

An Analysis of Major Issues for Culturally-Minded Professionals in Women's Health Care

Victoria Clark

A Senior Thesis submitted in partial fulfillment
of the requirements for graduation
in the Honors Program
Liberty University
Spring 2019

Acceptance of Senior Honors Thesis

This Senior Honors Thesis is accepted in partial fulfillment of the requirements for graduation from the Honors Program of Liberty University.

Melody Harper, Ph.D.
Thesis Chair

Frampton Fox, Ph.D.
Committee Member

Kimberly Mitchell, Ph.D.
Committee Member

Cynthia Goodrich, Ed.D.
Assistant Honors Director

April 23, 2019

Abstract

Women's health care professionals, such as general physicians, obstetricians and gynecologists, midwives, nurses, and doulas, in the US need to be aware of cultural issues and disparities.

Minorities and migrant women experience cultural challenges and disparities when receiving health care in the US. Without cultural sensitivity, patient care is compromised. Pregnancy and childbirth practices vary widely by culture, and potential differences in perspectives, beliefs, and treatment of these are critical issues for women's health care professionals to study. Female genital cutting (FGC), obstetric fistulas (OF), and female cancer are also discussed in this paper.

An Analysis of Major Issues for Culturally-Minded Professionals in Women's Health Care

Introduction

Women's health care professionals need to be aware of issues that arise in multicultural health care settings. This is not just for professionals who work overseas or in areas with a high concentration of migrants, as other minorities in the United States also experience health disparities because of health care professionals' lack of awareness. It is imperative that women's health care professionals understand major cultural issues in their field. Those who are unaware of cultural issues will not only be less competent in their care but may also contribute to preventable health disparities. In the area of women's health, these disparities can sometimes lead to serious negative health consequences, whether from childbirth, cancer, or specific cultural practices such as female genital cutting (FGC).

Training in cultural intelligence (CQ), having skills in CQ, and understanding issues key for culturally competent women's health care in the US would benefit women's health care professionals. Many cultural influences impact patients who receive care in the US. It is therefore necessary that US women's health care professionals prepare to interact with culturally diverse patients in order to provide the best possible health care. Being aware of cultural, racial, and ethnic factors in order to best communicate with, and ultimately care for, patients is important for a variety of women's health care professionals, including primary care physicians, obstetrician-gynecologists, nurses, and midwives (Cunningham, et al., 2014; Edwards, 2013; Guilliland, et al., 2015; Perry, Potter & Ostendorf, 2016; Wilson & Seaton, 2017). Scientific knowledge for treating patients is good, but if health care workers are unable to effectively

communicate with their patients and understand the cultural influences underlying their health issues and decisions, their practice will not be fully effective.

Since the US health care system impacts the way care is provided to all patients, including cultural minority groups, the roles of women's health care professionals need to be discussed. The amount of integration across roles impacts the quality of maternal health care provided to women (Vedam, et al., 2018). This can positively or negatively affect minority groups. To provide optimal care, each women's health care professional should not only fully understand his or her own role, but also those of other women's health care professionals.

Various studies have demonstrated that health care has not been as effective in treating some populations as others (Kothari, et al., 2016; Mendoza, Armbrister, & Abraído-Lanza, 2018; Villadsen, Mortensen, & Andersen, 2016). For example, African American women have a higher mortality rate than white women during childbirth (Cunningham, et al., 2014; Hopp & Herring, 2015). Therefore, it is important to explore disparities within women's health care and their causes. An understanding of the health care practices and beliefs unique to minority cultures prevalent in the US, such as African American women and Hispanic women, will better equip women's health care professionals to care for these populations. Immigrant women from a variety of nations have needs particular to their unique cultures as well. Women's health care professionals in the US, especially those who practice in areas that are particularly culturally diverse, must be aware of certain issues.

One of the largest areas of women's health is pregnancy and postnatal care. This is an aspect of health shrouded in deeply-rooted cultural beliefs. While knowing a woman's expectations solely from her culture is impossible, women's health care professionals who

understand the general beliefs of certain cultures towards childbirth improve the care of their patients from different cultures. US immigrants come from a plethora of backgrounds, and their home cultures may greatly influence their health needs and views towards prenatal care, pregnancy, labor, postnatal care (Kemp & Rasbridge, 2004; Lipson & Dibble, 2005). As it may be necessary to inquire about certain culturally sensitive topics that would impact providing optimal care during pregnancy and childbirth, awareness of potential cultural conflicts can also help professionals use their time effectively during healthcare visits.

The field of women's health is not limited to pregnancy and childbirth, however. For example, women's health care professionals treating migrant women with FGC should be aware of the issue culturally and how it relates to their health (Benza & Liamputtong, 2014). It is a sensitive subject, so professionals should be aware of the cultural aspects of the practice in order to treat their patients with utmost respect. Although rare in developed countries such as the US, obstetrical fistulas are a complication sometimes related to FGC that might need to be treated (Amodu, Salami, & Richter, 2017).

In addition to pregnancy care and FGC, cancer is a major treatment area in women's health. Cancer afflicts all women across the US, but breast and cervical cancer rates differ for some minority groups – specifically for African American and Hispanic women (Hutter, et al., 2011; Moore de Peralta, Holaday, & Hadoto, 2016). The underlying factors behind the disparities in these statistics should be explored so that health care professionals can improve care for these groups of women.

Women's health care professionals interact with various cultural groups within the US. These include minorities such as African Americans and Hispanics/Latinos, as well as

immigrants from a plethora of nations and cultures. Therefore, there is a need for awareness and understanding of diverse populations of patients. Lack of cultural sensitivity can result in decreased quality of communication and ultimately poorer quality of care for patients.

Please note that the various terms used throughout this thesis – black, white, African American, Caucasian, Hispanic, Latino, etc. – sometimes are very specifically defined within the sources cited. In order to preserve these distinctions, the original terms are used.

Cultural Intelligence

As understanding other cultures is key to effectively serving them and as there is a plethora of cultures within the US, it is important for health care professionals to train themselves for interaction across cultures. It is necessary to learn how to interact successfully in order to be a blessing to people who are from different cultures, but learning a list of cultural guidelines and taboos will not resolve all cultural conflict. On the other hand, learning theoretical principles alone can make implementation difficult (Livermore, 2009). In *Cultural Intelligence: Improving your CQ to engage our multicultural world*, Livermore explains the four dimensions of cultural intelligence (CQ) – drive, knowledge, strategy, and action (2015). All four of these are crucial to being completely effective in cross-cultural interactions.

Many types of professionals interact with people from different cultures regularly in the workplace, not just expatriates or those who work in international government positions. In health care, this is no exception. Not only are there significant differences among cultures of Americans who have lived in the United States for centuries, but there are also such differences from those with strong ties to a foreign culture because of recent immigration.

