AWHONN

PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

Perinatal Nursing

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FIFTH EDITION

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To all perinatal nurses and the mothers and babies they care for every day

&

To my parents, William and Dorothy; my husband, Dan; and my children, Daniel, Katie, Michael, John, and Elizabeth

—KRS

To Patrick, Sean, Melissa, and Kelly Mitchell

—PAC

To my husband, Mike, and my son, Thomas

—NOA

To my parents, Glenn and Ardis Egli; my husband, Marty; and my children, Katie, Mike, Kyle, and Rebecca

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To Alexa, Jack, Arielle . . . and Faith

—AJR

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Preface

The fifth edition of *AWHONN Perinatal Nursing* represents over 25 years of collaboration between Kathleen Simpson and Patricia Creehan and new partnership with Nancy O'Brien-Abel, Cheryl Roth, and Annie Rohan to produce this textbook. As with all important projects, working as a team offers an opportunity for contribution, innovation, and insight not possible with individual efforts. We have assembled expert nurses from across the country who were willing to volunteer their considerable time and talent to contribute to the book. It is only through their collective generosity that this book was possible. Expert reviewers offered their feedback as the work was underway and enhanced the content. We offer suggestions for clinical practice based on the most recent evidence, standards, and guidelines. Our goal is to provide a practical resource for perinatal nurses, and we hope we have succeeded.

Contents

CHAPTER 1

Perinatal Patient Safety and Quality

Kathleen Rice Simpson

INTRODUCTION

In the 1990s, a number of health scientists and leaders conducted a critical evaluation of the health system in the United States and found numerous opportunities to provide better care and avoid preventable adverse outcomes (Institute of Medicine [IOM], 1999). The landmark initial IOM publication and its follow-up report with additional detailed recommendations (IOM, 2001) were catalysts to what is now a more widely accepted view of the importance of patient safety as an essential element of high-quality care. The framework and recommendations in these seminal publications are still useful 20 years later and are worth reviewing periodically to get a sense of what has been accomplished and how much more needs to be done (IOM, 1999, 2001).

The focus on perinatal patient safety was advanced by recommendations for adopting the principles of high reliability in the maternity care setting (Knox, Simpson, & Garite, 1999). Attributes of perinatal units at high and low risk for preventable adverse outcomes were identified by applying high-reliability science to the review of hundreds of medical records involving adverse outcomes and professional liability claims. Key suggestions were made for making care safer for mothers and babies during the childbirth hospitalization. Minimizing risk of preventable adverse outcomes and decreasing professional liability were the main objectives (Knox et al., 1999; Knox, Simpson, & Townsend, 2003). Important recommendations were using evidence-based national standards and guidelines as the foundation for clinical practice, reducing unnecessary variations in practice, working together as a clinical team, mutual respect, professional behavior, accountability, speaking up in the context of unsafe practices, measurement, and highlighting the interests of mothers and babies as first priority (Knox & Simpson, 2011). Although initially some clinicians and leaders felt that these recommendations threatened physician autonomy and would not be practical in a hierarchical health system, they eventually have been adopted and enhanced by many patient safety scientists and leaders in the perinatal setting through multiple hospital, healthcare system, state, and national safety and quality collaboratives.

As the perinatal patient safety initiative has matured over the last two decades, there has been more emphasis on quality of care rather than liability exposure; however, these concepts are complementary. A number of healthcare systems have found that providing high-quality perinatal care based on the most recent evidence-based standards and guidelines has led to decreased liability costs (Clark, Belfort, Byrum, Meyers, & Perlin, 2008; Pettker et al., 2014; Simpson, Kortz, & Knox, 2009). A basic premise of perinatal patient safety and quality care is emphasizing "what is best for mothers and babies" over other issues when considering unit operations and clinical practices. Without this focus, often what is best (or more convenient or less costly) for hospitals, healthcare systems, leaders, and clinicians can be inappropriately prioritized at the expense of mothers and babies.

In the past few years, professional associations such as the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), American College of Nurse-Midwives (ACNM), American Academy of Nursing (AAN), American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics, and Society for Maternal-Fetal Medicine (SMFM), among others, have taken major steps in promoting perinatal safety and have been working with organizations and advocacy groups led by childbearing women and their families to seek realistic solutions to the current state of

perinatal healthcare. Participation in perinatal quality improvement projects has become common practice. Perinatal quality care collaboratives have been established in almost all states. Perinatal safety has been expanded beyond the focus of the inpatient setting. Heightened awareness of the poor standing of the United States on quality markers of maternity care, including maternal and infant mortality, when compared to other developed countries has fueled some of these changes. Our maternal mortality rate should be one of the lowest among developed countries in the world given our resources. Maternal and infant health status should reflect other measures of prosperity. We can and must do better for childbearing women and babies in the United States.

Many of the "traditional" but outdated ways of providing care to childbearing women are being replaced with partnerships. The patriarchal culture that involves telling women what to do, expecting them to follow without questions, and treating them disrespectfully when they are unable or unwilling to "comply" is being slowly transformed to include women and their families as true partners in care. The extent of the concerns and dissatisfaction with perinatal healthcare by many childbearing women, clinicians, and healthcare leaders can be measured in part by the wide coverage of the problems by the lay media including *ProPublica*, *USA Today*, *The New York Times*, *The Washington Post*, and *Consumer Reports*. There has been a rapid growth in advocacy groups for safe maternity care (Display 1–1), many led by women who have experienced complications during childbirth and by families of women who did not survive childbirth.

DISPLAY 1–1

Advocacy Groups for Safe Maternity Care

4Kira4Moms
Association of Maternal & Child Health Programs
Black Mamas Matter Alliance
Childbirth Connection
Effie's Grace
Every Mother Counts
March for Moms
Maternal Near-Miss Survivors
MomsRising
National Accreta Foundation
National Association to Advance Black Birth
National Partnership for Women & Families
Preeclampsia Foundation
Save The Mommies
SisterSong

In previous editions of AWHONN's *Perinatal Nursing*, this chapter has covered a variety of processes and systems focused on clinicians and individual hospitals and healthcare systems with suggestions for how to make care safer for mothers and babies and reduce professional liability (Simpson, 2014). Those recommendations, tools, and resources are still useful. In this edition, the focus is on the current state of maternity care in the United States and some of the projects and programs that have the most likelihood of achieving better outcomes on a large scale. National policies and national organization leadership have made a significant difference in widespread acceptance of the need for following the best evidence, reducing unnecessary variations in care, and working together as a collaborative team as ways to improve maternity care in our country. The resistance to these ideas that was prevalent 20 years ago (Knox et al., 1999) has been diminished, although not universally. It is anticipated that every state will eventually have a robust perinatal quality care collaborative, a maternal mortality review committee, and an active role in the Alliance for Innovation on Maternal Health (AIM) program. Every birthing hospital must be an active participant so the childbirth process for every mother and baby is as safe as it can be. Each of these processes requires perinatal nurse-leaders as vital participants. Nurses are in an ideal position to take a leadership role in improving maternity care in the United States and reducing risk of preventable adverse outcomes.

MATERNAL–INFANT OUTCOMES IN THE UNITED STATES

Data Sources and Definitions

The National Center for Vital Statistics at the Centers for Disease Control and Prevention (CDC) is the source of the majority of natality and mortality data in the United States. The Pregnancy Mortality Surveillance System of the CDC (2019b) collects data on maternal mortality. Data are based on death certificates of women on which there is a notation of recent pregnancy via a checkbox and links to fetal or infant death certificates from the prior year. Using vital statistics data as the main measure of maternal mortality has limitations, as there is minimal information from the death certificate to determine if the death was related to pregnancy. These events are likely underreported. Maternal mortality review committees are used to provide detailed information and analysis of each maternal death, including potential causative or associated factors; however, they have not been convened in every state. Various definitions are used to identify maternal deaths and other measures of maternal and infant health. Each definition has specific criteria and time frames (Display 1–2). It is important to be aware of these definitions when evaluating reports on the ongoing maternity care crisis in the United States.

Although other developed countries have shown improvement (World Health Organization, 2014),

DISPLAY 1–2
Definitions of Maternal and Infant Mortality

World Health Organization

Maternal mortality is defined as death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, not from accidental or incidental causes.

Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death. This category was introduced to facilitate identification of maternal deaths in circumstances in which cause of death attribution is inadequate.

Centers for Disease Control and Prevention

Maternal mortality. National Vital Statistics System uses *International Statistical Classification of Diseases and Related Health Problems*, 10th revision (ICD-10), diagnosis codes and a pregnancy checkbox on death certificates to identify maternal deaths up to 42 days postpartum.

Pregnancy-related death is defined as the death of a woman while pregnant or within 1 year of the end of a pregnancy, regardless of the outcome, duration, or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. The Centers for Disease Control and Prevention requests the 52 reporting areas (50 states, New York City, and Washington, DC) to voluntarily send copies of death certificates for all women who died during pregnancy or within 1 year of pregnancy, and copies of the matching birth or fetal death certificates, if they have the ability to perform such record links. All of the information obtained is summarized, and medically trained epidemiologists determine the cause and time of death related to the pregnancy.

Pregnancy-related mortality ratio is an estimate of the number of pregnancy-related deaths for every 100,000 live births.

Severe maternal morbidity is defined as including unexpected outcomes of labor and birth that result in significant short- or long-term consequences to a woman's health.

Infant mortality rate (IMR) is the number of infant (aged under 1 year) deaths per 1,000 live births. The IMR is the ratio of infant deaths to live births in a given year.

Neonatal infant deaths are deaths occurring within the first 28 days from birth.

Postneonatal infant deaths are deaths occurring after 28 days from birth to under 1 year of age.

Available at https://www.who.int/healthinfo/statistics/indmaternalmortality/en/; https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpmss.html; https://www.cdc.gov/nchs/data/databriefs/db285.pdf

data from the United States indicate a continued rise in maternal deaths. Each year in the United States, it is estimated that 700 to 900 women die from pregnancy or complications related to pregnancy (Building U.S. Capacity to Review and Prevent Maternal Deaths, 2018). For each maternal death, there are likely 70 to 100 other women who suffered severe maternal morbidity (ACOG, 2019; Ellison & Martin, 2017).

