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Lynn Clark Callister
Brigham Young University - Provo

Cheryl A. Corbett
Brigham Young University - Provo, cheryl-corbett@byu.edu

Shelly Reed
Brigham Young University - Provo

Cassidy Tomao
Brigham Young University - Provo

Katie G. Thornton
Brigham Young University - Provo

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Giving Birth
The Voices of Ecuadorian Women

Lynn Clark Callister, PhD, RN, FAAN; Cheryl Corbett, MSN, APRN; Shelly Reed, APRN, DNP; Cassidy Tomao; Katie G. Thornton

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Purpose: The purpose of this ethnographic study was to describe the perceptions of Ecuadorian childbearing women **Background:** No studies published in English could be found documenting the perspectives of Ecuadorian childbearing women about their birth experiences. **Method:** Thirty-two women who had recently given birth in Guayaquil, Ecuador participated in audiotaped interviews, which were analyzed as appropriate for ethnographic inquiry. **Results:** "Enduring birth to obtain the gift" was the overarching theme. Supporting themes included caring for self and accessing prenatal care to have a healthy newborn; relying on God to ensure positive maternal/newborn outcomes; submission of self to healthcare providers because of fear, pain, and lack of education; and valuing motherhood. The focus was on the well-being of the child rather than the quality of the birth experience. **Implications for Clinical Practice:** With a growing population of women of childbearing age immigrating into the United States from Central and South America, the need for culturally competent care is increasing. Sensitivity to the cultural beliefs and practices of Hispanic and other culturally diverse childbearing women is critical. Women's reliance on God to ensure positive outcomes should be respected. The provision of education and supportive care will help ensure positive outcomes in culturally diverse women.
Key words: *birth stories*, *Ecuadorian women*, *ethnographic inquiry*

With a growing population of women of childbearing age immigrating into the United States from Central and South America, the imperative for nurses to provide culturally competent care increases. Culturally competent nurses "understand the importance of social and cultural influences on health beliefs and behaviors and devise interventions that take these issues into account to assure quality health care delivery to diverse patient populations."[1(p294)] Developing cultural competence is essential for nurses caring for childbearing women.[2]

The purpose of this ethnographic study was to describe the perceptions of Ecuadorian childbearing women. This study will increase cultural understanding and foster cultural competence in nurses caring for childbearing women from Central and South America.

Author Affiliation: *Brigham Young University College of Nursing, Provo, Utah.*

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Corresponding Author: *Lynn Clark Callister, PhD, RN, FAAN, College of Nursing, 136 SWKT, Brigham Young University, Provo, UT 84602 (lynn_callister@byu.edu).*

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BACKGROUND

Perinatal health in Ecuador

Ecuador has an annual population growth of 1.55%. The population is primarily mestizo (mixed Indian and Spanish) with another 1.8% indigenous to the country and a few whites. There are 21.54 births per 1000 population. The fertility rate is 2.59 children born per woman. The female literacy rate is 87.7%. The infant

mortality rate is 21.35 deaths per 1000 live births. The maternal mortality rate is 110 per 100 000 births, with a lifetime risk of maternal death of 170.[3,4]

The Ecuadorian Law for the Provision of Free Maternity and Child Care (*Ley de Maternidad Gratuita y Atencion a la Infancia*) was enacted in 1999, and this initiative has both decreased neonatal mortality and increased primary healthcare services utilization among childbearing women of all ages.[5] Eighty-four percent of women have at least 1 prenatal visit and 58% have 4 or more prenatal visits.[4] Research has identified factors that continue to be associated with inadequate prenatal care in Ecuadorian women, including child care and transportation challenges.[6]

Many women living in Guayaquil receive their prenatal care through Hogar de Cristo, an Ecuadorian organization that initially built homes for poor families and now has grown to provide schooling, free healthcare, microcredit loans, and much more. Care is provided in small health clinics in poor neighborhoods, which make it easy for women to access prenatal care.