Training in cultural competency is not new; however, specific characteristics of cultures were emphasized in past models of training. Cultural beliefs were dangerously assumed to apply to large groups of people. Unfortunately, this increases the risk of stereotyping, which in turn can result in marginalization of groups such as migrants. An important part of cultural training in health care is developing an open, non-judgmental, and respectful attitude towards other perspectives on health care. Understanding one's own perspective on health is helpful in developing such an attitude (Villadsen, Mortensen, & Andersen, 2016).

All dimensions of CQ – CQ drive, CQ knowledge, CQ strategy, and CQ action – are absolutely necessary, but this thesis focuses on increasing the CQ knowledge of women's health care professionals. Training in cultural competence has become an important part of medical school curricula because of the need for culturally-sensitive care (Kripalani, et al., 2006). While cultural information should not be applied without utilizing the other aspects of CQ, increasing CQ knowledge is key to overall CQ growth. Increasing knowledge will not be sufficient to cover everything women's health care professionals should know when caring for women of different cultures. However, increasing knowledge in this area can begin the important process of seeking to understand and effectively care for women of different backgrounds.

Practitioner Roles

Women's health care professionals span a variety of levels. General physicians, obstetrician-gynecologists, maternal-fetal specialists, midwives, nurses, nurse-practitioners, and doulas are involved in US women's health care (*Your Pregnancy and Birth*, 2005; Gilliland, 2011). Midwives can practice with certain limitations in the US. Unlike a midwife or

obstetrician, a doula is not involved on the medical side of the birthing process, but she supports the parents when interacting with these professionals (Ross, 2012).

There is an intense, though perhaps unwritten, war within the realm of US women's health care over where, by whom, and how best a woman should give birth. In some cultures, childbirth is not treated as a medical event but rather as a natural process (Colin, 2005; Guarnero, 2005; Kemp & Rasbridge, 2004; Meleis, 2005; Waters & Locks, 2005; Zachariah, 2005). However, the current mainstream approach to childbirth, at least legally, is that it is to be regulated in a medicalized fashion. It is crucial for a pregnant woman to understand her health care choices, but this information is not always given to her by her general practitioner. General practitioners should give women a range of options for childbirth besides simply obstetricians, but this does not always happen (Ross, 2012).

Sources from physicians, specifically obstetricians and gynecologists, seem to be biased towards their own role as best and safest. *Your Pregnancy and Birth* (2005) by The American College of Obstetricians and Gynecologists states there are four women's health care professionals for perinatal care. Three of these are doctors, and the fourth is a nurse-midwife. Perhaps what is even more interesting is the absolute lack of mention of midwives that practice outside of hospitals in the section on health care professional options. Furthermore, *Your Pregnancy and Birth* (2005) recommends seeking perinatal care within a hospital over a freestanding birth center since "these centers may not offer all the services you may need if an emergency arises" (p. 14).

However, medicalizing the birth process does not indicate an increase in health for the mother and child. Although the number of cesarean births has had a significant rise in the last

few decades (Gilliland, 2011; Monari et al., 2008), infant and maternal mortality rates have not changed (Monari, et al., 2008). These statistics do not rationalize a higher rate of cesarean births. Gaskin (2011) said,

We now find ourselves in a situation in the US and many other parts of the world where women are increasingly being denied what is perhaps the most powerful and primal experience a woman can have: the right to give birth without the use of medical interventions unless these prove necessary (p. 6).

The World Health Organization (WHO) asserted there should be a medical need when a cesarean section is performed, as risk is increased in surgical interventions (Betran, Torloni, Zhang, & Gülmezoglu, 2015; Ross, 2012). In essence, the WHO claimed there is risk in performing cesarean sections, as they are a form of surgery, and that they should be used only when necessary.

Women's health care professionals sometimes hold opposing views towards medical interventions, specifically about cesarean sections. Monari, et al. (2008) found that obstetricians were more likely than midwives to believe an elective cesarean would be beneficial for the mother's stress levels and fecal incontinence prevalence; also, midwives more than obstetricians were likely to support a vaginal birth after cesarean (VBAC). Monari, et al. (2008) also reported that about two-thirds of midwives but only one-third of obstetricians thought there were too many cesarean sections in their area of the hospital. It is vital that women's health care professionals across a variety of roles work together (Cameron & Taylor, 2007; Raynor & England 2010). When they do not, the infant and mother's health are compromised. However, when professionals collaborate well, infant and maternal mortality substantially decreases. When

midwives are included in health care conversations with other health care professionals, good outcomes have been reported. Unfortunately, because of legal regulations, midwives in the US often are not integrated into the health care system well (Vedam, et al., 2018).

The term “midwife” carries a variety of connotations. Some think of it as an outdated profession, while others think of a woman who assisted a birth in their home, the hospital, or an alternate birthing center. In the last century, the profession of midwifery has changed radically within the US and has been largely pushed out by other medical professionals. However, for research and reporting purposes, midwives are sometimes considered together with medical professionals, such as physicians and nurses (Crisp & Chen, 2016).

In the US, only 10% of births have a midwife present as compared to 50-75% in countries with comparable per capita finances (Vedam, et al., 2018). These statistics are likely due to the fact that midwives in the US have difficulties with certification. Some women lack midwifery access because of the state in which they reside. The mother's experience and health outcomes are documented to increase along with midwife autonomy. There are also financial benefits from such a setup, as midwife costs are usually lower than those of general physicians or specialist physicians. There are three different routes to practice as a midwife in the US – as a Certified Nurse-Midwife (CNM), Certified Professional Midwife (CPM), or Certified Midwife (CM) (Vedam, et al., 2018).

The only type of midwife that requires a nursing credential is the CNM. A CNM receives a master's degree after a formal university nursing program. A CNM is allowed to practice in every state and Washington, DC. CNMs are trained to practice in any setting; in reality, they generally only work in hospitals. CPMs typically receive around three years of instruction and

training before they are certified and are recognized legally in 30 states. CPMs have a wide range of scope in non-hospital settings. CM training covers the same settings and scope as a CNM, but CMs can only receive a license in five US states. Regardless of race and a number of other factors, it was reported by one study that when CNMs were allowed to practice apart from physician supervision, outcomes such as surgical and preterm births and low birth weight decreased (Vedam, et al., 2018). However, according to Kelley & Mashburn (2014), “the medicalization of birth [has done] much to eliminate midwifery and [has continued] to influence and regulate the practice of nurse-midwifery,” so only 73 CMs and 12,025 CNMs were recognized by the American College of Nurse-Midwives and American Midwifery Certification Board in 2012 (p. 458). The extremely small number of CMs is likely because while CNMs may legally practice in all 50 states and the District of Columbia, there are only five states where CMs are even allowed to practice (“Six Ways for College Students,” 2017).

What sort of care does a midwife provide? Other issues besides childbirth and prenatal care are sometimes covered under well-woman care covered by a midwife. Not only is it necessary for women's health care professionals to understand cultural issues surrounding childbirth and pregnancy, but they should also have knowledge of cultural issues in other aspects of women's health. Specifically, gynecological issues such as FGC, obstetrical fistulas, and cancers – breast and cervical – will be discussed in regard to their cultural implications.

