the "male germ" in the female. Methods of preventing pregnancy were predominantly family planning or breast feeding or both. A pregnant woman is believed to be viewed differently than a nonpregnant woman. Specifically, respondents believed that people "treat you special," "with great respect and pride," that a pregnant woman is "usually helped more by others," and that she "receives more attention from people." A 23-year-old primigravida who had been in the United States for 5 months observed that, if a woman is married, "everybody smiles as you pass by; if unmarried, people look at you as if you are a disgrace." One stated that the pregnant woman is viewed as a sick person.

No special beliefs about bathing or cleansing during pregnancy were cited by the majority. Although there was a variation in responses, most of the women believed that it makes no difference what foods the pregnant woman eats or the type of liquid she drinks and that the pregnant woman sleeps more. No restrictions on sexual activity during pregnancy were expressed. The majority of subjects responded "no" to the question, "Are there parts of the body that should not be exposed or touched during pregnancy?"

All 10 believed there are no dangers associated with pregnancy, providing the pregnant woman does not have enemies. Dangers were associated with the woman's having enemies who might put bad spells on the baby: "Don't get involved with persons known to be spellers so that the baby does not get eaten in the mother's womb."

Medical care during pregnancy was believed to be very important by the majority of subjects answering the question, "How do you feel about medical care during pregnancy?" Subjects related the causes of labor to time for birth, such as "the 9-month period has ended," and "when baby is term, labor is one of the signs that tells baby is about to be born." The Haitians believed that hot tea should be taken during labor; two specified hot ginger tea and one added hot milk in addition to hot ginger tea. Liquids such as hot ginger tea or hot milk and "eating plenty of okra" during pregnancy can speed up labor. Activities identified as speeding up labor included firm abdominal massage, specifically in downward movements, "pushing hard," "walking up and down and fast during labor" and, finally, frequent sexual intercourse during the last days of pregnancy, which should speed up birth by dilating the birth canal. Chants or sounds of a woman in labor include praying, singing, crying, and mourning, in various combinations. One respondent said she must call upon her voodoo protectors.

All but one subject responded positively to the question, "Would you like to be touched when you are having the baby," Two specified a preference for being touched by a female, three preferred to be touched by a male, and three did not specify which sex but added that being touched was reassuring and comforting to them. Nine respondents stated that the father can be present during delivery; two specified that he is expected to be there and identified the father's support role during delivery.

A question was designed to elicit fears about vaginal examination, application of special equipment to check the fetus, and the use of intravenous fluids during labor and delivery. One respondent stated that she had never had medical care (this was her third pregnancy, her first in the United States). Most respondents expressed no fears of the vaginal examination, qualifying their responses with statements that the doctor or medical staff "knows best"; the vaginal examination "is embarrassing and it can be uncomfortable." One respondent observed that the use of intravenous needles and fluids are an indication that the mother is not doing well. In this sample of Haitian childbearing women, pain is the predominating fear related to labor. Tearing of the vagina is also expressed as a fear of labor as well as fear of the baby dying if labor is prolonged. In general, subjects agreed that the well-being of the baby must be established at birth.

The post partum period for all but one respondent, who did not know, ranged from birth through 1 month to birth through 18 months. Nine of the respondents expressed specific beliefs about the mother's exposure to hot or cold air during the post partum period. Five specifically identified "catching uterine cold if in cold air," and two of these also identified "catching abdominal cold." One stated that hot air increases vaginal discharge, and another described the need to wear a feminine pad "to keep air from entering the body." In response to the question designed to elicit bathing or cleansing practices during the post partum period, 90 percent of the respondents specified sitting in a hot bath; one specified that herbs, roots, and leaves should be added to the water and another that the hot bath should be one in which "leaves and different herbs were put to boil." One respondent indicated that sitting in the hot bath is of prime importance to "purge the uterus and tighten the woman's vagina." There was much variation in the bathing practices post partum. Responses were qualified in the following manner: no shower during the first week, shower second day, shower after 2 weeks, shower or bath after 3 months with sponge bath only before that time, and finally sponge bath up to 40 days.

There was consensus that some foods and liquids are to be taken or avoided during the post partum period, but variation about which ones. Respondents believed that the pregnant woman must avoid strenuous activities or heavy work; 30 percent cited the need to limit activity to light work and one specified no activity except taking care of the baby for 30 days.

In response to the twofold question, "Do you believe in contraceptives? What do you do to avoid pregnancy?" nine respondents believed in contra-

ceptives; the other had never used birth control. In all responses the only contraceptive method mentioned, other than the surgical procedure of tubal ligation, was birth control pills.

In answering "What kinds of food are given to the baby during the first month?" eight women specified breast feedings or breast milk, six added sugar water (three specified boiled sugar water), and three indicated baby formula. Other specific foods mentioned were custard, panade (soft pudding made out of white bread), cooked cereal, hot cereal, powdered rice, dry powdered plantain, and other powdered roots.