Incentivizing prenatal care by subsidizing the hospital costs for giving birth has increased the rates of early and adequate prenatal care. This is considered as a cost-reduction strategy, with the assumption that early and ongoing access to prenatal care is associated with fewer birth-related complications.[4] Perinatal studies conducted in Ecuador published in English are summarized in Table 1.[6–8,10–17,19] No studies were found documenting the perceptions of Ecuadorian childbearing women.

Significance of the study

Previous research has focused on the meaning of childbirth to culturally diverse women, including Guatemalan,[20] Mexican immigrants,[21] and other groups of childbearing women.[22] Further research was proposed to describe the childbirth experience of Ecuadorian women. It is crucial to gain knowledge of women's perceptions of childbirth, which will enhance nurses' ability to provide culturally sensitive care.

Work in *The Lancet* verifies that women's wisdom represents a significant source of expert knowledge for healthcare providers. The voices of women can be utilized to inform healthcare.[23] Having the opportunity to talk about feelings related to a significant life event such as childbirth has been documented to be an emotionally satisfying experience.[24]

This study is an extension and replication of similar studies of the meaning of childbirth to culturally diverse women,[25] focusing on Ecuadorian childbearing women since no studies could be found documenting their perspectives. The theoretical framework utilized was the Health Belief Model with constructs, including cultural beliefs, attitudes, values, and actions. This framework is used to guide clinical research, practice, and health policy.[26]

The purpose of this ethnographic study was to describe the perceptions of Ecuadorian childbearing women. The research question is, what are the perceptions of Ecuadorian women giving birth in a large public maternity hospital in Guayaquil, Ecuador?

METHODS

Following university and hospital institutional review board approvals, 32 Ecuadorian women who had given birth to healthy-term infants were approached on the postpartum unit in a large public maternity hospital in Guayaquil, Ecuador, or in the community and invited to participate in the study. Following informed consent and completion of the Spanish demographic data form, 30- to 60-minute audiotaped interviews were conducted in Spanish with one of the investigators using a semistructured interview guide based on Nichol's[27] work.

Each mother was given a small baby gift as an expression of appreciation for participating in the study. Interviews were conducted from 12 hours after giving birth to 6 months postpartum. A focused ethnographic approach was utilized, with intensive participant observation of and interviews with Ecuadorian childbearing women both in the hospital and in the community.[28,29] Fieldwork was the focus of this study. Triangulation was used to strengthen the breadth of the study, with multiple data sources and settings focusing on a single concept. The investigators were immersed in understanding the childbearing experiences of Ecuadorian women as they "stepped into their world." The researchers were the instruments in this study.

Setting

The maternity hospital where the study was conducted is managed by the Junta de Beneficencia of Guayaquil, a private nonprofit organization founded 120 years ago. This hospital provides healthcare to the poorest of the population of Guayaquil and surrounding areas, estimated to cover more than 3 million people. At this maternity hospital, 7% of the childbearing women giving birth were 15 years of age or younger, and 25% were 19 years of age or younger.[6] There are 90 births daily and approximately 2700 births a month with a birth census of 32 400 yearly. Low-risk women labor together in a large room, with 1 row of stretchers for 22 women