The most recent data on pregnancy-related deaths in the United States from the CDC (2019b) are reported in Figure 1–1. Unfortunately, there is a significant lag time between events and reporting; however, despite not yet including data from 2016 to 2019, the increasing trend in deaths from 1987 to 2015 is apparent. Of the 7,208 deaths within a year of the end of pregnancy that occurred during 2011 to 2014 and were reported to CDC, 2,726 were found to be pregnancy related. The pregnancy-related mortality ratios were 17.8, 15.9, 17.3, 18.0, and 17.2 deaths per 100,000 live births in 2011, 2012, 2013, 2014, and 2015, respectively. Considerable racial disparities in pregnancy-related mortality were noted. During 2011 to 2015, the pregnancy-related mortality ratios were (CDC, 2019b):

- 42.8 deaths per 100,000 live births for Black non-Hispanic women
- 32.5 deaths per 100,000 live births for American Indian/Alaskan Native non-Hispanic women.
- 14.2 deaths per 100,000 live births for Asian/Pacific Islander non-Hispanic women
- 13.0 deaths per 100,000 live births for White non-Hispanic women
- 11.4 deaths per 100,000 live births for Hispanic women

Figure 1–2 shows causes of pregnancy-related deaths in the United States during 2011 to 2015 (CDC, 2019b):

- Cardiovascular diseases (15.1%)
- Noncardiovascular diseases (14.3%)
- Infection (12.4%)
- Hemorrhage (11.2%)
- Cardiomyopathy (10.8%)
- Thrombotic pulmonary embolism (9.2%)
- Cerebrovascular accidents (7.6%)
- Hypertensive disorders of pregnancy (6.8%)
- Amniotic fluid embolism (5.5%)
- Anesthesia complications (0.3%)
- Unknown (6.7%)

A recent report from nine states' maternal mortality review committees highlights the need for more scrutiny for each maternal death and offers insight on causative factors and potential strategies for prevention (Building U.S. Capacity to Review and Prevent Maternal Deaths, 2018). In a review of 237 deaths, they found that 63% were likely preventable. Some clinical factors have been suggested as associated with increased risk of maternal death. They include maternal age, maternal morbidities, and cesarean birth. These factors have also been associated with adverse neonatal outcomes. Opportunities

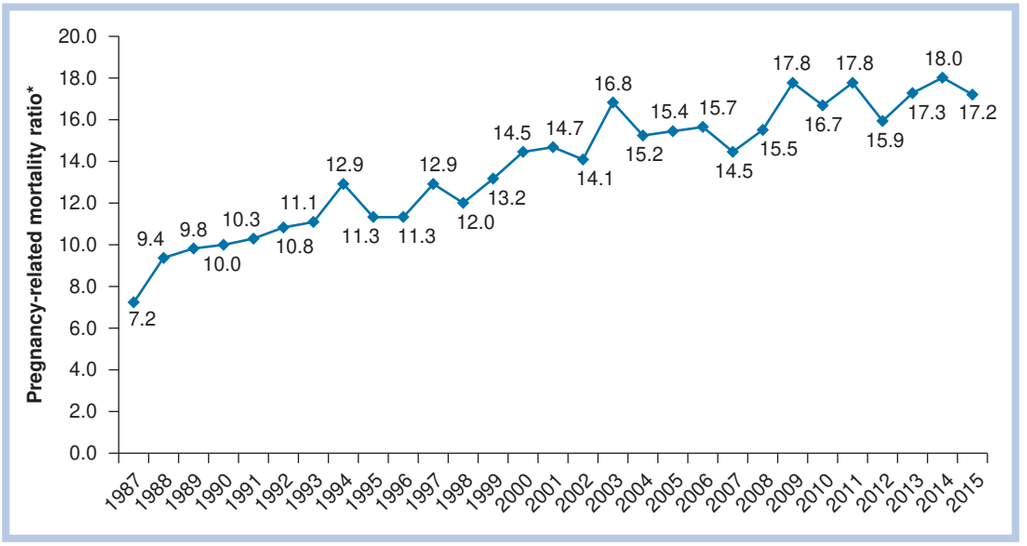

FIGURE 1–1. Trends in pregnancy-related mortality in the United States: 1987–2015. *Number of pregnancy-related deaths per 100,000 live births per year. (From Centers for Disease Control and Prevention. [2019b]. *Pregnancy Mortality Surveillance System.* Atlanta, GA: Author.)

for improvement in care of pregnant women have been identified in several large studies of severe maternal morbidity (near-miss maternal mortality) and maternal deaths (Building U.S. Capacity to Review and Prevent Maternal Deaths; Creanga, 2018; Ozimek et al., 2016). Suggestions for how to conduct a rigorous case review have been published (ACOG & SMFM, 2015) as well as measurement techniques (Main et al., 2016).

Maternal Age

Maternal age has increased over the past three decades (Martin, Hamilton, Osterman, Driscoll, & Drake, 2018). Figure 1–3 illustrates that trend from 1990 to 2017. In 2017, the mean age of mothers at first birth was 26.8 years, a record high for the United States (Martin et al., 2018). As births to

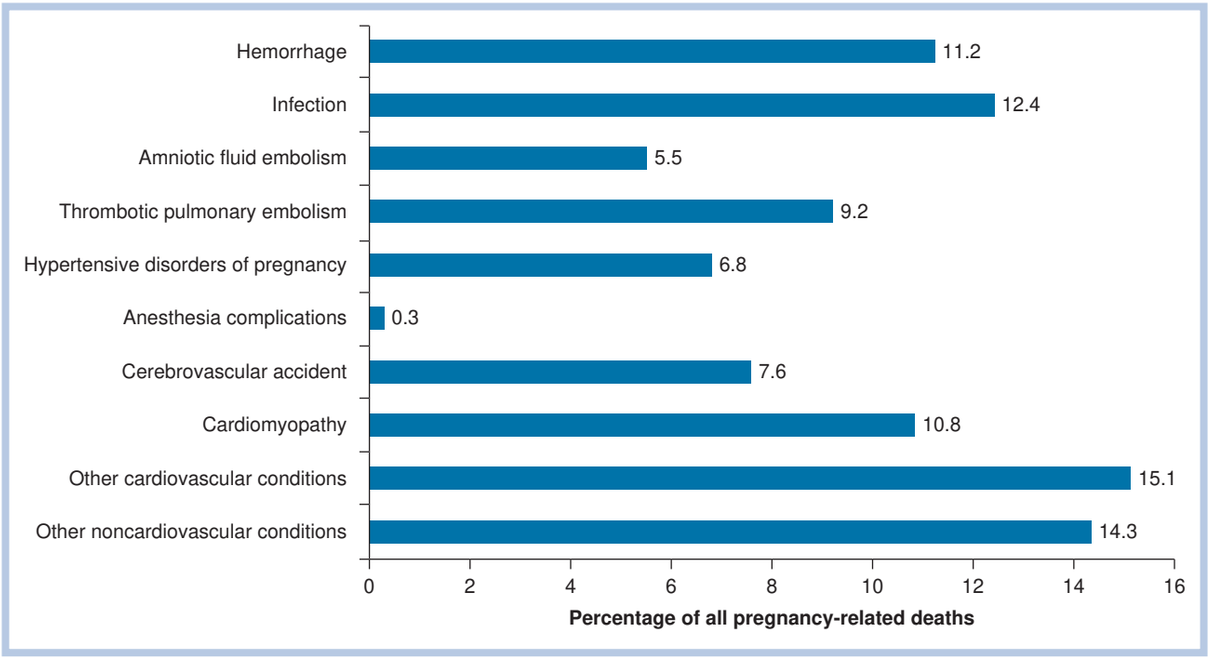

FIGURE 1–2. Causes of pregnancy-related death in the United States: 2011–2015. Note: The cause of death is unknown for 6.7% of all pregnancy-related deaths. (From Centers for Disease Control and Prevention. [2019b]. *Pregnancy Mortality Surveillance System.* Atlanta, GA: Author.)

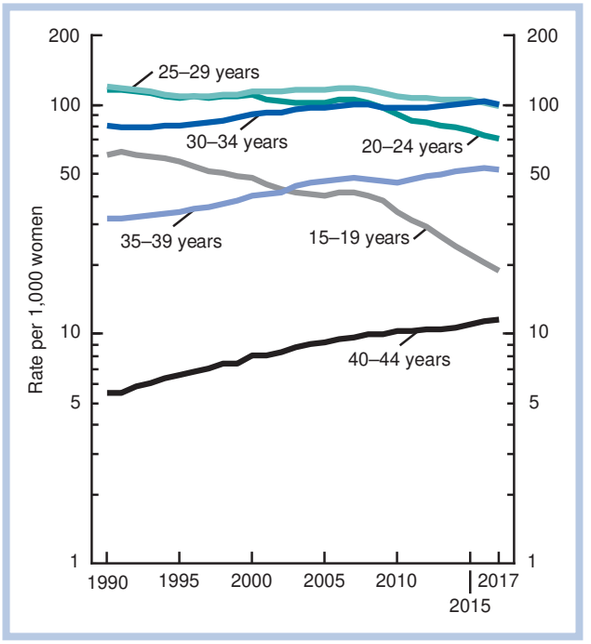

FIGURE 1–3. Births by age of mother from 1990 to 2017. Note: Rates are plotted on a logarithmic scale. (From Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Driscoll, A. K., & Drake, P. [2018]. Births: Final data for 2017. *National Vital Statistics Reports, 67*[8], 1–50.)

teenage mothers decreased during this period, births to women from 35 to 39 years and 40 to 44 years increased significantly. Maternal age is associated with more morbidity including diabetes, hypertension, and heart disease. In a recent report from the Agency for Healthcare Research and Quality (AHRQ), severe maternal morbidity was highest among women aged ≥40 years and lowest for those aged 20 to 29 years (248 and 136 per 10,000 births, respectively) (Fingar, Hambrick, Heslin, & Moore, 2018). Figure 1–4 shows the increase in maternal morbidity from 2006 to 2015. Rate of severe maternal morbidity at birth increased 45% from 2006 to 2015, from 101.3 to 146.6 per 10,000 hospitalizations for birth (Fingar et al., 2018). Age of mother is a factor in the outcome of the baby. Figure 1–5 shows the differences in infant, neonatal, and postnatal mortality based on maternal age (Ely, Driscoll, & Matthews, 2018). The highest rates of adverse outcomes were at the extremes of maternal age. Babies of teen mothers and women aged ≥40 years had worse outcomes.

Cesarean Birth

Cesarean birth is an often-mentioned factor in the rise in maternal morbidity and mortality, mainly due to hemorrhage and placental abnormalities in subsequent pregnancies (Korb, Goffinet, Seco, Chevret, & Deneux-Tharaux, 2019). Cesarean births have risen from 4.5% in 1965 to 31.9% in 2018—more than a 600% increase (Fig. 1–6) (Hamilton, Martin, Osterman, & Rosen, 2019). Figure 1–7 shows the most common types of maternal morbidity based on method of birth including blood transfusion, ruptured uterus, unplanned hysterectomy, and admission to the intensive care unit (Curtin, Gregory, Korst, & Uddin, 2015).