Seven women cited size and color as particular characteristics the baby must have, and eight specified general condition, "look," and appearance. Crying a lot and changes in the character of the cry were described as ways of knowing if the baby is sick as well as changes in sleeping, eating, or bowel movement habits, facial expression, drawing legs up, and body gestures.

Only two respondents directly answered the question, "When is the baby bathed for the first time?" Both stated the next day. The second part of the question was, How would you give the baby the bath? The remaining subjects identified sponge bath as the method for bathing, adding that this is necessary until the umbilical cord falls off; after this time the baby can get a tub bath. In addition, two specified that the tub bath is not given for the first month. Keeping the baby wrapped and warm was important to most respondents.

During the first week of life, respondents specified that touching the baby is limited to people present at the delivery or the immediate family. Responses to "Where does the baby sleep?" were that the baby sleeps with the mother; two specified in the same bed with the mother. One said, "The baby sleeps with the mother, if living alone, and between the mother and father if they are living together." Another said the baby sleeps with the mother, but her friend told her that in the United States the baby must sleep in his crib. Nine subjects mentioned grandma or close relative or friend of the family as taking care of the baby when mother is out working on the farm or has to go to town. Two specified a baby sitter, and one added that this person is usually a very close friend or relative.

Individual responses of interest. Particularly interesting responses of individuals follow. A 17-year-old in her first pregnancy believed menstruation to be "bad blood being forced out of the body." Two

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respondents identified restrictions during menstruation as do not eat or drink citrus fruits because of the acid content and do not swim in very cold water. One 34-year-old respondent, one of the oldest in the sample, stated that the pad (sanitary napkin) is burned and tea is made out of the ashes, then given to the young girl so that evil people cannot harm her (this is done during the first or second menustration). A 34-year-old respondent did not associate menstruation with fertility, stating "some girls bleed internally." A 33-year-old who has been in the United States the longest (30 months), stated that pregnancy can be prevented by a long period of breast feeding or medications or if a bad spell has been put upon a woman.

Reasons for avoiding cold air during pregnancy were to keep the mother and baby from catching cold and, as stated by a 34-year-old, "if the woman stays too long in cold air, the baby may be born with head cold." Avoiding tub baths and swimming were cited as special beliefs about bathing or cleansing during pregnancy. A 17-year-old indicated that the pregnant woman should not sit facing the flow of a running river to avoid water from entering her vagina.

Some women believed that, in pregnancy, foods disagreeable to the stomach must be avoided; very spicy food and hot pepper should be avoided. One woman reported that one should avoid hot pepper and spices and eat lots of okra. Another reported that the pregnant woman must eat lots of okra and drink lots of tisane, a tea made of lettuce.

Comments on sexual activity during pregnancy included decreased sexual activity in early pregnancy and increased sexual activity in late pregnancy to dilate the birth canal. One respondent cited the abdomen as a body part not to be exposed or touched during pregnancy—a belief held in Haiti but not in the United States. A woman who had experienced two home births in Haiti stated that she would prefer

home delivery because of the family support. Another who had experienced eight births in Haiti stated that a doctor is fine if available, but a midwife does as well as a physician. In response to "Is it best to deliver at home or in the hospital," three said that it is best to deliver in the hospital, five stated that they prefer the hospital, and one saw no difference but stated that she preferred to deliver at home.

The responses identifying delivery positions also varied. Three respondents simply stated, "lying down"; another three, "lying on her back." One further elaborated, "In the hospital the woman lies on her back; in the home she may kneel down if birth is difficult." One identified "lying in bed," and another specified that a woman should deliver "on a stretcher." The remaining two described the delivery position as "sitting on a low chair," one specifying "with legs widely spread," and the other elaborating, "with another person sitting in back of the woman, embracing her whole body to give support." In response to "Does it make any difference who attends labor and birth; should the woman in labor be attended by a male or female?" three respondents stated that it makes no difference who attends labor and birth; five would prefer to be attended by "a female," (one specified a woman doctor). The remaining two respondents would prefer to be attended "by a male."

Beliefs about what can happen to the baby during birth included the birth canal may not be wide enough, the umbilical cord may strangle the baby, baby may drown in blood from the uterus, and baby may be stillborn or deformed.

Initiating the first cry was identified as the special thing that must be done for the baby immediately after birth. Four specifically mentioned massaging the head and pinching the nose to give shape, one further describing that both cheeks or the chin are pressed to place dimples, which are viewed as a beauty mark. One respondent specified that the umbilical cord should be cut, then palm oil with fat is massaged gently around the baby's head, and then a cotton pad is placed in the baby's hat.

In response to the question, "Are there special ways to handle the umbilical cord or placenta after delivery," two women indicated that the umbilical cord and placenta should be disposed of properly, one qualifying her response with the observation that, in home delivery, the placenta should be buried under the fireplace. Some respondents relied on whatever is normally done in the hospital, and one stated that the umbilical cord and afterbirth can be handled any way as long as other people don't have access to it.