Table 1. Studies of perinatal healthcare in Ecuador

Study	Purpose	Findings
Blankenship[7]	To describe the experiences of a North American midwife caring for Ecuadorian childbearing women	Ecuadorian women value giving birth
Eggleston et al[8]	The relationship between unintended pregnancy and infant birth weight	Unwanted pregnancy associated with LBW in Ecuador
Chedraui et al[6]	Determinants of pregnancy in Ecuadorian adolescent women	Early sexual initiation, poor reproductive health knowledge, disruption of family structure associated with pregnancy in Ecuadorian adolescents 15 years or younger
Harvey et al[9]	Description of perinatal quality improvement initiatives in Ecuadorian healthcare facilities	Better education of providers essential in the provision of skilled care for childbearing women
Paredes et al[10]	Barriers to inadequate prenatal care in Ecuadorian women	Barriers were economic difficulties, child care, and transportation issues
Rosenberg et al[11]	Examination of birth outcomes in immigrant Latina women	Birthplace including Ecuador significant predictor of LBW infants
Chedraui et al[12]	Relationship between demographic characteristics and knowledge of family planning and HIV-prevention knowledge in Ecuadorian adolescent women	Older age associated with higher knowledge of family planning methods. Contraception use and HIV-protection behavior low in adolescent women
Vivar[13]	Description of cultural issues for Ecuadorian childbearing women	Only 30% of indigenous women receive skilled care during birth compared with 80% of nonindigenous women
Chedraui[14]	Description of trends, risk factors, and maternal-perinatal outcomes in Ecuadorian adolescent and other high populations of Ecuadorian women	Increasing prenatal care through subsidized healthcare in poor Ecuadorian women in a healthcare cost-reduction strategy leads to reduced complications
Chiriboga[5]	To describe Ecuador's provision of subsidized maternal and child healthcare	The Ley de maternidad gratuita y atencion a la infancia has offset the social determinants of health
Gaus et al[15;16]	To describe an Ecuadorian rural hospital initiative to improve healthcare	A "bottoms up" approach starting at the community level is effective in improving Ecuadorian healthcare
Gomez and Speizer[17]	The effect of childhood abuse and IPV in Ecuadorian women	Childhood abuse highly predictive of IPV
Parkes et al[18]	Describes promotion of health in marginalized populations in Ecuador	Educational initiatives in Cuban medical school for Ecuadorian medical students funded by Canadians

Abbreviation: HIV, human immunodeficiency virus; IPV, intimate partner violence; LBW, low birth weight.

in active labor, 1 row for women waiting for a cesarean birth, and a third row for women experiencing a fetal loss awaiting care.

There is 1 fetal monitor for the entire group of laboring women, and each is monitored briefly to ensure fetal well-being. Women scheduled for cesarean births are not monitored. The majority of laboring women receive no pain medication. One 20-year-old, first-time mother with a sixth-graduate education said her childbirth education consisted of the following advice from a friend, that when the pains were strong, "Just open your legs and push and then the baby will be out."

Because of space constraints and privacy issues, no support persons are allowed in the labor room. Individualized professional support from nurses or physicians is minimal to nonexistent, with nurses focusing on technical tasks and completion of paperwork. If women cry out, they are told that doing so would be harmful to their unborn child. All the women receive intravenous fluids. The nurse-to-patient ratio is 3 to 4

nurses for 22 laboring women. Three or 4 medical residents, most of them women, supervised by an attending obstetrician care for women in active labor.

There is little communication between healthcare staff and laboring women. For example, when vaginal examinations are conducted, information on dilation or fetal descent is not communicated to the women. When the women are fully dilated, they are moved to a birthing room with 8 or more beds, which are placed close together with minimal privacy. Mediolateral episiotomies are routinely performed, especially for primiparas. After the birth, the newborns are separated from their mothers and not returned for many hours.

There is also a high-risk room for women with gestational diabetes, hypertensive diseases of pregnancy, and other complications. This room is staffed with 1 attending obstetrician, 2 medical residents, 1 nurse, and a technician for 3 to 5 women. The women labor and give birth in the same room. One of the authors cared for a 19-year-old primipara who was very frightened. She knew nothing, not why she was in the high-risk room, whether she were having a son or a daughter, how far she was dilated, what the fetal monitor measured, or what the physicians were going to do for her. Because of late decelerations, she had a cesarean birth and wept with anxiety for the well-being of her unborn child. She gave birth to a beautiful daughter, the outcome she desired.

The immediate postpartum room, adjacent to the labor rooms, houses the women who have given birth, including low- and high-risk vaginal births, and women who had cesarean births. This room holds up to 30 women and, if full, postpartum women may be kept on their stretchers out in the hall. Women are generally kept in this room for 1 to 2 hours after birth, and newborns are seldom allowed to be with their mothers during this period.