Cultures Within America

Globally, the US is near the top in per capita healthcare spending. However, out of 224 nations, it ranks 56th for infant mortality (Kothari, et al., 2016). The WHO reports that in the US, there were about 3.6 neonatal deaths per 1000 live births. This is better than the global average

of 18.0 deaths per 1000, but it is worse than rates such as 2.6 in the United Kingdom, 2.4 in France, 2.2 in Cuba, 2.1 in Australia, 1.7 in Spain, or 0.9 in Japan (“Global Strategy for Women’s, Children’s, and Adolescents’ Health,” 2016). The higher infant mortality rates in the US are largely because of ethnic/racial minority disparities (Kothari, et al., 2016). Hispanics and African Americans are two populations for which this is the case, but infant mortality rates are also high in other minority and immigrant populations (Hayes, Enohumah, & McCaul, 2011). African American, Hispanic, and immigrant women face unique challenges when seeking healthcare in the US.

African Americans

Unlike other minorities, African Americans are unique in that most did not migrate to the US for freedom but instead were forced to the US in bondage. This history has profoundly impacted African American culture. The impact of slavery included distrust of white physicians from black slaves when receiving medical care, which was often inadequate. Today, there are still problems with the quality of care in the US between different populations. Mortality for a black woman during childbirth is 3.7 times that of a white woman (Hopp & Herring, 2015), and infant mortality is 2.2 times higher in black populations than in whites (Kothari, et al., 2016).

The matter extends beyond women’s health care concerns. Poverty is much more common in black populations – 2.6 times higher than for white Americans (Kothari, et al., 2016). There is a higher rate of poverty within predominantly black neighborhoods than in predominantly white neighborhoods as well (Kothari, et al., 2016). The disparity between black and white American women has slightly decreased since the 1990s for the categories of low birth weight and very low birth weight, which are important indicators of likelihood of infant

mortality. However, Hopp & Herring (2015) explained that this disparity has mostly been because of the “the increase in these two categories among [white] women, rather than a reduction among [black] women” (p. 255).

Even if social status, economic standing, and prenatal care accessibility are factored out, disparities still exist between African American and white women (Vedam, et al., 2018). Research has demonstrated greater health risks correlated with gender and racial discrimination. African Americans experience long-term stress due to the psychological effects of racism (Perry, Harp, & Oser, 2013), so some have suggested racism is the true culprit. Discrimination and racism can add psychological stress to a person for years that can result in biological issues (Clark, Anderson, Clark, & Williams, 2013; Vedam, et al., 2018), including less healthy newborns (Vedam, et al., 2018).

Hispanics/Latinos

Among US minority groups, Hispanics are increasing more than any other group (Moore de Peralta, Holaday, & Hadoto, 2016). Latinos are from a variety of regions. About a third of Latinos were born in a different nation. Although sixteen percent of all people in the US are considered Latino, a lower rate of access to healthcare is a reality of Latinos living in the US. Non-Latino whites also have a greater health care satisfaction than Latinos (Mendoza, Armbrister, & Abraído-Lanza, 2018).

Immigrants and Refugees

Immigrants and refugees may also experience challenges in receiving optimal US health care. In 2011, annual legal immigration numbers reached to just over one million in the US (Hayes, Enohumah, & McCaul), and in 2017, 1.1 million people immigrated legally to the US

("Table 1. Persons Obtaining Lawful," 2018). By definition, these migrants were born in a different country than their present residence. Half of the 214 million migrants worldwide in 2010 were women (Gagnon, et al., 2014). When women migrate, they also bring cultural ideas towards birth and pregnancy with them. Migrant women's expectations for childbirth and pregnancy often stem from their original cultures (Benza & Liamputtong, 2014). In some countries, migrant women receive equal or better health care as the women of the receiving country; but in others, the migrant women receive worse care (Gagnon, et al., 2014).

In some countries, there are disparities between the health of the native-born people and the migrants. Specifically, immigrants from Asia and Africa were more likely to experience infant or fetal mortality than native-born residents throughout the world (Gagnon, et al., 2014). Health care access, utilization of available services, and quality of care figure into health inequality measurements among various sociocultural groups. Researchers in a group called ROAM (Reproductive Outcomes and Migration) found that in more than 50 percent of reviewed studies, migrant women had worse health outcomes for prenatal care, infection, maternal health, congenital defects, infant and fetal mortality, and cesarean birth rates. Migrants from Asia, North Africa, and sub-Saharan Africa experienced fetal and infant mortality more often than non-migrants in their new home countries (Gagnon, et al., 2014). ROAM suggested that migrant women be aided in receiving knowledge of how care is provided where they now live (Villadsen, Mortensen, & Andersen, 2016).

Disparities in populations of migrant women can result from poor interactions between patient and health care professionals (Villadsen, Mortensen, & Andersen, 2016). Communication is one key to giving the best possible care to migrants (Gagnon, et al., 2014). Hands-on

experiences are helpful in communicating effectively. For example, one study found that showing a new mother how to properly put her infant to sleep was not as effective as giving her instruction while she did it herself (Villadsen, Mortensen, & Andersen, 2016).

Besides a lack of adequate communication, prejudice towards migrants is another reason inequalities in migrant health care can arise (Gagnon, et al., 2014). Racism, prejudice, or discrimination was reported in studies of some migrant women (Benza & Liamputtong, 2014; Carolan & Cassar, 2010; Herrel, et al., 2004; Straus, McEwen, & Hussein, 2009). This understandably discourages them from attending appointments for their maternal health care services. Insensitivity towards migrant women creates much of the unmet expectations they experience (Benza & Liamputtong, 2014). Immigrants tend to assimilate over time to their new culture, but those who have more recently left their home nations are more likely to be connected to the beliefs of their native culture (Hopp & Herring, 2015). Furthermore, those immigrants who have a higher economic standing tend to be the ones who assimilate more, while the poorer immigrants tend to hold to their home beliefs more frequently (Hopp & Herring, 2015).

One area of disparity between migrant and non-migrant women in Western nations is the amount of prenatal care received. Migrants are less likely to be aware of the health services available. Not only are migrant women under-cared for before their pregnancy, but also afterwards (Villadsen, Mortensen, & Andersen, 2016). Migrant women have a higher rate of postnatal depression (PND) than other women (Schmied, Black, Naidoo, Dahlen, & Liamputtong, 2017). About 20% of migrant women have PND symptoms within a year of giving birth. This is one-and-a-half to two times higher than non-migrant women (Schmied, Black, Naidoo, Dahlen, & Liamputtong, 2017). Cultural practices that would be typical in their home

countries are not always afforded to migrant women. For example, a woman may have to return to work instead of taking a traditional period of rest after pregnancy. Migrant women are prone to PND because many of them have left behind their extended family, who would normally act as an emotional and practical support system (Benza & Liamputtong, 2014).