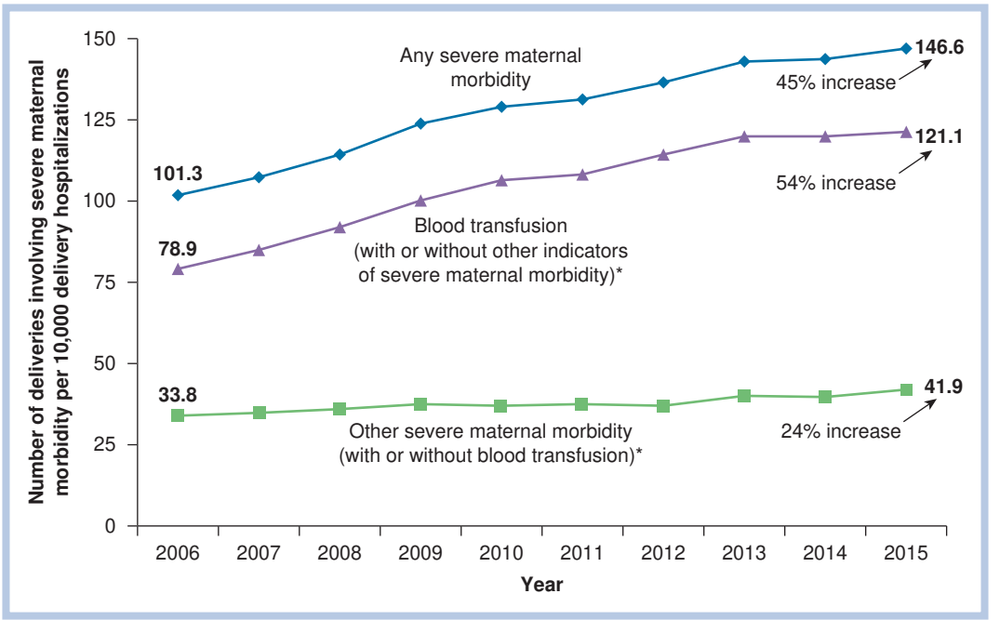

FIGURE 1–4. Trends in birth hospitalizations involving severe maternal morbidity from 2006 to 2015. *If a birth involved blood transfusion and 1 of the other 20 types of severe maternal morbidity, the birth was counted in both categories. (From Fingar, K. F., Hambrick, M. M., Heslin, K. C., & Moore, J. E. [2018]. *Trends and disparities in delivery hospitalizations involving severe maternal morbidity, 2006–2015* [Statistical Brief No. 243]. Rockville, MD: Agency for Healthcare Research and Quality.)

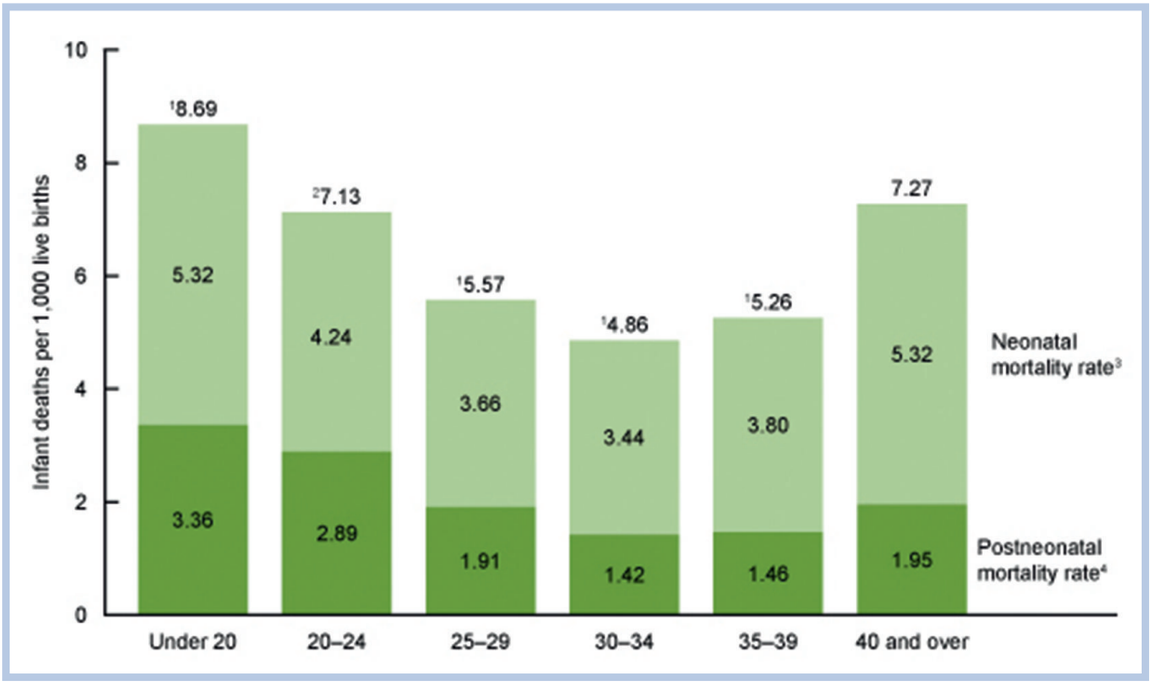

FIGURE 1–5. Infant, neonatal, and postnatal mortality rates by maternal age in 2016. [1]Significantly different from all other maternal age groups ($p < 0.05$). [2]Significantly different from all other maternal age groups except aged 40 and over ($p < 0.05$). [3]Significant difference between all age groups except between those under age 20 and aged 40 and over, and between those aged 25–29 and 35–39 ($p < 0.05$). [4]Significant difference between all age groups except between those aged 25–29 and 40 and over, and between those aged 30–34 and 35–39 ($p < 0.05$). Notes: Total neonatal and postneonatal mortality rates may not sum to totals due to rounding. (From Ely, D. M., Driscoll, A. K., & Matthews, T. J. [2018]. *Infant mortality by age at death in the United States, 2016* [NCHS Data Brief, No. 326]. Hyattsville, MD: National Center for Health Statistics.)

Racial and Ethnic Disparities

Similar to data reported by the CDC (2019b; Petersen et al., 2019), the report based on the nine states' maternal mortality review (Building U.S. Capacity to Review and Prevent Maternal Deaths, 2018) found wide variations in adverse outcomes based on race and ethnicity of the mother and baby. Non-Hispanic White women and non-Hispanic Black women differed in cause of death. Cardiovascular and coronary conditions (15.5%), hemorrhage (14.4%), infection (13.4%),

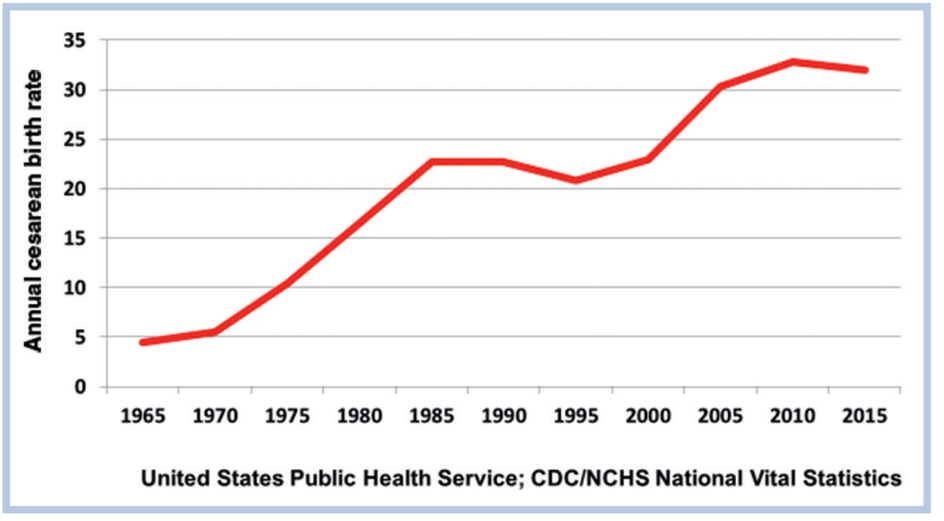

FIGURE 1–6. Trends in cesarean birth in the United States from 1965 to 2015. (From Centers for Disease Control and Prevention/National Center for Health Statistics, National Vital Statistics System.)

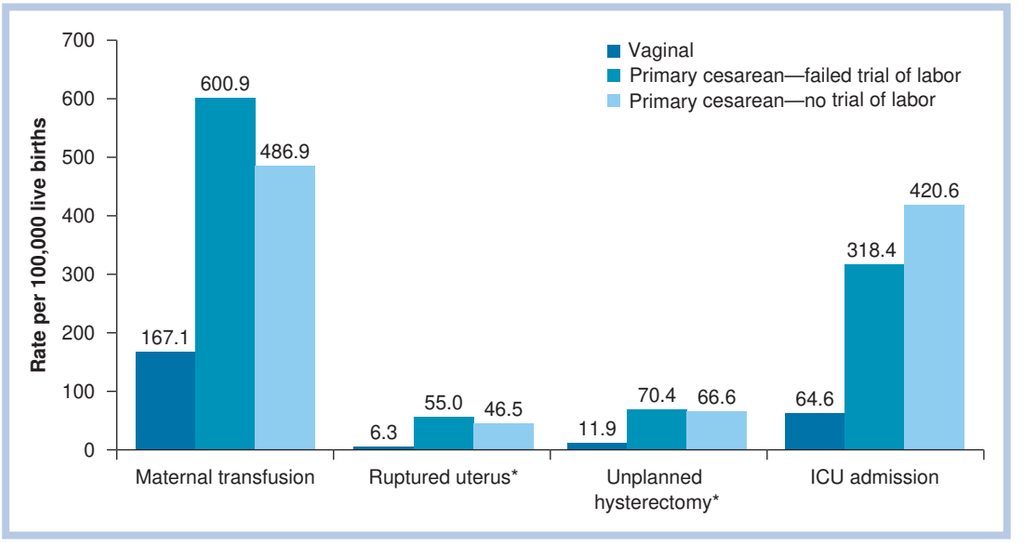

FIGURE 1–7. Maternal morbidity for women without a prior cesarean birth by method of birth and trial of labor (41 states and District of Columbia in 2013). Note: The birth certificate reporting area represented 90% of all U.S. births in 2013. ICU, intensive care unit. *Difference in rates between Primary cesarean—failed trial of labor and Primary cesarean—no trial of labor is statistically significant. (From Curtin, S. C., Gregory, K. D., Korst, L. M., & Uddin, S. F. [2015]. Maternal morbidity for vaginal and cesarean deliveries, according to previous cesarean history: New data from the birth certificate, 2013. *National Vital Statistics Reports*, *64*[4], 1–13.)

mental health conditions (11.3%), and cardiomyopathy (10.3%) were leading causes for White women, whereas cardiomyopathy (14%), cardiovascular and coronary conditions (12.8%), preeclampsia and eclampsia (11.6%), hemorrhage (10.5%), and embolism (9.3%) were leading cause for Black women (Building U.S. Capacity to Review and Prevent Maternal Deaths, 2018).

The AHRQ report on maternal morbidity found that although on average Black mothers were younger than White mothers, the rate of severe maternal morbidity was 112% to 115% higher for Black mothers than for White mothers in 2006 (164 vs. 76) and 2015 (241 vs. 114) (Fingar et al., 2018). Although deaths decreased for all races/ethnicities from 2006 to 2015, in-hospital mortality was 3 times higher for Black mothers than for White mothers in 2015 (11 vs. 4 per 100,000 births). Infant mortality is likewise associated with maternal race and ethnicity. Outcomes for babies differ by race and ethnicity (CDC, 2019a). Figure 1–8 shows infant mortality rates by race and ethnicity for 2016. Non-Hispanic Black babies had worse outcomes than those of other races and ethnic groups.