On the mother/infant unit, mothers care for themselves and their newborns who are housed in the same bed. All of the mothers breast-feed. Visiting hours are 90 minutes long in the middle of the day, and many fathers are not able to visit because of their employment. Paternal involvement varies from fathers who are very engaged and excited to those having little or no involvement.

Data analysis

Audiotaped interviews were transcribed and translated into English verbatim by Spanish-speaking members of the research team. Data collection proceeded concurrently with data analysis. Observations and photographs contributed to data analysis. Members of the research team analyzed the data independently to identify preliminary themes, engaging in reflection and extracting significant data bits. Themes were generated by the research team to finalize the results and identify definitive themes based on rich narrative data.[30] It was not feasible to contact study participants to conduct member checks. Demographic data were analyzed using descriptive statistics. Trustworthiness of the data was ensured by prolonged engagement in the study site by the investigators as participant observers, field notes kept documenting insights gained during the interviews, and consultation with an experienced qualitative nurse researcher.

Three members of the research team had lived in Central America or the Dominican Republic for 18 months. Four are fluent Spanish speakers, and 2 (1 labor and delivery nurse, the other a family nurse practitioner) had given humanitarian service with Hispanic populations in developing countries.

FINDINGS

Demographic data are summarized in Table 2. The study participants were mostly mestizo (mixed indigenous and white), Afro-Ecuadorians, and women from indigenous groups such as Kichwa, Cofan, and Siona.

Table 2. Demographic data

Maternal age range: 15–36 y, mean age of 23
Maternal education: ranged from none to 1 college graduate, with most not having completed secondary school
Parity: 14 primiparas and 18 multiparas
Perinatal loss: 8 miscarriages, 6 stillbirths or infant deaths, 1 woman had lost 5 of 7 children
Range of living children: 1–7, with a mean of 3 children
Prenatal care: range of weeks' gestation at first visit ranged from no prenatal visits in a woman who had 5 children to 16 wks at first visit. One woman who was not seen until 16 wks had lost 5 of 7 children
Prenatal care: ranged from 0 to 10 visits, with a mean of 4 visits
Type of birth: 7 cesarean births, 25 vaginal births (1 epidural, 24 unmedicated)
Length of labor: 30 min–24 h with a mean of 5 h
Complications: Pregnancy induced hypertension, postpartum hemorrhage, wound infection, and newborn sepsis

The overall theme emerging from the narrative data was "enduring birth to obtain the gift." The 4 supporting themes were (*a*) caring for self and accessing prenatal care to have a healthy newborn, (*b*) relying on God to ensure positive maternal/newborn outcomes, (*c*) submission of self to healthcare providers because of fear, pain, and lack of education, and (*d*) valuing motherhood.

Enduring birth to obtain the gift

The women did not focus on the quality of their birth experience; rather, they seemed to view birth as a painful but time-limited moment, to be endured in order to obtain the gift of a child. For example, 1 woman explained, "One must sacrifice for her child." Another woman said, "Endure it because the pains come, but then they are gone and then comes the joy because you have your baby."

Caring for self and accessing healthcare to have a healthy newborn

Speaking of the importance of self-care and maintaining a healthy lifestyle, 1 woman said, "It's important that [the woman who is pregnant] takes care of herself, and delivers normal. Eating, taking vitamins, [eating] soups, [drinking] liquids, things that she herself can do to take care of herself."

Another spoke of the importance of seeking healthcare, "[It's important] that you go to your checkups constantly more than anything, because that helps a lot. The doctors see how the baby is doing." The focus was on ensuring having a healthy newborn. Some women sacrificed to access healthcare, traveling many kilometers to the clinic.

Relying on God to ensure positive maternal/newborn outcomes

These women relied on God and their deep spirituality even before they gave birth, "I prayed during the whole pregnancy that everything would turn out well." Another woman said,

> There are a lot of special prayers you say during pregnancy. There are so many virgins and each has her own prayer, so it depends who you are devoted to. So you pray to whichever virgin you want. We always give thanks to God.