Lacking language skills poses a real barrier for some migrant women in receiving quality care (Villadsen, Mortensen, & Andersen, 2016). Like in other aspects of care for migrant women, not understanding the language spoken by a health care professional can be a rationale for problems with postpartum care (Benza & Liamputtong, 2014). On the other hand, accurate interpreting services offer a real benefit where available. Often, the issue is that these interpreting services are insufficient or underused (Villadsen, Mortensen, & Andersen, 2016).

Maternal health care can be provided well to immigrant populations. Although maternal mortality risk is higher in migrant women (Villadsen, Mortensen, & Andersen, 2016), the health of migrant mothers and their newborns improves when culturally sensitive care is provided (Benza & Liamputtong, 2014). Making culturally relevant educational health care information available in a language migrants can understand is one example (Gagnon, et al., 2014). One of the best ways to find out information about a patient's beliefs is from the patients, if sought out in a nonjudgmental and earnest manner. Another beneficial source includes staff members of the same cultural and ethnic group as that of the patient (Hopp & Herring, 2015).

Pregnancy & Childbirth Practices

Understanding various beliefs of cultures US health practitioners may encounter during childbirth and pregnancy is beneficial to effective care for women in pregnancy and afterwards, referred to as prenatal, perinatal, and postnatal care. Cultural beliefs and practices of childbirth

are rooted deeply into their respective societies. In one study, while some migrant women reported anxiety about the tension between cultural practices, others felt secure in these practices and did not feel intimidated to compromise or conform to their new society. Some migrant women shared that they hold preferences of using natural methods for relief during labor pain and towards birth in general, and some migrant women appreciated the new practice of their husbands' presence for support during childbirth, even if this was atypical in their countries of origin (Benza & Liamputtong, 2014).

African Americans

Prenatal care is regularly sought out by the majority of African American women early on in pregnancy. Their partners are involved in the process, and many attend prenatal classes. In lieu of an African pregnancy ritual of geophagy, eating dirt or clay, African American women sometimes consume boxed starch. A lack of minerals in the diet may explain cravings for this. It is thought this may be due to a lack of minerals in the diet required for the child to develop properly in the womb. During pregnancy, there are typically no work or activity restrictions (Waters & Locks, 2005).

At birth, African American women are free to express their emotions and pain. They usually give birth in hospitals, do not avoid taking medications, and are compliant with health care professionals. Vaginal delivery is preferred over a cesarean section unless there is a medical need for one. Female infants do not undergo circumcision (Waters & Locks, 2005).

Latin Americans

Immigrants from Latin America share some traditional beliefs towards pregnancy. For example, women throughout Central America feel free to moan and cry out during the labor and

prefer delivery in a hospital (Kemp & Rasbridge, 2004; Kunkel, Aragón, & Meoño de Kunkel, 2005). However, for Central American women, if a hospital is inconvenient, as in many rural areas, midwives assist with birth (Kunkel, Aragón, & Meoño de Kunkel, 2005). A Central American woman typically desires her mother's presence more than her husband's during labor (Kemp & Rasbridge, 2004). However, Latin America encompasses many subcultures and extends beyond Central America. Nuances exist among these subcultures.

Many women from Guatemala will not seek prenatal care. Part of this is likely because they see birth not as a medical event, but as a natural process that can be taken care of by a midwife. Additionally, some Guatemalans do not have legal status or sufficient funds to cover prenatal care. During pregnancy, the mother is to avoid lifting heavy objects and aim for a healthful diet. Kemp & Rasbridge (2004) say that Guatemalans think of pregnancy as "a 'hot' time and women must avoid becoming overheated when they are pregnant" (p. 171). Kemp & Rasbridge also explain that after pregnancy, the mother is thought to be in a cold state, so she tries to eat hot food and drink to "restore balance" (p. 172).

Cuban women tend to seek out prenatal care when they have immigrated to the US (Kemp & Rasbridge, 2004; Varela, 2005). While a Cuban woman is pregnant, it is advisable to avoid negative or potentially stressful conversations (Kemp & Rasbridge, 2004). She tries to avoid people who have health problems and deformities or discussion about these issues. She also tries to not exert excessive energy and tries to stay inside when possible (Kemp & Rasbridge, 2004; Varela, 2005). Cubans in the US should be aware that not all US hospitals offer circumcision (Kemp & Rasbridge, 2004), a preference of many Cuban immigrants for their male infants (Kemp & Rasbridge, 2004; Varela, 2005). A woman's mother typically leads labor and

delivery, and the husband is not present (Kemp & Rasbridge, 2004), although Cuban immigrants who are more comfortable with US culture may allow the husband to be present for the birth (Varela, 2005). Cuban women stay at home approximately forty days postpartum (Kemp & Rasbridge, 2004; Varela, 2005). Many of these practices are similar to other Latin American immigrants, although male circumcision is not mentioned for immigrants of all Latin American nations.

Immigrant women from Mexico may not feel any need for prenatal care, as they see childbirth as a normal, non-medical event. Like in other rural areas, Mexicans who are from rural areas typically receive pregnancy and labor care from midwives. After pregnancy, Mexican mothers recover for two or three months and are supported by their family members (Guarnero, 2005).

Asians

Mothers-to-be in China place high value on prenatal care, even in the first trimester of pregnancy. To treat nausea, fatigue, and edema during pregnancy, Traditional Chinese Medicine practices can be used. Kemp & Rasbridge (2004) explain that *zuo yuezi*, the practice of "sitting in for the first month," is typical subsequent to pregnancy (p.137). This includes a diet devoid of cold food and drinks, avoidance of contact with substances considered cold, including water and wind, and abstinence from sex and parties. The woman remains inside her home during this time (Kemp & Rasbridge, 2004).

Cambodians, preferably referred to as Khmer, also have unique childbirth traditions. Advice is typically given by an older woman in lieu of prenatal care, and the woman's mother or

a *chomp* (midwife) assists during labor. Cesarean births are accepted when necessary but are not preferred (Kulig & Prak, 2005).

In Burma, women usually receive prenatal and neonatal care from their *lethare* (midwife), but in non-rural areas, hospitals and clinics are also typically involved in pregnancy and childbirth. Because some tribes in hilly areas have traditional food restrictions during pregnancy, it is important that these women receive prenatal nutritional counseling. Some women are at risk for sepsis and tetanus due to a tradition in which the umbilical stump is painted with charcoal after a midwife has sliced the cord with a sliver of bamboo. Common beliefs include that women in the postpartum period are “cold” because of blood loss and an overall greater susceptibility to illness. They advise these women to eat sour and bitter foods during the postpartum time period to decrease blood loss (Kemp & Rasbridge, 2004).

Immigrants from Afghanistan will usually seek prenatal care (Lipson & Askaryar, 2005). Afghan women are accustomed to receiving assistance during childbirth from a midwife, particularly if they lived in a rural region (Kemp & Rasbridge, 2004). Some Afghan husbands strongly oppose male obstetrician treatment of their wives. The woman's husband and mother have key roles in emotionally supporting the laboring Afghan woman. It is expected that an immigrant woman from Afghanistan will express labor pains verbally and loudly (Lipson & Askaryar, 2005).