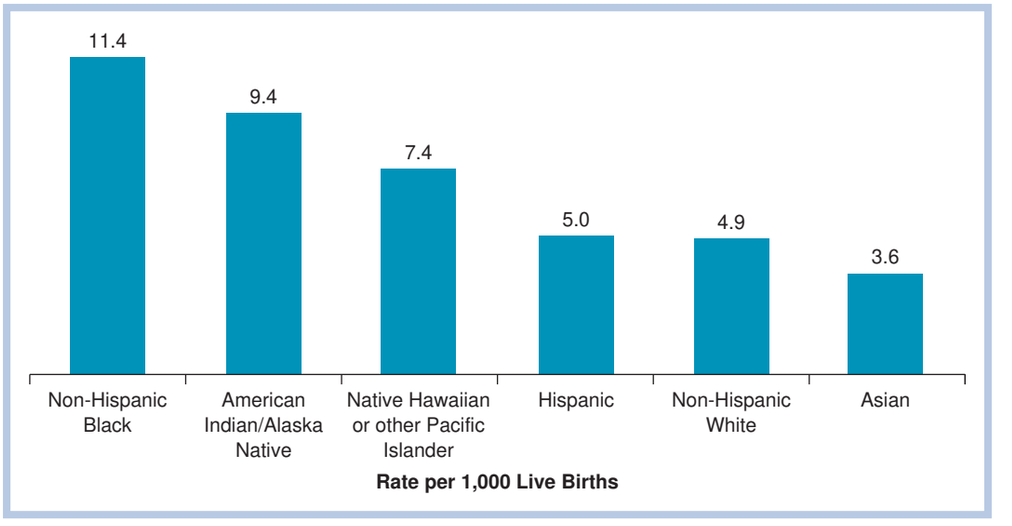

FIGURE 1–8. Infant mortality rates by race and ethnicity, 2016. (From Centers for Disease Control and Prevention/National Center for Health Statistics, National Vital Statistics System.)

It is important to note that instead of race as a factor, racism and racial inequity in how healthcare is available, accessed, and provided are more likely causative (Howell et al., 2018). Race and ethnicity are factors that cannot be modified; however, racism must be acknowledged, addressed, and eliminated. A patient safety bundle "Reduction of Peripartum Racial and Ethnic Disparities" was recently published (Howell et al., 2018). See Display 1–3 (Council on Patient Safety in Women's Health Care, 2016). The bundle offers a number of suggestions on topics such as patient and caregiver education; making sure everyone who needs interpreter services gets them; easier patients' access to their health records; promoting shared decision making; being aware of implicit biases; establishing ways for patients, families, and caregivers to report care that is not respectful or equitable; enhancing discharge teaching including warning signs of potential postpartum complications; offering better coordinated care after hospital discharge for childbirth; and examining care processes and operations for disparities based on race or ethnicity. These recommendations have now been supplemented by a conceptual framework and consensus statement prepared by the bundle workgroup, which details many of the issues behind the racial and ethnic disparities in care and outcomes for minority women in the United States (Howell et al., 2018). The focus is on modifiable causes and potential solutions to promoting safe and equitable healthcare during childbirth (Howell et al., 2018).

Underlying factors in racial and ethnic disparities in healthcare include challenges in knowing the full scope of the problem because issues involving healthcare disparities are not well studied; lack of recognition or awareness of inequitable care; lack of appreciation of the social determinants of health, poverty, and long-standing disadvantages; fragmented care through pregnancy, birth, and postpartum; miscommunication; poor communication; language and cultural barriers to understanding health information; and general misconception of etiologies and potentially successful strategies for improvement (Howell et al., 2018). Bundle workgroup experts offer suggestions for improvement including learning about personal, institutional, and system implicit biases and ways to tackle each of these problems (Howell et al., 2018). Mindfulness and applying the just culture framework to equitable care may be beneficial. Advocating for processes to identify, report, and remedy instances of bias and inequitable healthcare has merit. Implicit bias can be addressed with self-awareness, a focus on concern for others (a characteristic of the vast majority of caregivers in all disciplines), and leadership support from the top of the organization and all others. Eliminating racism in the healthcare system has the potential to reduce the disparity between women and babies of different races and ethnicity and promote healthier outcomes.

DISPLAY 1–3
Peripartum Racial/Ethnic Disparities Bundle

Readiness
Every Health System

- Establish systems to accurately document self-identified race, ethnicity, and primary language.
  - Provide system-wide education and training for all clinicians and team members on how to ask demographic intake questions.
  - Ensure that patients understand why race, ethnicity, and language data are being collected.
  - Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
  - Evaluate non-English language proficiency (e.g., Spanish proficiency) for providers who communicate with patients in languages other than English.
  - Educate all clinicians and team members (e.g., inpatient, outpatient, community based) on interpreter services available within the healthcare system.
- Provide education for all clinicians and team members on
  - Peripartum racial and ethnic disparities and their root causes
  - Best practices for shared decision making
- Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams.

Recognition and Prevention
Every Patient, Family, and Staff Member

- Provide education for all clinicians and team members on implicit bias.
- Provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the maternal patient, in a clear and simple format that summarizes information most pertinent to perinatal care and wellness.
- Establish a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.

Response
Every Clinical Encounter

- Engage in best practices for shared decision making.
- Ensure a timely and tailored response to each report of inequity or disrespect.
- Address reproductive life plan and contraceptive options not only during or immediately after pregnancy but at regular intervals throughout a woman's reproductive life.
- Establish discharge navigation and coordination systems after childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their healthcare provider.
  - Provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern.
  - Design discharge materials that meet patients' health literacy, language, and cultural needs.

From Council on Patient Safety in Women's Health Care. (2016). *Reduction of peripartum racial/ethnic disparities.* Washington, DC: American College of Obstetricians and Gynecologists.

DISPLAY 1–4
Never Events in the Perinatal Setting

- Infant abduction
- Infant death or serious disability (kernicterus) associated with failure to identify and treat neonatal hyperbilirubinemia
- Infant discharged to the wrong person
- Maternal or infant death or serious disability associated with a hemolytic reaction resulting from the administration of ABO-incompatible blood or blood products
- Maternal death or serious disability associated with labor and birth in a low-risk pregnancy in a healthcare facility
- Maternal or infant death or serious disability associated with a medication error, for example, errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration (includes overdose of oxytocin, misoprostol, and magnesium sulfate)
- Death or serious injury of a neonate associated with labor or birth in a low-risk pregnancy
- Wrong surgical procedure performed on a mother or infant (e.g., circumcision, tubal ligation)
- Retention of a foreign object in a mother or infant after surgery or other procedure
- Artificial insemination with the wrong donor sperm or procedure involving wrong egg

Suggested Additions

- Infant breastfed by wrong mother or breast milk given to wrong infant
- Death or serious disability of a fetus/infant with a category II fetal heart rate (FHR) pattern on mother's admission for labor, that was not acted on in a timely manner, barring any acute unpredictable event
- Prolapsed umbilical cord after elective rupture of membranes with the fetus at high station
- Prolonged periods of untreated uterine tachysystole during oxytocin or misoprostol administration
- Prolonged periods of a category II or III FHR pattern during labor unrecognized and/or untreated with the usual intrauterine resuscitation techniques
- Fundal pressure during birth involving shoulder dystocia
- Ruptured uterus following prostaglandin administration for cervical ripening/labor induction to a woman with a known uterine surgical scar
- Missed administration of RhoGam to a mother who is an appropriate candidate
- Circumcision without pain relief measures
- Neonatal group B streptococcus or HIV infection after missed intrapartum chemoprophylaxis
- Infant death or disability after multiple attempts with multiple instruments to attempt an operative vaginal birth
- Infant death or disability after prolonged periods of sustained coached second-stage labor pushing efforts without intrauterine resuscitation measures during a category II or III FHR pattern
- Death or serious injury of an infant during the first 2 hours postpartum when the mother or baby has been left unattended
- Death or serious injury of an infant while breastfeeding or being held in the arms of the new mother when the mother has been told that 24/7 rooming-in is the only option in the maternity unit

Adapted from National Quality Forum. (2011). *List of serious reportable events.* Washington, DC: Author; Simpson, K. R. (2006). Obstetrical "never events." *MCN: The American Journal of Maternal/Child Nursing, 31*(2), 136.

THREATS TO PATIENT SAFETY

In 2002, the National Quality Forum published a list of serious reportable events, also known as *never events*. They have been updated over the years, with the last update in 2011 (NQF, 2011). Suggestions have been made for additional events specific to the perinatal setting (Display 1–4) (Simpson, 2006). Recent data on sentinel events reported to The Joint Commission (2019b) from 2015 to 2018 indicate that these issues still require attention. There are numerous threats to patient safety and high-quality maternity care. Each participant and stakeholder bring factors, preferences, and considerations to the process and outcome of childbirth.

Clinicians working in a flawed system are often challenged to provide safe, high-quality care (Simpson, 2018a). Dedicated clinicians in these conditions are at risk for stress, burnout, and involvement in a preventable adverse outcome. There has been an appropriate focus on systems as major contributing factors to adverse outcomes instead of blaming individual clinicians. Clinicians involved in an error or adverse event often suffer negative consequences for months and years after. Clinicians have responsibilities for speaking up when they see an unsafe situation; keeping up on the latest evidence, standards, and guidelines; supporting colleagues; and not participating in disruptive behavior. Partnering with patients, respecting their autonomy, and making sure they have enough information and in a format that they understand for decision making are responsibilities of individual clinicians (Simpson, 2019). Display 1–5 lists some common threats and risks and offers potential solutions. The list is not all inclusive.

EVOLVING SOLUTIONS

Collaboration Using Best Evidence

Adopting clinical guidelines based on rigorous evidence can occur by a variety of strategies. Individual hospitals and healthcare systems can initiate change or they can be part of participation in statewide quality improvement collaboratives. Within either framework,