Women spoke of the importance of relying on God during childbirth. One said, "I trusted God and I had [the] strength to give birth. It takes a lot of strength and courage." Another woman reported, "I asked God and the Virgin that everything would turn out good and yes, they helped. The Virgin, I even saw her at my side. It helped me by being by my side between her and God."

Other women described giving birth as a spiritual experience. As one woman said, "[Giving birth] is spiritual because it is from above that God gave me a gift of a son."

Another woman explained the transcendence she felt as she gave birth, "[Giving birth was spiritual] because it takes you away." A mother of 5 said, "[Giving birth] is an experience where you have put yourself in God's hands."

Another woman did not think giving birth was a spiritual experience, and distinguished between "immaculate conception" and her own bearing of a child,

> Spiritual is what we call what God did to Maria which was that He sent her a son, instead of being between two people. He sent her a son. Whereas for me no, but it is still a blessing that God has given me a child.

The mother of 3 sons who had previously lost a daughter when she was 6 days old gave birth to a fourth son following a high-risk pregnancy. She spoke of her birth experience,

> Thanks to God my baby was just fine. I asked God with all my heart that my baby would be all right from the moment I found out I was pregnant. God is great. He knows how I asked Him. I cried every day and I pleaded, saying, "Lord, I will suffer anything, but please don't take my son away. He listed to all my petitions and my cries because I lost a child already, and I wanted to die when that happened. I had faith in God and He didn't take my boy. I put my life in God's hands. That's what I did with all my children, and that's why they are all fine. I thanked the Lord that He allowed me to have my baby.

She also described an experience that occurred 8 days before her son was born,

> One day, I almost fell backwards, but I felt as if someone caught me and nothing happened. It was a beautiful experience. I was falling, but I felt a hand grabbing me. All this was as if angels were around me. I knew God was going to be there at every minute, and I never stopped asking Him. He gave me strength. I always put my faith in Him.

Submission of self to healthcare providers because of fear, pain, and lack of education

Passive reliance on healthcare providers was exemplified by this data bit, "For me, I wanted the doctors to [make the decisions] . . . they tell you that if you are calm, everything is going to turn out okay." Another woman explained that having the doctors make the decisions was critical, "It doesn't matter as long as it was good for the baby."

A 17-year-old mother of 2 who had also previously had an abortion said, "I wanted the doctors to make the decisions. They are the doctors. They know what they are doing. What do I know? I'm not the doctor, they are the doctors."

One woman explained that it was important just to follow physician instructions, "She [the doctor] said you need to not be nervous and not cry because that causes too much labor . . . it is when you hemorrhage and there's blood and blood and blood, if you are really worried."

Another woman described the traumatic intensity of her birth experience in this way, Because of lack of knowledge and fear coupled with pain, I felt like I was going to die. The pains came much stronger. I didn't know what to do. They examined me again. They examine you all the time. I felt like I was going to die because I still had the strong pains. And then I just gave three big pushes and that was it.

A first-time mother explained what she had been told by extended female family members about giving birth, "My mother told me not to scream, not to open your mouth so that nothing comes out. Because if not, the baby goes inside and the labor was going to get more complicated." She was conditioned to submit herself to her healthcare providers to be stoic and passively accept the pain and any medical assessments and procedures.

Valuing motherhood

The women in this study highly valued motherhood above almost everything else in their lives and expressed that it is through motherhood that deepest fulfillment is found. One woman said, "I was the happiest person when they told me I was pregnant." Another said, "If a baby is going to come into the world, it brings you joy."

A study participant described her feelings during pregnancy, "It is something very beautiful to have someone living [inside you] over nine months." Another mother explained, "When I actually gave birth and my son came out, that replaced the pain because I felt enormous joy when I saw him be born. A lot of pain, but I said deep down, I was going to have a son so I felt happy." Estrella said, "With joy you have a baby. It comes in the name of God."

Because of hospital protocols, the new mothers often did not get to see or hold their infants for several hours after giving birth. Adela described that moment,

> Later they brought him to me. And he came crying because he wanted to breast-feed. So I picked him up and gave him the breast. I felt happy. I was the happiest woman because he came out normal, without anything wrong.