Africans

African pregnancy and labor care has some similar traditions with other parts of the world, but also some unique ones. Globally, the country most likely for a woman to give birth solitarily is Nigeria (Amodu, Salami & Richter, 2017). Egyptian women typically would not

want to see a male practitioner for any of their care during pregnancy. They see pregnancy as Allah's will, particularly those who are under-class or extremely religious. Only under certain medically justifiable circumstances would abortion not be considered to be sin or allowed legally in their community (Kemp & Rasbridge, 2004).

From a study in Ethiopia, it was found that the majority of births occur at home. It is more common to have traditional birth attendants assisting birth than health care professionals. Health care professional birth attendants are often seen as unnecessary, especially as they are not customary, more expensive, or far away. Furthermore, there is little to no communication between traditional birth attendants and official health care workers (Shiferaw, Spigt, Godefrooij, Melkamu, & Tekie, 2013). Western medicine is not always trusted, according to a study from Western Africa (Amodu, Salami & Richter, 2017). Shiferaw, et al. (2013) found that in Ethiopia, "women who preferred to deliver at home indicated that some health care professionals are not sensitive to their privacy and care little to give them psychological support when they need it most" (p.5). Additionally, Shiferaw, et al. (2013, p. 6) reported from this same Ethiopian study that "there seems consensus among the health workers that knowledge about the importance of delivering in health facilities is fairly low."

Female Genital Cutting

Female genital cutting (FGC) is a health issue that U.S. women's health care professionals may encounter when they are working with immigrants, refugees, or in overseas health clinics (Ruiz, 2017). Because of migration, FGC problems do not remain in the areas where they are most commonly practiced (Reisel & Creighton, 2015). One of the issues that some migrant women will face are new laws towards FGC, which may be much different than

their home countries. FGC can cause problems with pregnancy and birth, and some women have reported experiencing trauma when giving birth because of FGC. Being cared for by obstetricians or midwives unfamiliar with the practice is even less helpful (Benza & Liamputtong, 2014).

A woman considered to be a midwife will often perform the cuts with various tools, such as a kitchen knife, glass shard, razor blade, or scissors, that have not been sanitized or sterilized (Kemp & Rasbridge, 2004). The WHO created four categories by which to classify the types and levels of cutting that occurs in FGC (Biglu, et al., 2016). Kemp & Rasbridge (2004) explain the WHO categories:

Type I is the removal of the prepuce and/or part or all of the clitoris... Type II is the removal of the prepuce and clitoris together with the partial or complete excision of the labia minora... Type III (or infibulation) is the most extreme form of FGC and consists of the removal of the clitoris, the adjacent labia (majora and minora), followed by the pulling of the scraped sides of the vulva across the vagina. The sides are then secured with thorns or sewn with catgut or thread. A small opening to allow passage of urine and menstrual fluid is left... Type IV Unclassified refers to any of several practices, including pricking, piercing, or excision of the clitoris or labia; stretching of the clitoris or labia; regional cauterization; scraping of the vaginal orifice (angurya cuts) or cutting the vagina (gishiri cuts); introducing caustic substances into the vagina to cause narrowing; and other practices that damage female genitalia (pp. 70-71).

Gishiri cuts, a type of FGC, are used on some women in Hausa tribes in an attempt to alleviate issues with obstructed labor (Amodu, Salami & Richter, 2017). Abdulcadir, et al. (2016) say,

however, that “the WHO classification of [FGC] misleadingly reports that some forms of [FGC] involve total removal of the clitoris. However, anatomically, it is the visible part of the clitoris (the glans) that is cut” (p. 227). Reisel & Creighton (2015) state that the United Nations International Children's Emergency Fund (UNICEF) has a different classification for FGC than the WHO. UNICEF's categories distinguish four types: “(1) cut, no flesh removed, (2) cut, some flesh removed, (3) sewn closed, (4) type not determined/not sure/does not know” (p. 49).

The practice varies, but the prepuce, clitoris, labia majora, and labia minora may all be affected (Brisson, Patel, & Feins, 2001). After cutting is done to the genitalia, sometimes the sides are sewn together with only a small hole remaining. This is called infibulation (Dawson, et al., 2015). Sometimes women are deinfibulated – that is, the reverse of infibulation. In fact, in the UK, it is a required step to prepare women for a vaginal birth. Although FGC was made illegal in 1985 in the UK, infibulation is still a regular medical practice there because of immigration. Furthermore, deinfibulation can eliminate or decrease issues that FGC Type III has caused and is therefore recommended or required for women who are giving birth. Although it has been requested by some women who have undergone deinfibulation for pregnancy, reinfibulation is outlawed in the UK (Safari, 2013).

Annually, approximately two million females undergo FGC, typically between the ages of four and twelve, although this may vary from as young as infancy to as late as the female's first pregnancy (Kemp & Rasbridge, 2004). One study found that about half of women who had undergone FGC received the procedures before they were three years old (Biglu, et al., 2016). FGC is a traditional practice in about 28 African countries. Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Mali, Mauritania, Northern Sudan, Sierra Leone, and Somalia all have

reported about 70% of women in their populations with FGC (Salam, et al., 2016). FGC also occurs in Kurdistan, Iraq, Syria, & Yemen (Biglu, et al., 2016).

In a Kurdistan study, religion was the largest motivator reported for FGC (Biglu, et al., 2016). FGC is a practice widely occurring in some predominantly Muslim countries (Kemp & Rasbridge, 2004), although not all predominantly Muslim countries regularly practice FGC (Johnsdotter, 2016). Many Somalians believe that FGC is necessary to stay in line with their religious beliefs, but FGC has been around since before both Christianity and Islam (Biglu, et al., 2016).

FGC lacks a medical purpose and no positive health outcomes result from it (Biglu, et al., 2016; Reisel & Creighton, 2015). Many serious health implications result from FGC, however. Death is a legitimate risk from FGC because infection and hemorrhage can occur (Dawson, et al., 2015; Kemp & Rasbridge, 2004). Acute issues arising from FGC include septicemia, tetanus, gangrene, traumatic bleeding, and wound infection. Disorders of a genitourinary nature, as well as infections, are more likely to occur throughout life in women with FGC. Scarring and cysts in the woman's genital area can result, and sometimes the cysts must be surgically removed. In addition to the clear physical consequences, it can cause short and long-term psychological damage. Studying the negative impacts of FGC can be difficult since many women with FGC live in communities where the practice is very common and thus consequences are not seen as abnormal or related to FGC (Reisel & Creighton, 2015).

This issue has become quite a hot topic in global women's health issues in the last few decades. It is considered a human rights violation by various organizations, including the WHO (Biglu, et al., 2016). The number of people who support FGC seems to be steadily decreasing.

FGC has also been termed female circumcision (Kemp & Rasbridge, 2004), but those who are strongly opposed to FGC and desire to outlaw it completely and globally prefer to call the practice female genital mutilation, which likewise carries its own implications (Johnsdotter, 2016).