DISPLAY 1–5
Threats to Perinatal Patient Safety and High-Quality Maternity Care

Stakeholder/setting	Threat/risk	Recommendations/potential strategies for improvement
Hospitals/health care systems	Prioritizing cost, convenience, or provider preferences over what is best for mothers and babies	Each unit operation should be based on the answer to the question "What is best for mothers and babies?" Cost, convenience, and provider preferences should be secondary considerations in a high-quality healthcare system.
	Prioritizing graduate medical education over what is best for mothers and babies	Administrative and clinical leaders must acknowledge that quality evidence-based patient care, patient safety, and optimal patient outcomes are the primary goals of hospital and healthcare system. Graduate medical education is a secondary and compatible goal. Proper supervision of trainees and patient consent are essential as part of the process.
	Failure to hold leaders accountable for adopting evidence-based national standards and guidelines	Evidence-based national standards and guidelines are the hallmark of safe, high-quality perinatal care. Establish processes in which new standards and guidelines promulgated by professional associations and other pertinent bodies are reviewed on monthly basis and plans made for adoption in a timely manner.
	Failure to financially and administratively support clinician leaders in participating in perinatal quality care collaboratives and quality improvement initiatives	Participation in quality care collaboratives and other similar quality improvement processes often meet with resistance. Active participation requires support including a person designated to lead the project, persons to monitor practices, allocation of times for lead participants, and resources for data collection.
	Failure to hold leaders accountable for professional behavior and not acting in the context of disruptive clinician behavior including sexual harassment	Zero-tolerance polices similar to those recommended by The Joint Commission (2016) and professional organizations such as ACOG (2017) and American Nurses Association (ANA, 2015b) should be in place.
	Failure to support and protect clinicians who speak up in the context of threats to patient safety	The ANA *Code of Ethics for Nurses* details nursing responsibilities for speaking up to advocate for the rights, health, and safety of patients and the nurse's primary commitment to the patient. Administrative and clinical leaders must support the nurse in these efforts and protect them from retaliation if it occurs (ANA, 2015a). ACOG (2009) committee opinion on patient safety outlines how all clinicians have responsibility of speaking up and should be able to do so without fear of retribution. A joint publication from AWHONN, ACNM, ACOG, and SMFM offers further guidance on effective professional communication and support of those who speak up as needed to promote and protect patient safety (Lyndon et al., 2015).
	Failure to financially support following the AWHONN (2010) and AAP and ACOG (2017) nurse staffing guidelines for safe, quality care during hospitalization for childbirth	Administrative team leaders should review, budget for, and support following the nurse staffing guidelines (AAP & ACOG, 2017; AWHONN, 2010).
	Failure to financially support offering continuing education for the clinical team, including a nurse responsible for orientation and continuing nursing education	The importance of education, training, and competence validation care is critical to the provision of safe, high-quality care. Accreditation bodies require evidence of this process.
Perinatal services	Failure to have policies, procedures, protocols, and algorithms based on national standards and guidelines	*Guidelines for Perinatal Care* (AAP & ACOG, 2017) detail the need for perinatal services to have these types of resources available. AWHONN, ACNM, AAP, ACOG, ASA, and SMFM each offer numerous publications and clinical guidelines available on their Web site. Some require membership to access; most do not.
	Failure to make sure all clinicians are competent in knowledge and skills for the responsibilities they are assigned	AWHONN (2013) offers details of knowledge and skills required to care for childbearing women. *Guidelines for Perinatal Care* (AAP & ACOG, 2017) detail the need for all clinicians to be competent in their area of practice.

(continued)

DISPLAY 1–5
Threats to Perinatal Patient Safety and High-Quality Maternity Care *(Continued)*

Stakeholder/setting	Threat/risk	Recommendations/potential strategies for improvement
	Failure to follow the AWHONN (2010) and AAP and ACOG (2017) nurse staffing guidelines for safe quality care during hospitalization for childbirth. Specific areas of concern include one nurse to no more than three patients for OB triage; one nurse for each woman in labor with complications; one nurse for each woman in labor receiving IV oxytocin; at least two nurses at every birth (one for mother and one for baby), a full 2-hour recovery after every birth with a nurse in attendance and no other patient assignment; no more than three mother–baby couplets per nurse; a nurse and a nursery available to care for newborns as per the mother's choice; and a nurse with knowledge and skill to help women achieve their breastfeeding goals.	Review, budget for, and support following the nurse staffing guidelines (AAP & ACOG, 2017; AWHONN, 2010).
	Inflexible, restrictive policies and practices and unit operations that inhibit the choices of childbearing women and families including visitors/support persons, 24-hour mandatory rooming-in, and video recording	Support women in their choices for childbirth. Respect their autonomy. Offer information that is comprehensible, literacy level appropriate, and in a language they understand (provide interpretive services as necessary). If patient safety precludes granting their requests, thoroughly explain rationale and offer alternatives (National Quality Forum, 2018).
Clinicians	Failure to keep up with evidence, standards, and guidelines specific to their area of clinical practice	Membership in professional organizations specific to area of practice such as AWHONN, ACNM, ACOG, ASA, AAP, and SMFM is an essential aspect of keeping up with current evidence, standards, and guidelines. Develop processes to actively seek information about new evidence, standards, and guidelines as they are published. Seek certification in specific area of practice such as electronic fetal monitoring and inpatient obstetrics.
	Failure to follow national standards and guidelines	National standards and guidelines are available; unit policies, procedures, practices, protocols, and algorithms should offer details. Safe, high-quality care is based on standardized evidence-based national standards and guidelines. AWHONN, ACNM, AAP, ACOG, ASA, and SMFM each offer numerous publications and clinical guidelines available on their Web site. Some require membership to access; most do not.
	Disruptive behavior	Each clinician has a personal responsibility to act in a professional manner in all professional interactions. These resources can be helpful in offering review of behaviors and expectations (ACOG, 2009; ANA, 2015a, 2015b). A joint publication from AWHONN, ACNM, ACOG, and SMFM offers further guidance on effective professional communication and support of those who speak up as needed to promote and protect patient safety (Lyndon et al., 2015).
	Attitudes and care practices that do not respect autonomy of childbearing women	Be open; listen to women. Support women in their choices for childbirth. Respect their autonomy. Offer information that is comprehensible, literacy level appropriate, and in a language they understand (provide interpretive services as necessary). If patient safety precludes granting their requests, thoroughly explain rationale and offer alternatives (National Quality Forum, 2018).

AAP, American Academy of Pediatrics; ACNM, American College of Nurse-Midwives; ACOG, American College of Obstetricians and Gynecologists; ASA, American Society of Anesthesiologists; AWHONN, Association of Women's Health, Obstetric and Neonatal Nurses; SMFM, Society for Maternal-Fetal Medicine.

the change is initially led by innovative leaders trying to make a positive difference in outcomes for mothers and babies. Their efforts are often initially met with resistance. Comprehensive perinatal patient safety initiatives that are based on adopting evidence-based standardized clinical protocols and guidelines, promoting professional collaboration through improving teamwork and unit culture, and measuring outcomes have shown promise in reducing adverse obstetric events and professional liability, including number of claims and costs of claims (Clark et al., 2008; Pettker et al., 2014; Pettker et al., 2009; Pettker et al., 2011; Simpson et al., 2009). As perinatal patient safety and quality improvement have become widespread, and measures have been initiated by accrediting bodies and regulatory agencies, acceptance and participation have increased. Hospitals accredited by The Joint Commission (2018) with at least 300 live births per year are required to report on the perinatal care core measures listed in Display 1–6.

The Joint Commission released information in August 2019 about new standards to keep mothers safe during childbirth that will be effective July 1, 2020 for their accredited hospitals. The focus of the new standards for maternal safety are to reduce likelihood of harm related to maternal hemorrhage and severe hypertension and preeclampsia (The Joint Commission, 2019a). For postpartum hemorrhage, the standards involve establishing written clinical protocols, a postpartum hemorrhage supply kit, education of clinicians, hemorrhage drills, case reviews, and patient education on signs and symptoms of postpartum hemorrhage and when and how to seek care for these symptoms after hospital discharge (The Joint Commission). The standards for severe hypertension and preeclampsia include accurate and timely blood pressure measurement, clinician education, case reviews, severe hypertension drills patient education on signs and symptoms of severe hypertension and preeclampsia, when and how to seek care for these symptoms after hospital discharge, and when to schedule follow-up postpartum care (The Joint Commission).

The AIM program of the Council on Patient Safety in Women's Health Care (2016), which has partnered with most of the leading professional organizations for maternal health in the United States including AWHONN, ACNM, ACOG, SMFM, the American Academy of Family Physicians, and the Health Resources and Services Administration Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, is a coalition working to collectively promote safe maternity care for all women through maternal patient safety research, programs and tools, education, dissemination, and promotion of a culture of respect, transparency, and accountability. The goal is to decrease the number of severe maternal morbidity events by 100,000 and to avoid at least 1,000 maternal deaths (AIM, 2016). As of April 2019, 26 states are participating, with more expected soon (ACOG, 2019). The AIM program has collaboratively developed various maternal safety bundles including obstetric hemorrhage; severe hypertension/preeclampsia; maternal prevention of venous thromboembolism; safe reduction of primary cesareans/support for intended vaginal birth; reduction of peripartum racial disparities; postpartum care basics for maternal safety; and patient, family, and staff support after a severe maternal event (AIM, 2016). Each bundle is formatted similarly with key aspects of readiness, recognition and prevention, response, and reporting/systems learning and focuses on giving the best care to every woman in every setting whenever an event occurs (AIM, 2016). Each aspect of the framework includes key points for every woman, care giver and provider, and birthing facility as applicable. References to supportive evidence are likewise organized in this framework (Council on Patient Safety in Women's Health Care, 2016).

DISPLAY 1–6

The Joint Commission Perinatal Care Core Measures Effective January 2019

Measure	Brief definition
Elective Delivery	Women with elective vaginal birth or elective cesarean birth at ≥37 and <39 completed weeks of gestation
PC-02: Cesarean Birth	Nulliparous women with a term, singleton baby in a vertex position born by cesarean
PC-03: Antenatal Steroids	Women at risk for preterm birth at ≥24 and <34 weeks' gestation receiving antenatal steroids prior to giving birth to preterm newborns
PC-04: Health Care- Associated Bloodstream Infections in Newborns	Staphylococcal and gram-negative septicemias or bacteremias in high-risk newborns
PC-05: Exclusive Breast Milk Feeding	Exclusive breast milk feeding during the newborn's entire hospitalization
PC-06: Unexpected Complications in Term Newborns	The percentage of babies with unexpected newborn complications among full-term newborns with no preexisting conditions

From The Joint Commission. (2018). New perinatal care measure. *Perspectives, 38*(8), 7–8.

DISPLAY 1–7
Patient Safety Bundles and Tools

- Maternal Mental Health: Depression and Anxiety
- Maternal Venous Thromboembolism (+AIM)
- Obstetric Care for Women with Opioid Use Disorder (+AIM)
- Obstetric Hemorrhage (+AIM)
- Postpartum Care Basics for Maternal Safety
  - From Birth to the Comprehensive Postpartum Visit (+AIM)
  - Transition from Maternity to Well-Woman Care (+AIM)
- Prevention of Retained Vaginal Sponges After Birth
- Reduction of Peripartum Racial/Ethnic Disparities (+AIM)
- Safe Reduction of Primary Cesarean Birth (+AIM)
- Severe Hypertension in Pregnancy (+AIM)
- Severe Maternal Morbidity Review (+AIM)
- Support After a Severe Maternal Event (+AIM)

AIM, Alliance for Innovation on Maternal Health.
Available at https://safehealthcareforeverywoman.org/patient-safety-bundles/

DISPLAY 1–8
California Maternal Quality Care Collaborative Toolkits

- Improving Health Care Response to Maternal Venous Thromboembolism, 2018
- Improving Health Care Response to Cardiovascular Disease in Pregnancy and Postpartum, 2017
- Toolkit to Support Vaginal Birth and Reduce Primary Cesareans and Implementation Guide, 2016
- Improving Health Care Response to Obstetric Hemorrhage, V2.0, 2015 (V1.0 released in 2010)
- Improving Health Care Response to Preeclampsia, 2014
- Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age, 2010 (Licensed to March of Dimes)

Available at https://www.cmqcc.org/resources-tool-kits/toolkits

The council also offers a Maternal Early Warning Signs (MEWS) Protocol and a toolkit for Implementing Quality Improvement Projects. There are abundant evidence-based resources available at no charge from the council and from other organizations. Nurses and other members of the multidisciplinary team that provide maternity care should be familiar with these bundles, tools, and references. Display 1–7 lists some of the AIM patient safety bundles.