The women put red or red and black bracelets on their newborns made from a string of dried berries to prevent evil forces from affecting their infant. The newborns wear the bracelet for 1 or 2 months. Adults also wear these as jewelry and not necessarily for their protective powers.

DISCUSSION

The study has essential implications for healthcare for childbearing women giving birth in Ecuador as well as immigrant Ecuadorian women giving birth in the United States.

Issues for women giving birth in Ecuador

In Ecuador, the social role of motherhood is highly valued. It has been suggested that "fertility and procreation play a major role in women's health and wellbeing in most societies."[31(p3)] For these Ecuadorian women, *motherhood* is seen as the "realization of her gender role."[31(p38)] and *womanhood* is defined as producing a desirable number of children.[31]

During pregnancy and while giving birth, children are highly valued. It is not about the birth experience; it is about the outcome of a child, the gift from God. This was exemplified in the words of a 17-year-old mother, "My main goal was that the baby be born well, because this is the best gift that God has given me in life."

For these Ecuadorian women, as described by Alvadji,[32(p39)] "the physical, emotional and social experience of pregnancy and childbirth is characterized by pain, fear, and solitude." These women seem to be willing to go through anything to have a healthy child. These women chose to access prenatal care and to give birth in a public maternity hospital because they were seeking positive outcomes for their newborns.

A strong theme was reliance on God to ensure positive outcomes. These deeply religious women relied on Jesus and multiple virgins. It appeared that the most spiritual part of giving birth was not the actual moment of birth, but holding their newborn in their arms. These socially disadvantaged women gave birth in a hospital, leaving family support to labor alone. They had little or no control over their labor and birth experience, which increased their sense of powerlessness and dependence on biomedical healthcare. Cultural passivity was evident. Women accorded total trust in their doctors and rarely questioned their care. These childbearing women tolerated lack of respect and lack of modesty and endured invasion of privacy because they believed that "doctors know best." Any cultural considerations are virtually absent.

Table 3. Implications for clinical practice

Include spiritual and cultural assessment in healthcare visits and demonstrate respect for the spiritual and sociocultural dimensions of women's lives
Ask the question, "Is there anything I need to know about your culture that would help me provide care for you?" This may prove helpful in individualizing nursing care for culturally diverse childbearing women
Be aware that stoicism and passivity may characterize the behavior of laboring women from South and Central America who may not verbalize complaints of pain. Perceptions of pain, behaviors associated with childbirth pain, and preferences for management of pain are culturally bound. Use of a coping algorithm rather than a pain-rating scale may be more appropriate in this population of laboring women
Traditional knowledge and cultural practices that are health promoting should be incorporated into the plan of care
Use translators for women with limited English proficiency
Provide education in each healthcare visit and involve women in healthcare decisions
Implement cultural-competency education in facility-based perinatal quality improvement programs[3;40–50]

Their experience has been described in this way: "when childbirth is seen as a critical life event and individual women do not know beforehand the outcomes of their pregnancies, women hand over control of their situation to health care providers."[31(p11)]

Their childbearing experiences were not characterized by education, personalized care, appropriate pain management, or clear communication with their providers. Narratives document that giving birth is characterized by passivity and endurance. However, their overpowering sense of love for their newborn makes the negative aspects of giving birth worth everything.

Emancipation in decision making in women's healthcare has been described in the literature as including personal reflection, personal knowledge, awareness of social norms, and a flexible environment.[33] By participating in this study, Ecuadorian women had the opportunity to reflect on their feelings about their birth experiences with interested nurse researchers. It is hoped that the personal knowledge of these women was increased through participating in the interviews and that they were able to consider alternatives in healthcare in relationship to themselves. This knowledge is generally lacking for these women.

Continuing international collaboration in Ecuador is recommended to improve psychosocial outcomes in maternal/newborn health. Although notable efforts are being made to decrease maternal morbidity and mortality, it is essential that attention be turned to psychosocial issues and the provision of culturally congruent care beyond the biophysical issues.