One study found that midwives in Australia had experience in working with women with FGC, but their knowledge and confidence in caring for such women was limited. Although it is not normally practiced, and is even outlawed in areas such as Australia, Europe, New Zealand, and the US, immigrant women with FGC may be treated by health care professionals in these places. A study of midwives in Australia found that they were aware of some very basic facts of FGC and had interacted with women with FGC, but they did not feel confident with certain skills when treating women with FGC (Dawson, et al., 2015).

As FGC is such a prevalent cultural practice in some areas of the world, health care professionals working with migrant women have a high chance of running across a woman with FGC during their practice. It is crucial that professionals are prepared to address the issue and treat the woman in a culturally sensitive manner. It is possible that women who are not treated in such a way may try to avoid seeking care whatsoever and thus end up with worse health outcomes than they would perhaps even in their own home country.

Obstetric Fistulas

Obstetric fistula (OF) is another global women's health issue that can be common among immigrant women; therefore, it may be an issue that women's health care professionals see in the US. OF is rare in high-income countries, partially because there is better access to healthcare services for laboring women. Among the Hausa people in West Africa, OF cases have been

linked to FGC. Gishiri cuts, a type of FGC, are used on some women in Hausa tribes in an attempt to alleviate issues with obstructed labor. During prolonged obstructed labor, an OF may result. It is essentially a tear between the bladder and vagina (vesico-vaginal fistula) or between the rectum and vagina (recto-vaginal fistula) that causes the vagina to leak urine or feces in a physiologically uncontrollable way. There are a number of other complications which are associated with OF, including stillbirths, scarring, rash, infection, and ulcers (Amodu, Salami & Richter, 2017).

OFs are more likely to occur in younger women, who also carry a higher risk for issues of anemia, postpartum hemorrhage, and eclampsia (Salam, et al., 2016). The prevalence of OFs in Hausa women are influenced strongly by the tendency towards young marriages and subsequent young childbearing, sociocultural constraints on women leading to less health care access, and female circumcision coupled with a lack of a trained birth attendant (Amodu, Salami & Richter, 2017). The serious medical implications of OFs necessitate an awareness of the issue by health care professionals who may treat women with or at risk for OF.

Female Cancer

There are a number of cancers that affect women, but two that are particular to women are breast cancer and cervical cancer. No other malignancy is more prevalent among women globally than breast cancer, with just over half of these cases occurring in the developed world (Alley, 2013). Although age-adjusted rates for breast cancer among African American women are lower than those for white women, the mortality rate for African American women and the likelihood of being diagnosed at a later stage is higher. Accepted risk factors do not explain this disparity between white women and African American women (Hutter, et al., 2011).

Globally, cervical cancer ranks as the second most common cancer impacting women. It is less common in countries with high economic rankings. In the US, cervical cancer has a 2.4% mortality rate. The occurrence of cervical cancer varies in the US. It is at 9.5 cases per 100,000 for Hispanics and 9.0 per 100,000 for African Americans, but it is only at 7.1 per 100,000 for non-Hispanic whites (Alley, 2013).

Various cancers – cervical, vulvar, vaginal, and some types of oropharyngeal – are linked to some types of human papillomavirus (HPV). According to statistics from the American Cancer Society, an excess of 80% of women will eventually be infected with HPV during their life. Therefore, it is vital that women receive the HPV vaccine. The two HPV strains responsible for 70% of cervical cancers may be safely protected against through the HPV vaccine. In the US, Hispanic women rank second highest in HPV infection. A study on Hispanic women found that some of them had not gotten the vaccine because they reported fear about potential side effects associated with the vaccine. Although influence of family members was the number one reason women in the study received the HPV vaccine, the next most common reason was the recommendation by a health care professional (Stephens, Tamir, & Thomas, 2016), showing the influence that women's health care professionals have on their patients.

Another key to reducing cervical cancer in Hispanic women is increasing the number of Hispanic women who receive a Pap test, as they have the lowest cancer screening rate of all US racial and ethnic groups. A study surveyed Hispanic women ranging in age from 18-65 years regarding their beliefs towards cervical cancer screening and cervical cancer in general. Similar to the fact that Hispanic women are more likely to get vaccinated for HPV at the recommendation of a health care professional, it was also found that Hispanic women are

influenced towards cancer screening when health care professionals suggest it (Moore de Peralta, Holaday, & Hadoto, 2016). Suggesting cancer screening to all women, especially to those who are less likely to get screened already, can be a major way that women's health care professionals can influence the rate of cancer mortality in their female patients.

Conclusion

In learning about other cultures' views of medicine and health, communication between medical professionals and their patients can become more effective, and better patient outcomes may result. Not only may very obvious barriers such as language pose challenges, but other cultural perceptions and barriers also exist. Certainly, issues will arise that cannot be prepared for, but knowing how to approach those identified here is a very beneficial step. In a medical setting where lives are daily on the line, it is crucial to be as prepared as possible to meet cultural encounters. Understanding the need for and principles of cultural intelligence and the dynamics of women's health care professional interactions provide a needed backdrop for treating patients.

There is a vast array of cultural influences within the US on women who come to health care professionals for routine health care and emergency medical needs. Health disparities in ethnic minority groups such as African American women and Hispanic women display the need for better awareness of stereotypes and discrimination. There is a clear need to be respectful and considerate of varying cultural views of migrant women towards their healthcare as well, especially in regards to childbirth. There are real dangers to not being culturally aware since childbirth carries high risks for both the mother and child's life.

Other issues also need to be part of the preparation of women's health care professionals. They may come across FGC or discrimination in cancer screenings. These are vastly different

issues, but they are related because of the wide scope of practice of women's health care professionals. The issues identified here do not fully explain all of the factors to be considered for any of these health concerns. However, this analysis aims to serve as a springboard and catalyst for health care professionals to seek better understanding with their patients as well as conduct personal research to know what issues may be present in the area in which they work. It is the job of a health care professional to serve the patient just as any other professional seeks to please the client and meet their needs. If culture is a major barrier to meeting these needs, as it clearly seems to be, then this is something that all women's health care professionals should care about and seek to address in their practice. Furthermore, working together across disciplines to do this can better serve not only patients that are coming from other cultures, but all of the women who are seeking health care services.