Although individual hospitals can make a significant difference, working with a multidisciplinary team in a variety of clinical settings in many states has the potential to raise the impact of these collective efforts exponentially. This premise is the foundation of the National Network of Perinatal Quality Collaboratives sponsored by the CDC (Henderson et al., 2018; Simpson, 2018b). The program was initiated in 2016 by the CDC and the March of Dimes Foundation. The main goal is to assist statewide perinatal quality collaboratives in their work to improve care and outcomes for mothers and babies (Gupta, Donovan, & Henderson, 2017). Many states have perinatal quality collaboratives, although there are a variety of organizational structures, clinical goals, funding, and leadership teams. The CDC offers a resource guide on how to develop and sustain a perinatal quality collaborative.

Some state programs, such as the one in California, have been in operation for many years and have robust data collection processes, widespread participation, and developed a number of helpful resources. The California Maternal Quality Care Collaborative (CMQCC) has multiple well-developed toolkits for maternal patient safety as well including topics such as obstetric hemorrhage, promoting vaginal birth, reducing primary cesareans and preeclampsia, and elimination of nonmedically indicated births before 39 weeks' gestation. Display 1–8 lists some of the CMQCC toolkits. They describe current evidence and suggest strategies for promoting best practices on each topic. California is the only state where maternal mortality rates have decreased over the past 14 years (MacDorman, Declercq, Cabral, & Morton, 2016). The difference between California and the rest of the United States is likely due to intensive team efforts between hospitals, healthcare systems, professional organizations, and public health agencies to address some of the major complications from obstetric hemorrhage and preeclampsia, via encouragement to adopt evidence-based protocols sponsored by CMQCC. This work was not easy, and there were many ongoing challenges, but by perseverance and working together as an interprofessional team, adoption and implementation have been successful in many participating hospitals (Lyndon & Cape, 2016).

Perinatal quality collaboratives have produced excellent results including a decrease in healthcare-associated bloodstream infections in newborn babies (Gupta et al., 2017), fewer elective births before 39 completed weeks of gestation (Kacica, Glantz, Xiong, Shields, & Cherouny, 2017; Simpson, Knox, Martin, George, & Watson, 2011), a lower cesarean birth rate (Main et al., 2019), and a decline in severe pregnancy complications (Main et al., 2017). Success in part is due to the team approach. These efforts are not led by individual physicians, nurses, or hospital administrators; rather, they are initiated by clinicians, researchers, and public health experts with a stake in perinatal outcomes such as midwives, perinatal

and neonatal nurses, obstetricians, maternal–fetal medicine specialists, neonatologists, pediatricians, and family medicine physicians. New mothers are an essential part of the group, and their voices are highly valued. The ongoing results of perinatal quality collaboratives provide evidence that clinicians from many professional disciplines can work together for a common goal.

Mothers and babies can benefit from standardized clinical protocols for the most common maternity care situations. When everyone has reviewed the evidence, practiced using drills, knows the step-by-step plan in an emergent situation, and works as a team in a culture of safety with mutual respect and collaboration, there is the best chance for healthy outcomes. Many aspects of maternal morbidity and mortality are preventable (Council on Patient Safety in Women's Health Care, 2016). Standardized clinical protocols for maternity care may offer an opportunity to reduce risk of preventable harm.

Partnering with Patients and Families for Shared Decision Making during Childbirth

Childbearing women have the most vested interest in their pregnancy and outcome, and they know their bodies and their preferences, concerns, and fears best. Safe, high-quality care begins with listening to women, followed by making efforts to meet their needs and desires. Choice of prenatal care setting, care provider, and birth place all have significant implications for the process and outcome of childbirth. It is important to consider that some women do not have these choices because they are in situations based on where they live, their socioeconomic status, and insurance coverage in which access to care is challenging and continuity of care is minimal.

When a woman presents in labor, often, she goes along with directions from nurses, midwives, and physicians during the childbirth process, trusting that they know best (Sakala, Declercq, Turon, & Corry, 2018; Simpson, Newman, & Chirino, 2010). Some women have a birth plan, but most do not. In a study that included 14,630 births, only 12% of women had a birth plan and less than one third had attended prepared childbirth classes (Afshar et al., 2017). Women often seek childbirth information online, but not all sites offer accurate data (English, Alden, Zomorodi, Travers, & Ross, 2018; Sakala et al., 2018).

During childbirth hospitalization, many clinical events involve choice (Display 1–9). The list is not all inclusive. Most allow ample time for detailed conversation and patient consent. Information should be provided at the appropriate literacy level and language. Interpreter services should be used as needed. Women should be treated as true partners in their care. Shared decision making involves communication between clinicians and patients to make healthcare decisions that are consistent with key patient preferences (NQF, 2018). Information should be evidence based, unbiased, and individualized and include potential benefits and risks (NQF, 2018). Choice goes beyond clinical decisions. Women's preferences for support persons in her room during labor, birth, and postpartum should be respected. Restrictive policies about "visitors" including who, when, how many, must be immediate family, and so forth need careful scrutiny; in some hospitals (but not most), concerns about space and security limit options. At times, contagious diseases limit options. The woman decides how "family" is defined. Restrictive policies about video recording are outdated. Nurses are ideally positioned as part of the healthcare team to facilitate shared decision making during childbirth.

DISPLAY 1–9

Events and Options during the Childbirth Process that Warrant Confirming Patient Knowledge or Offering Additional Information so She and Her Family Can Make an Informed Decision

- Whether or not to be admitted based on labor status and maternal–fetal condition
- Cervical ripening, induction, or augmentation of labor (if any, what type)
- Intravenous line placement and oral intake
- Type of fetal assessment (intermittent auscultation, continuous or intermittent electronic fetal monitoring; external or internal)
- Evaluation of labor progress
- Hydrotherapy via shower or tub
- Pain relief measures including epidural analgesia
- Ambulation; use of the peanut ball; positioning
- Artificial rupture of membranes
- When to begin pushing during second stage labor and type of pushing method
- Method of birth
- Episiotomy
- Skin-to-skin contact with the newborn after birth
- Method of newborn feeding
- Routine newborn care and rooming-in
- Circumcision
- Participation of trainees in their care including nursing, midwifery, or medical students or resident physicians in training
- Support persons in attendance

From Simpson, K. R. (2019). Partnering with patients and families during childbirth: Confirming knowledge for informed consent. *MCN: The American Journal of Maternal/Child Nursing, 44*(3), 180. doi:10.1097/NMC.0000000000000527

Maternal Mortality Review Committees

All cases of severe maternal morbidity and maternal mortality should be reviewed by an interdisciplinary quality committee. Criteria for identifying cases for review of severe maternal morbidity have been offered by ACOG and SMFM (2016) and include transfusion of four or more units of blood and admission of a pregnant or postpartum woman to an intensive care unit.

By evaluating processes involved in near-miss cases, lessons can be learned that can potentially avoid maternal deaths. Thorough review of the process of care, such as timely and appropriate diagnosis and treatment, can be extremely useful in developing plans for improvement and potentially preventing a subsequent similar case.

Findings from the nine states' maternal mortality review committees suggest that there are common contributing factors (Building U.S. Capacity to Review and Prevent Maternal Deaths, 2018). They include patients' lack of knowledge on warning signs and the need to seek care, healthcare provider misdiagnosis and ineffective treatments, and systems of care factors such as lack of coordination between providers. Based on these data, the review committees offered a number of recommendations specific to common causes of death. Overall recommendations included adopting levels of maternal care (ACOG & SMFM, 2019), enhancing prevention initiatives, enforcing policies and procedures on obstetric hemorrhage, and improving policies about patient management. Participating in reviews of severe maternal morbidity and maternal mortality at the facility level and as part of a state review committee are opportunities for nurses to be involved as active members in significant efforts to understand causation and develop prevention strategies. Together, we must do better in preventing these types of adverse events.

SUMMARY

On a national level, recommendations for improving the state of maternity care in the United States to reduce maternal mortality include establishing maternal mortality committees in each state, participation in perinatal quality care collaboratives, adoption of standardized practices such as those in the bundles published by the AIM project, expansion of Medicaid for all states, making sure women receive the appropriate care in a facility capable of providing that care including patient transfer as necessary, providing more comprehensive and timely postpartum care, and better reporting of vital statistics data about women and newborns including data stratified by race and ethnicity (ACOG, 2019; SMFM, 2019). Local and national policies must be revised to improve access to maternity care and access to health insurance benefits, reduce healthcare disparities, eliminate racism, and standardize data collection on maternal morbidity and mortality (ACOG, 2019; SMFM, 2019).

In the hospital setting and for each clinician, when the focus of care is putting safety of mothers and babies first, practice based on the cumulative body of science and national standards and guidelines is a natural and obvious conclusion. Partnering with childbearing women and making sure they have enough information to make informed decisions about their care is essential. Keeping current is critically important for perinatal nurses to maximize safe care for mothers and babies and to minimize the risk of patient injuries and professional liability. Effective leadership and interdisciplinary collaboration are essential. When there is mutual respect and professional behavior among all members of the perinatal team, a safe care environment is enhanced. Practice in a perinatal setting where patient safety is the number one priority is professionally rewarding and personally fulfilling.

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CHAPTER 2

Integrating Cultural Beliefs and Practices When Caring for Childbearing Women and Families

Lynn Clark Callister

INTRODUCTION

Maria, a Mexican American woman having her first baby, attended a childbirth education class where the expectant fathers learned labor support techniques. She declined to lie on the floor surrounded by other men while her husband massaged her abdomen. Inaam, a Muslim Arabic woman experiencing her first labor, was attended by her mother and mother-in-law. As the labor slowly progressed and Inaam began to be more uncomfortable, the two mothers alternated between offering her loving support, chastising her for acting like a child, and praying loudly that mother and baby will be safe from harm. Nguyet, a primiparous Vietnamese immigrant, had been in the United States only a short time when she went into labor. She arrived at the birthing unit in active labor dilated to 5 cm. Nguyet and the father of the baby, Duc, spoke very limited English. Her labor was difficult, but she did not utter a sound. Duc entered the birthing room only when the nurses asked him to translate for Nguyet. After 20 hours of labor, a cesarean birth was performed. On the mother–baby unit, Nguyet cooperated with the instructions from the nurse to cough and deep breathe, but she became agitated when the nurse set up for a bed bath and began bathing her. When she was encouraged to walk, she shook her head and refused. She also refused the chilled apple juice the nurse brought to her. Because of abdominal distention and dehydration, a nasogastric tube was inserted, and intravenous fluids were restarted. No one could understand why she was so uncooperative.

Because of a concerning fetal heart rate tracing, Koua Khang needed an emergent cesarean birth. The nurse told her she would need to remove a nondescript white string bracelet from her wrist before surgery. Koua became hysterical, gesturing and trying to convey the message that the bracelet would protect her during the birth from evil spirits. Michelle, a certified nurse midwife, cared for a Mexican immigrant mother who finally confided in her that during her postpartum hospitalization she went in the shower and turned on the water but was very careful not to get wet. She was following instructions from her nurse while trying to practice her own cultural traditions. Mei Lin, a Chinese woman in graduate school in the United States, promised her mother she would follow traditional Asian practices after her son was born, including "doing the month" and subscribing to the hot/cold theory. Even though this woman was intellectually aware these practices had little scientific basis, she demonstrated her respect for her mother and her culture by honoring her mother's request. Sameena was having a scheduled cesarean birth. Her family had a tradition that the newborn be placed immediately in a blanket that had been in the family for generations but were concerned that since it was a surgical birth, the tradition would not be followed. The nurses accommodated this cultural tradition, and the blanket was placed inside the hospital receiving blanket when their child was born. The grandmother was pleased and grateful.