In the neighboring country of Peru, the health ministry, the United Nations Family Population Agency, and other international aid agencies and nonprofit organizations have partnered to establish Mamawasi's or "mother's houses," which provide culturally sensitive care for childbearing women by creating birthing centers that simulate Peruvian homes.[34,35] This model is a strategy worth consideration for implementation in Ecuador because it focuses on culturally sensitive care. Although the National Sexual and Reproductive Rights Plan was implemented in Ecuador in 2006, following the 2004 Maternal and Child Health Law, the integration of culturally sensitive care into health services in Ecuador has not been fully implemented. Cultural barriers exist to maternal health in Ecuador.[36]

A limitation of the study is that it may not be reflective of the perceptions of all women giving birth in Ecuador. Women giving birth at home, rural hospitals, or in private hospitals may not report the same birth experiences. However, the study adds important insights into the perceptions of socially disadvantaged Hispanic women giving birth. There are also implications for immigrant Hispanic women giving birth in the United States.

Qualitative evidence can be utilized to promote evidence-based practice.[37] Listening to the personal narratives of women can contribute to nursing's knowledge base about human responses and the meaning of pivotal life events such as giving birth.[38]

Issues for Ecuadorian immigrant women giving birth in the United States

Hispanics, including Ecuadorians, are the largest and fastest growing minority group in the United States, expected to comprise 25% of the population by 2050. Hispanic women have the highest fertility rate of all ethnic groups, comprising 23% of births in the United States, representing a significant number of childbearing women cared for by nurses.[39] It is essential that childbearing women's spirituality, as well as deeply held religious beliefs and practices, should be acknowledged, respected, and incorporated into

the plan of care as mandated by The Joint Commission on Accreditation of Health Care Organizations standards.[40] A recent study documented a correlation between a high level of religiosity and fewer health-risk behaviors in childbearing women.[41] Thus, supporting childbearing women's spirituality and religiosity is critical.

Awareness of social norms is a crucial consideration when caring for these women. Assessing power structure and healthcare decision-making patterns is essential.[42] Emancipation might or might not occur depending on sociocultural context because established cultural behaviors are challenging to change.

Stoicism and passivity are social norms for Ecuadorian childbearing immigrant women, as are the expectations of enduring childbirth pain rather than being medicated. It is critical to "deliver care in a compassionate manner that preserves patient autonomy, dignity, safety, and rights."[43(p9)] Use of a coping algorithm rather than a pain-rating scale may be appropriate for Hispanic immigrant women.[44]

Childbearing women who do not speak English and are immigrants may be stereotyped as "unresponsive and unintelligent."[45(p55)] English is not the primary language for more than 47 million US residents older than 5 years, so linguistic barriers need to be overcome through the appropriate use of translators and the use of nonverbal communication strategies.

A flexible welcoming birth environment is vital to meet the needs and desires of culturally diverse childbearing women. The clinical environment should reflect respect for the diversity of the women served.[46] Gaining an understanding of and respect for cultural beliefs and practices, including those of Ecuadorian women, is essential, since cultural beliefs define what constitutes a satisfying birth experience.[46] Developing a relationship of trust, with interactions characterized by openness, understanding, and respect is pivotal.

A culturally competent nurse personalizes care on the basis of the cultural values and beliefs of childbearing women and their families.[42] A culturally competent model of care incorporates evidence-based practice, including research findings, clinical experience, women's cultural values, and social context.[47] *The Blueprint for Action: Steps Toward a High-Quality, High Value Maternity Care System* includes improving care for vulnerable populations of childbearing women and their families.[48] Clinical implications are summarized in Table 3.[42–52]

The birth stories articulated by Ecuadorian women may prove helpful in increasing sensitivity to the needs of culturally diverse childbearing women. Qualitative research findings contribute to evidence-based practice.[53] Qualitative data can be used to generate clinical practice guidelines, which include a woman-centered, culturally appropriate approach to care delivery.

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