References

- Abdulcadir, J., Botsikas, D., Bolmont, M., Bilancioni, A., Djema, D.A., Demicheli, F.B., Yaron, M., & Petignat, P. (2016). Sexual anatomy and function in women with and without genital mutilation: A cross-sectional study. *The Journal of Sexual Medicine, 13*(2), 226-237. <http://dx.doi.org/10.1016/j.jsxm.2015.12.023>
- Alley, L. G., Paxton, H. D., Flores, M. D., & Etchason, J. (2013). "Cancer as a public health problem: An overview for allied healthcare professionals," in *Global health care: Issues and policies*, edited by Carol Holtz, 2nd ed. Burlington, MA: Jones & Bartlett Learning, LLC.
- Amodu, O.C., Salami, B., & Richter, S. (2017). Obstetric fistula and sociocultural practices in Hausa community of Northern Nigeria. *Women and Birth, 30*(5), e258-e263.
- Benza, S. & Liamputtong, P. (2014). Pregnancy, childbirth, and motherhood: A meta-synthesis of the lived experiences of immigrant women, *Midwifery, 30*(2014), 575-584. <http://dx.doi.org/10.1016/j.midw.2014.03.005>
- Betran, A.P., Torloni, M.R., Zhang, & J.J., Gülmezoglu. (2015). WHO statement on caesarean section rates. *BJOB: An International Journal of Obstetrics & Gynaecology, 123*(5), 667-670. <https://doi.org/10.1111/1471-0528.13526>
- Biglu, M., Farnam, A., Abotalebi, P., Biglu, S. & Ghavami, M. (2016). Effect of female genital mutilation/cutting on sexual functions. *Sexual & Reproductive Healthcare, 10*(2016), 3-8. <http://dx.doi.org/10.1016/j.srhc.2016.07.002>
- Brisson, P., Patel, H., & Feins, N. (2001). Female Circumcision. *Journal of Pediatric Surgery, 36*(7), 1068-1069. doi:10.1053/jpsu.2001.24755

- Cameron, J. & Taylor, J. (2007). Nursing and midwifery: Reevaluating the relationship. *International Journal of Nursing Studies*, 44(5), 855-856.
<https://doi.org/10.1016/j.ijnurstu.2007.02.009>
- Carolan, M. & Cassar, L. (2010). Antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia, *Midwifery*, 26(2), 189-201.
<https://doi.org/10.1016/j.midw.2008.03.005>
- Clark, R., Anderson, N.B., Vlack, V.R., & Williams, D.R. (2013). Racism as a Stressor for African Americans. In T.A. LaVeist & L.A. Isaac (Eds.) *Race, Ethnicity, and Health* (pp.79-103). San Francisco, CA: John Wiley & Sons, Inc.
- Colin, J.M. (2005). Haitians. In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 221-235). San Francisco, CA: University of California.
- Crisp, N., & Chen, L. (2016). "Global supply of health professionals," ed. David J. Hunter & Harvey V. Fineberg in *Readings in global health: Essential reviews from The New England Journal of Medicine*. New York, NY: Oxford University Press.
- Cunningham, F.G., Leveno, K.J., Bloom, S.L., Spong, C.Y., Dashe, J.S., Hoffman, B.L., Casey, B.M., & Sheffield, J.S. (Eds.) (2014). *Williams Obstetrics*. New York, NY: McGraw Hill Education.
- Dawson, A.J., Turkmani, S., Varol, N., Nanayakkara, S., Sullivan, E., & Homer, C.S.E. (2015). Midwives' experiences of caring for women with female genital mutilation: Insights and ways forward for practice in Australia, *Women and Birth*, 28(2015), 2017-214.

- Edwards, M. (2013). Health Literacy, Health Care Disparities, and Culturally Responsive Primary Care. In T.M. Buttaro, J. Trybulski, P.P. Bailey, & J. Sandberg-Cook (Eds.) *Primary care: A collaborative practice* (pp. 34-39). St. Louis, MO: Elsevier.
- Gagnon, A.J., DeBruyn, R., Essén, B., Gissler, M., Heaman, M., Jeambey, Z., Korfker, D., McCourt, C., Roth, C., Zeitlin, J., & Small, R. (2014). Development of the Migrant Friendly Care Questionnaire (MFMCQ) for migrants to Western societies: An international Delphi consensus process. *BMC Pregnancy and Childbirth*, *14*(200), 1-10.
<http://www.biomedcentral.com/1471-2393/14/200>
- Gaskin, I. M. (2011). *Birth Matters*. New York, NY: Seven Stories Press.
- Gilliland, A.L. (2011). After praise and encouragement: Emotional support strategies used by birth doulas in the USA and Canada, *Midwifery*, *27*(4), 525-531.
<https://doi.org/10.1016/j.midw.2010.04.006>
- Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). (2016). Retrieved March 13, 2019, from <http://apps.who.int/gho/data/node.gswcah>
- Guarnero, P.A. (2005). Mexicans. In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 330-342). San Francisco, CA: University of California.
- Guilliland, K., Pairman, S., Thompson, T., Davies, L., & Thorogood, C. (2015). Midwifery and maternity in a global context. In S. Pairman, J. Pincombe, C. Thorogood, & S. Tracy (Eds.) *Midwifery: Preparation for practice* (pp.72-86). Chatswood, NSW, Australia: Elsevier.
- Hayes, I., Enohumah, K., & McCaul, C. (2011). Care of the migrant obstetric population, *International Journal of Obstetric Anesthesia*, *20*, 321-329. doi: 10.1111/imig.12306

- Herrel, N., Olevitch, L., DuBois, D.K., Terry, P., Thorp, D., Kind, E., & Said, A. (2004). Somali refugee women speak out about their needs for care during pregnancy and delivery, *Journal of Midwifery & Women's Health*, 49(4), 345-349.
<https://doi.org/10.1016/j.jmwh.2004.02.008>
- Hopp, J. W. & Herring, R. P. (2015). "Promoting health among Black Americans: An overview." Edited by Robert M. Huff, Michael V. Kline, and Darleen V. Peterson, in *Health promotion in multicultural populations: A handbook for practitioners and students*. 3rd edition. Los Angeles, CA: Sage Publications, Inc.
- Hutter, C.M., Young, A.M., Ochs-Balcom, H.M., Carty, C.L., Wang, T., Chen, C.T.L., Rohan, T.E., Kooperberg, C., & Peters, U. (2011). Replication of breast cancer GWAS susceptibility loci in the women's health initiative African American SHARe study, *Cancer Epidemiol Biomarkers Prev*, 20(9), 1950-1959. 10.1158/1055-9965.EPI-11-0524
- Johnsdotter, S. & Essén, B. (2016). Cultural change after migration: Circumcision of girls in Western migrant communities. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 32(April 2016), 15-25. <https://doi.org/10.1016/j.bpobgyn.2015.10.012>
- Kelley, M. A. & Mashburn, J. (2014). "The Certified Nurse-Midwife," in *Advanced Practice Nursing: An Integrative Approach*, ed. Ann B. Hamric, et al. (St. Louis: Elsevier Saunders, 2014), 458.
- Kemp, C. & Rasbridge, L. (2004). Refugee and immigrant health: A handbook for health professionals. Cambridge, UK: Cambridge University Press.