Childbirth is a time of transition and social celebration in all cultures (Callister, 1995). A Wintu child living in Africa, in deference to his mother, refers to her as, "She whom I made into mother." Culture also influences the experience of perinatal loss because the meaning of death and rituals surrounding death are culturally bound. Healthcare beliefs and health-seeking behaviors surrounding pregnancy, childbirth, and parenting are deeply rooted in cultural context. Culture is a set of behaviors, beliefs, and practices, a value system that is transmitted from one woman in a cultural group to another (Lauderdale, 2011). It is more than

skin color, language, or country of origin. Culture provides a framework within which women think, make decisions, and act. It is the essence of who a woman is. The extent to which a woman adheres to cultural practices, beliefs, and rituals is complex and depends on acculturation and assimilation into the dominant culture within the society, social support, length of time in the United States or Canada, generational ties, and linguistic preference. Even within individual cultural groups, there is tremendous heterogeneity. Although women may share a common birthplace or language, they do not always share the same cultural traditions.

Diversity is a reality in the United States (Napier et al., 2014). Nurses provide care to immigrants, refugees, and women from almost everywhere in the world, many of whom are of childbearing age. Nurses are finding the profile of childbearing women in their practice are increasingly culturally diverse (Callister, 2016). More than 30% of the U.S. population now consists of individuals from culturally diverse groups other than non-Hispanic Whites, whereas only 9% of registered nurses come from racial or ethnic minority backgrounds. It is projected that by the year 2050, minorities will account for more than 50% of the population of the United States. Each year, nearly 1 million immigrants come to the United States, half of whom are immigrant women of childbearing age. Since 1980, more than 200,000 refugees have resettled in the United States (United States Bureau of Population, 2016). One in every 12 U.S. residents is foreign-born. Twenty-seven percent of women living in the United States are women of color. One of the challenges for healthcare in this century is that members of racial and ethnic minorities make up a disproportionately high percentage of persons living in poverty.

Poverty brings many challenges in healthcare delivery (United States Census Bureau [USCB], 2015; U.S. Department of Health and Human Services [USDHHS], Office of Minority Health, 2017). Women and families in poverty can be considered a culture associated with health disparities and increased vulnerability in childbearing women.

Clinical examples in this chapter represent only a fraction of the possible cultural beliefs, practices, and behaviors the perinatal nurse may see in practice (Display 2–1). It is beyond the scope of this chapter to thoroughly discuss in detail each cultural group. Although generalizations are made about cultural groups, a stereotypical approach to the provision of perinatal nursing care is not appropriate. Cultural beliefs and practices are dynamic and evolving, requiring ongoing exploration. In any given culture, each generation of childbearing families perceives pregnancy, childbirth, and parenting differently. Each individual woman should be treated as such—an individual who may or may not espouse specific cultural beliefs, practices, and behaviors.

DISPLAY 2–1
Culture and Birth Traditions

African American/Black
- Strong extended family support
- Matriarchal society
- Present time orientation
- May engage in folk practices ("granny," "root doctor," voodoo priest, spiritualist) depending on background

American Indian and Native Alaskan
- Healthcare decision making by families/tribal leaders
- Often stoic; don't make eye contact, limit touch
- Strong spiritual foundation
- May use a medicine man or shaman
- Present time orientation

Asian American and Pacific Islander
- Culturally and linguistically heterogeneous
- Healthcare decision making by families
- "Hot/cold" theory of illness (pregnancy considered a "hot" condition, except among Chinese women, who consider it a "cold" condition)
- Asians are often stoic.
- Strong extended family support
- Asian fathers may choose not to attend the birth.
- Chinese postpartum focuses on "doing the month."
- Asian Americans have future orientation, whereas Pacific Islanders have present orientation.
- Asians have high respect for others.
- Asians may utilize an acupuncturist/acupressurist, herbalist.

Hispanic/Latino
- Healthcare decision making by families
- Strong extended family support
- Prenatal care may not be valued because pregnancy is a healthy state.
- Enjoy strong extended family support
- Fathers may choose not to attend the birth.
- May use folk healers and Western medicine concurrently (curandero, espiritualista, yerbero)
- Present time orientation
- Believe in the "evil eye"
- Postpartum maternal–newborn dyad vulnerable or delicate

White/Caucasian
- Often considered a noncultural group
- Value autonomy and personal decision making
- Eastern European women avoid cutting or coloring hair during pregnancy.
- Future time orientation
- Focus on achievement

Cultures are not limited to the obvious traditional ethnic or racial groups. Examples of other "cultures" include refugees and immigrants, poverty-stricken women, women who have experienced ritual circumcision, adolescent childbearing women, women with disabilities, and deeply spiritual women such as those espousing the religious beliefs. Perinatal nursing units may also be considered a culture, for some women a "foreign country."

CULTURAL FRAMEWORKS AND CULTURAL ASSESSMENT TOOLS

Cultural frameworks and cultural assessment tools have been developed to guide perinatal nursing practice. The Sunrise Model is based on culture care theory (McFarland & Wehbe-Alamah, 2015) (Fig. 2–1). The Transcultural Assessment Model (Giger, 2016) includes variables such as communication, space, social organization, time, environmental control, and biologic variations (Fig. 2–2). Others have identified the dimensions of culture, including values, worldview, disease etiology, time orientation, personal space orientation and touch, family organization, and power structure (Purnell & Paulanka, 2013). The Transcultural Nursing Model is illustrated in 16 considerations in caring for childbearing women (Andrews & Boyle, 2015) (Fig. 2–3). Mattson (2015) has conceptualized specific ethnocultural considerations in caring for childbearing women (Fig. 2–4). Four assumptions define the influence culture has on pregnancy, childbirth, and parenting (Display 2–2). Models should focus on the person, the processes, the environment, and the outcomes. Recently, a model has been proposed for person, family, and culture-centered nursing care (Lor, Crooks, & Tluczek, 2016).

Cultural Competence

The process of cultural competence in the delivery of healthcare includes cultural awareness, skills, encounters, and knowledge (Campinha-Bacote, 2014). Cultural competence is more than a nicety in healthcare. Cultural competence has become imperative because of increasing health disparities and population diversity; the competitive healthcare market; federal regulations on discrimination; complex legislative, regulatory, and accreditation requirements; and our litigious society (deChesnay, Hart, & Branan, 2016; Rorie & Brucker, 2015; The Joint Commission, 2019) (Fig. 2–5).

Acculturation is a complex variable that is challenging to measure, and current measures need to be refined. Acculturation can be at a cultural or group level and a psychological or individual level (Beck, 2006). Anderson and associates (2010) have identified conducting cultural health assessment.

A framework for acculturation has been identified by Berry (1980). Acculturation may be characterized by (1) assimilation; (2) establishment of relationships in the host society at the expense of the patient's native culture; (3) integration, in which cultural identity is retained and new relationships are established in the host society; (4) rejection, in which one retains

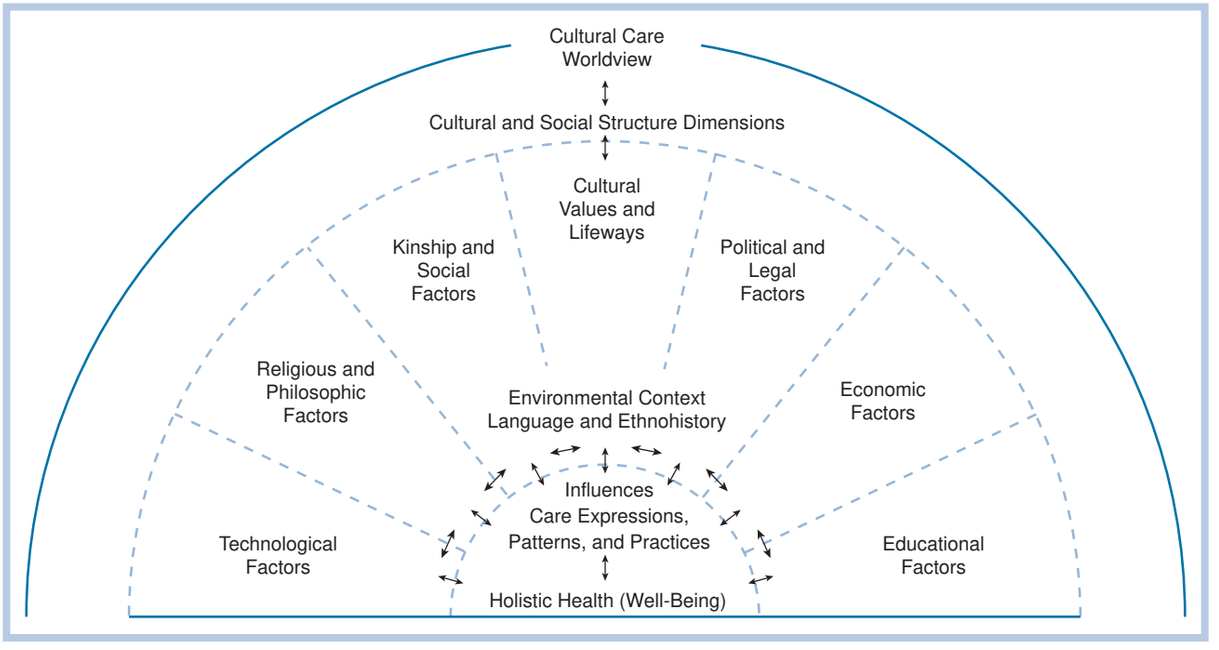


FIGURE 2–1. The Sunrise Model. (From McFarland, M. R., & Wehbe-Alamah, H. B. [2015]. *Leininger's cultural care diversity and universality: A worldwide nursing theory* [3rd ed.]. Sudbury, MA: Jones & Bartlett.)

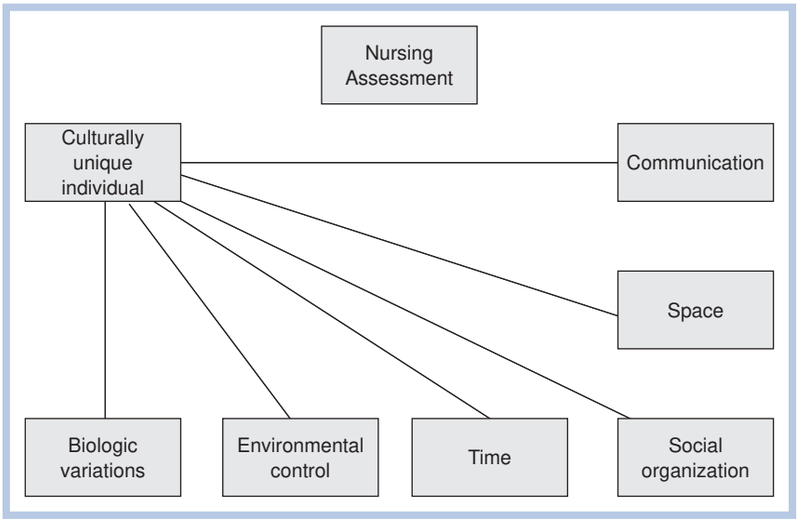


FIGURE 2–2. Transcultural Model. (From Giger, J. N. [2016]. *Transcultural nursing: Assessment and intervention* [7th ed.]. St. Louis, MO: Elsevier.)

cultural identify and rejects the host society; and (5) deculturation, in which one values neither. Nurses will encounter immigrant and refugee women who fall into different categories of acculturation.