Beliefs about postbirth vaginal drainage included relating such discharges to uterine contractions and identifying it as cleansing the remains of pregnancy. One described it as "bad blood and sanguineous drainage that needs to be drained out from the body, to clean the woman's pelvis."

Foods and liquid to be avoided post partum were eggplant, black pepper, cold drinks, and milk. Of these foods, rice, bananas, okra, and fish were considered to be cold foods, and tomatoes were believed to increase vaginal discharge. One respondent stated that one should eat plenty of everything to regain strength; another specified eating heavy food to avoid gas, lots of green leafy vegetables, and meat and beef liver. One respondent said, "My friends told me there are foods not to be eaten after delivery, but I forgot what they've told me."

The time frame for resuming sexual intercourse varied from 30 days to 3 months post partum. In addition, one respondent stated, "whenever she wants"; another, "after the bleeding stops"; and another, "when all vaginal discharge ceases." One respondent, who identified 3 months as the time frame, qualified her response with "when the woman is clean again."

Special ways or attitudes expected of the new mother included "to be caring for the baby," breast feeding (the mother breast feeds on the third day), observing the baby's breathing, and watching for oral mucus. Although the mother is expected to breast feed the infant immediately after birth, several qualified their responses as follows: if breast milk is available; on the third day post partum; on the second day, if breast milk is available; not immediately; next day or two. One respondent had never breast fed before. One woman who responded positively qualified her response with, "but my friends told me that in the United States, women don't breast feed."

Following are comments regarding fears or dangers in the post partum period: "as long as good care is taken of the body there is nothing to be afraid of," "mostly to avoid exposure to air draft and cold wind," "may hemorrhage, catch cold from vagina," "uterus may not return to proper position," "infection, air entering abdomen, and uterine cold." Two subjects referred to the "voodoos spirit" as special ceremonies or rituals that must be observed after the baby is born. One stated that she was told to feed the "lous" (voodoos spirit), but she does not practice voodoo. One stated that she had done the necessary (meaning she pays dues to the voodoo

spirit) and talked about losing four children who had been taken away from her by "bad spirit."

Interpretations of the purpose and care of the umbilical cord varied. One stated the belief that the cord must dry out and fall off within 2 weeks of life and that oil and nutmeg powder are sometimes placed on the stump to speed the healing process and avoid "catching umbilical cold." Another subject stated that the stump can serve many purposes as to increase child's intelligence by boiling the stump and giving the water to the baby to drink.

Three women specified that first bowel movements are the remainings of the mother's womb; three stated it is bad material that must be expelled; two described the baby's first bowel movement as being "black and gooey." Two respondents went on to describe a speeding up of the process by purging the baby with castor oil and other ingredients; one specified giving orally a "lok" which she described as a purgative made out of castor oil, nutmeg powder, and mashed garlic.

Limitations regarding viewing the new baby were for the first week, only the people present at delivery; the immediate family only; "not the first day of life"; "not the first few days"; "after 5 days." Respondents' fears about what might happen to the baby included evil spirits putting spells on the baby, the baby might get sick and the mother might not know what to do to care for the baby. One respondent who expressed fear of spells stated that she feared exposure to strangers or individuals known to be bad spellers. Responses as to when the baby is taken out into the community ranged from 1 week to 40 days, with some respondents specifically stating, "on a sunny day of the second week." Finally, one respondent stated, "Unless it is necessary to go out to clinic, the baby is kept inside until he starts crawling." Another specified that after 5 days the baby is taken out from the delivery room (usually the bedroom) to the living area, then after 1 month to the outside. Places where the baby is taken are the next door neighbor's, to church, and to relatives.

Applications in Clinical Practice

The Key-Galenic framework was used to organize the cultural assessment data. The goals and nursing interventions are based on the belief that each childbearing client has individualized perceptions and a range of knowledge that must be assessed before the nurse proceeds with management of the client's care. Nursing personnel need to support those individualized beliefs, values, and practices that are either beneficial or harmless and modify those that are harmful. The authors have compiled a list of care givers' goals and interventions directed toward specific beliefs, values, and practices. These are organized according to the components of the adapted Kay-Galenic framework.

Conclusion

Assumptions held by nursing personnel that all Haitian childbearing clients who have recently arrived in south Florida are so different as to have few characteristics in common with the American culture are not supported by the findings of this investigation. Rather, the findings suggest that the 10 Haitian female refugees who were interviewed generally perceived pregnancy and its particular needs and characteristics in much the same way and with similar concerns as their American counterparts. The variations in their responses reemphasize the need for accurate culture-specific assessment of each client in order to provide appropriate health care. Replicating the study among the other cultures in the Miami area would extend the interpretations of this study and be an exciting challenge.

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