- Kothari, C.L., Paul, R., Dormitorio, B., Ospina, F., James, A., Lenz, D., Baker, K., Curtis, A., & Wiley, J. (2016). The interplay of race, socioeconomic status and neighborhood residence upon birth outcomes in a high black infant mortality community. *SSM – Population Health*, 2, 859-867. <https://doi.org/10.1016/j.ssmph.2016.09.011>
- Kripalani, S., Bussey-Jones, J., Katz, M.G., & Genao, I. (2006). A prescription for cultural competence in medical education. *J Gen Intern Med*, 21(10), 1116-1120. doi: 10.1111/j.1525-1497.2006.00557.x
- Kulig, J.C. & Prak, S. (2005). Cambodians (Khmer) In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 73-84). San Francisco, CA: University of California.
- Kunkel, P.J., Aragón, D.R., & Meoño de Kunkel, M.M. (2005). Central Americans (Guatemalans, Nicaraguans, and Salvadorans). In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 85-97). San Francisco, CA: University of California.
- Lipson, J.G. & Askaryar, R. (2005). Afghans. In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 1-13). San Francisco, CA: University of California.
- Lipson, J.G. & Dibble, S.L. (2005). *Culture & Critical Care*. San Francisco, CA: University of California.
- Livermore, D. (2009). *Cultural intelligence: Improving your CQ to engage our multicultural world*. Grand Rapids, MI: Baker Academic.
- Livermore, D. (2015). *Leading with cultural intelligence: The real secret to success*. Retrieved from <https://ebookcentral-proquest-com.ezproxy.liberty.edu>
- Meleis, A.I. (2005). Arabs. In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 42-57). San Francisco, CA: University of California.

- Mendoza, S., Armbrister, A.N., & Abraído-Lanza, A.F. (2018). Are you better off? Perceptions of social mobility and satisfaction with care among Latina immigrants in the U.S., *Social Science & Medicine*, 219(2018), 54-60. <https://doi.org/10.1016/j.socscimed.2018.10.014>
- Monari, F., Di Mario, S., Facchinetti, F., & Basevi, V. (2008). Obstetricians' and midwives' attitudes towards cesarean section, *Birth* 35(2), 129-135. <https://doi.org/10.1111/j.1523-536X.2008.00226.x>
- Moore de Peralta, Holaday, & Hadoto. (2017). Cues to cervical cancer screening among U.S. Hispanic women, *Hispanic Health Care International*, 15(1), 5-12.
doi: 10.1177/1540415316682494
- Perry, A.G., Potter, P.A., & Ostendorf, W.R. (2016). *Nursing Interventions & Clinical Skills*. St. Louis, MO: Elsevier.
- Perry, B.L., Harp, K.L.H., & Oser, C.B. (2013). Racial and gender discrimination in the stress process: Implications for African Americans women's health and well-being, *Sociological Perspectives*, 56(1), 25-48.
<https://www.jstor.org/stable/10.1525/sop.2012.56.1.25>
- Raynor, M. & England, C. (2010). *Psychology for midwives: Pregnancy, Childbirth, and Puerperium*. Maidenhead, Berkshire, England: Open University Press.
- Reisel, D. & Creighton, S.M. (2015). Long term health consequences of Female Genital Mutilation (FGM), *Maturitas*, 80(1), 48-51.
<https://doi.org/10.1016/j.maturitas.2014.10.009>
- Ross, S. (2012). *Doulas: Why every pregnant woman deserves one*. Rockpool Publishing: Summer Hill, Australia. *Maturitas*, 80(1), 48-51.

- Ruiz, I.J., Martínez, P.A., & Giménez, L.G. (2017). Eradicating Female Genital Mutilation; a viable reality. Raising awareness in the men involved. *Procedia – Social and Behavioral Sciences*, 237(21February2017), 784-791. <https://doi.org/10.1016/j.sbspro.2017.02.122>
- Safari, F. (2013). A qualitative study of women's lived experience after deinfibulation in the UK, *Midwifery*, 29(2013), 154-158. doi:10.1016/j.midw.2011.12.005
- Salam, R.A., Faqqah, A., Sajjad, N., Lassi, Z.S., Das, J.K., Kaufman, M., & Bhutta, Z.A. (2016). Improving adolescent sexual and reproductive health: A systematic review of potential interventions, *Journal of Adolescent Interventions*, 59(2016), S11-S28. <http://dx.doi.org/10.1016/j.jadohealth.2016.05.022>
- Schmied, V., Black, E., Naidoo, N., Dahlen, H.G., & Liamputtong, P. (2017). Migrant women's experiences, meanings and ways of dealing with postnatal depression: A meta ethnographic study. *PLoS One*, 12(3), 1-27. <https://doi.org/10.1371/journal.pone.0172385>
- Shiferaw, S., Spigt, M., Godefrooij, M., Melkamu, Y., & Tekie, M. (2013). Why do women prefer home births in Ethiopia?, *BMC Pregnancy and Childbirth*, 13(5), 1-10. <http://www.biomedcentral.com/1471-2393/13/5>
- “Six Ways for College Students to Prepare for Midwifery School,” American College of Nurse Midwives, <http://www.midwife.org/For-College-Students> (accessed December 7, 2017).
- Stephens, D.P., Tamir, H., & Thomas, T.L. (2016). Factors motivating HPV vaccine uptake among vaccinated and nonvaccinated Hispanic young adult women, *Hispanic Health Care International*, 14(4), 184-191. doi: 10.1177/1540415316679808

Straus, L., McEwen, A., & Hussein, F.M. (2009). Somali women's experience of childbirth in the UK: Perspectives from Somali health workers, *Midwifery*, 25, 181-186.

doi:10.1016/j.midw.2007.02.002

Table 1. Persons Obtaining Lawful Permanent Resident Status: Fiscal Years 1820 to 2017.

(2018, October 02). Retrieved from <https://www.dhs.gov/immigration-statistics/yearbook/2017/table1>.

Varela, L. (2005). Cubans. In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 121-131). San Francisco, CA: University of California.

Vedam, S., Stoll, K., MacDorman, M., Declercq, E., Cramer, R., Cheyney, M., Fisher, T., Butt, E., Yang, Y.T., & Kennedy, H.P. (2018). Mapping integration of midwives across the United States: Impact on access, equity, and outcomes, *PLoS One*, 13(2), 1-20.

<https://doi.org/10.1371/journal.pone.0192523>

Villadsen, S.F., Mortensen, L.H., & Andersen, A.N. (2016). Care during pregnancy and childbirth for migrant women: How do we advance? Development of intervention studies – The case of the MAMA ACT intervention in Denmark, *Best Practice & Research Clinical Obstetrics and Gynaecology* 32(2016), 100-112.

<http://dx.doi.org/10.1016/j.bpobgyn.2015.08.013>

Waters, C.M. & Locks, S. (2005). African Americans. In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 14-26). San Francisco, CA: University of California.

Wilson, D. & Seaton, L. (2017). Cultural competence and safety. In G. Koutoukidis, K. Stainton, & J. Hughson (Eds.) *Tabbner's Nursing Care: Theory and Practice* (pp. 194-211). Chatswood, NSW, Australia: 2017).

Your Pregnancy and Birth. (2005). 4th edition. Washington, D.C.: The American College of Obstetricians and Gynecologists.

Zachariah, R. (2005). East Indians. In J.G. Lipson and S.L. Dibble (Eds.) *Culture & Critical Care* (pp. 146-162). San Francisco, CA: University of California.