The General Acculturation Index scale can be used to assess level of acculturation, and it includes items such as written and spoken language, the country where the childhood was spent, the current circle of friends, and pride in cultural background (Balcazar, Peterson, & Krull, 1997). Other instruments include the Short Acculturation Scale, the Acculturation Rating Scale for Mexican Americans (ARSMA), the ARSMA-II, and the Bidimensional Acculturation Scale for Hispanics (Beck, 2006).

What constitutes a positive and satisfying birth experience varies from one culture to another (Callister, Eads, & Yeung Diehl, 2011; Corbett, Callister, Gettys, & Hickman, 2017; Reed, Callister, Kavaefiafi, Corbett,

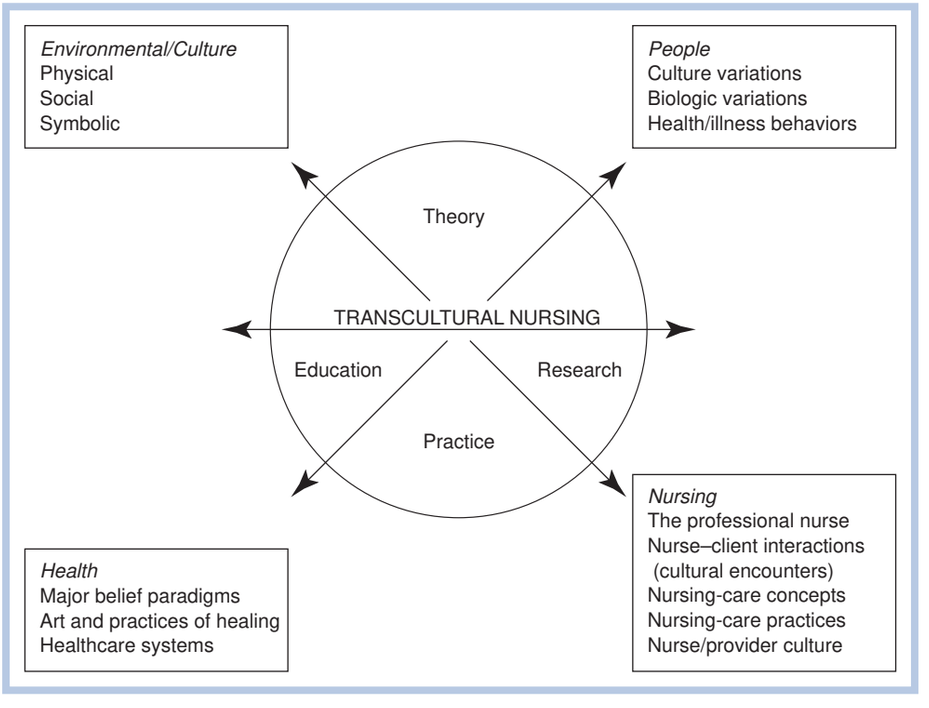


FIGURE 2–3. Transcultural Nursing: assessment and intervention.

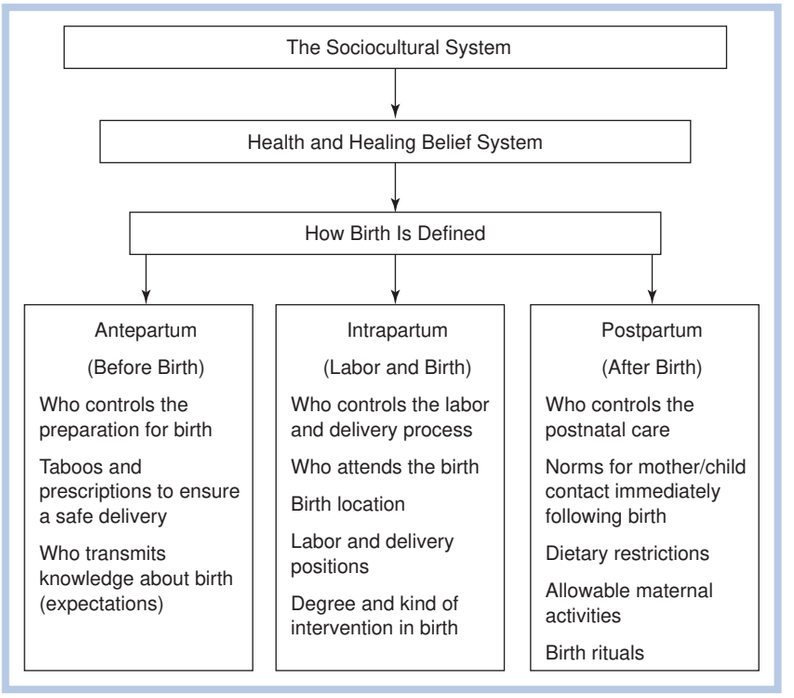
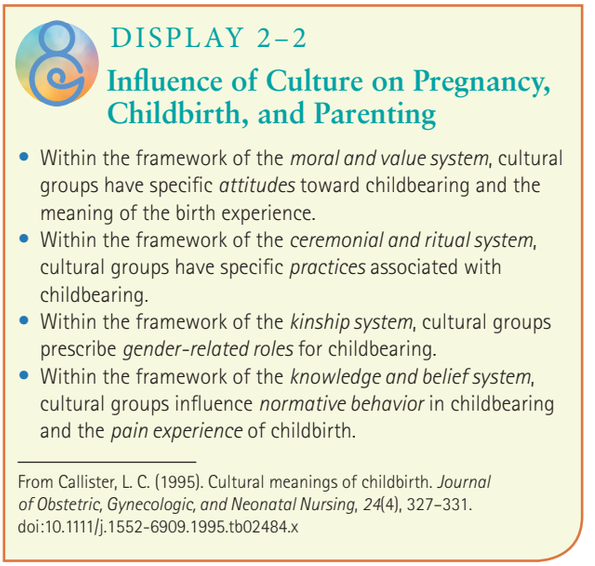


FIGURE 2–4. The sociocultural system, health and healing belief system, and how birth is defined. (From Mattson, S. [2015]. Ethnocultural considerations in the childbearing period. In S. Mattson & J. E. Smith [Eds.], *Core curriculum for maternal-newborn nursing* [5th ed., pp. 66]. St. Louis, MO: Elsevier.)

& Edmunds, 2017). For example, within the Japanese culture, there is the belief in a process called "education of the unborn." A happy mother is thought to ensure joy and good fortune because the unborn child learns, communicates, and responds in utero. The individual personality is formed before birth. Such a belief about the fetus is reflected in many cultures, with concern during pregnancy about evil spirits and birthmarks. Other cultural considerations include fertility rites and beliefs about what determines the gender of the unborn child.

Rich meaning may be created by women espousing traditional religious beliefs and also influence healthy promoting behaviors (Callister & Khalaf, 2010;



DISPLAY 2–2

Influence of Culture on Pregnancy, Childbirth, and Parenting

- Within the framework of the *moral and value system*, cultural groups have specific *attitudes* toward childbearing and the meaning of the birth experience.
- Within the framework of the *ceremonial and ritual system*, cultural groups have specific *practices* associated with childbearing.
- Within the framework of the *kinship system*, cultural groups prescribe *gender-related roles* for childbearing.
- Within the framework of the *knowledge and belief system*, cultural groups influence *normative behavior* in childbearing and the *pain experience* of childbirth.

From Callister, L. C. (1995). Cultural meanings of childbirth. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 24*(4), 327–331. doi:10.1111/j.1552-6909.1995.tb02484.x

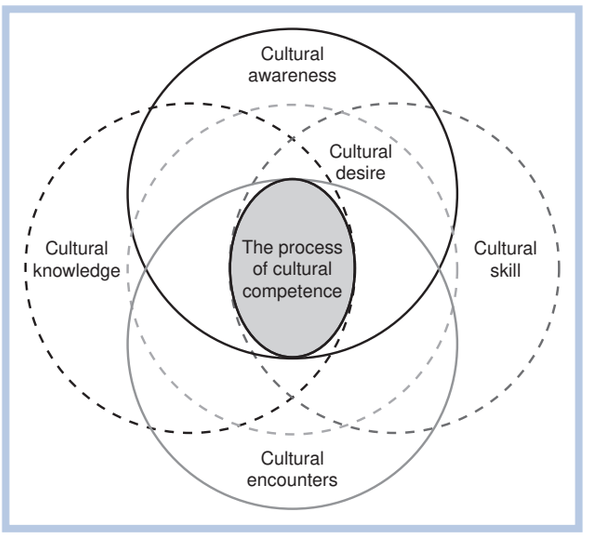


FIGURE 2–5. The process of cultural competence in the delivery of healthcare.

Murray & Huelsman, 2009). An Orthodox Jewish mother gives silent thanks in the ancient words of the Psalms following the birth of her firstborn son. She believes that by birthing a son she has fulfilled the reason for her creation in obedience to rabbinical law. The creation of life and giving birth represent obedience to religious law and the spiritual dimensions of the human experience.

Giving birth is a significant life event, a reflection of a woman's personal values about childbearing and child rearing and the expression and symbolic actualization of the union of the parents. For Muslim women, giving birth fulfills the scriptural injunctions recorded in the Quran. Muslim women may be asked soon after getting married, "Do you save anything inside your abdomen?" meaning, "Are you pregnant yet?" Pregnancy in a traditional Asian family is referred to as a woman having "happiness in her body." In Latin America, if you were to ask an expectant mother when her baby is due, the direct translation from Spanish to English is "When are you going to give light?"

PRACTICES ASSOCIATED WITH CHILDBEARING

There are many diverse cultural rituals, customs, and beliefs associated with childbearing. American Indian mothers believe tying knots or weaving will cause birth complications associated with cord accidents. Navajo expectant mothers do not choose a name or make a cradleboard because doing so may be detrimental to the well-being of the newborn. Arabic Muslim women do not prepare for the baby in advance (such as no baby showers, layette accumulation, or naming the unborn child) because such planning has the potential for defying the will of Allah regarding pregnancy outcomes. Similarly, Eastern European women do not make prenatal preparations for the newborn, believing such actions would create bad luck. Filipino women believe that daily bathing and frequent shampoos during pregnancy contribute to having a clean baby. Asian American women may not disclose their pregnancy until the 120th day, when it is believed the soul enters the fetus. In many cultures, girls are socialized early about childbearing. They may witness childbirth or be present when other women repeat their birth stories, especially extended female family members. In the Sudan, a pregnant woman is honored in a special ceremony, as extended female family members rub her belly with millet porridge, a symbol of regeneration, empowering her to give birth. Because of the importance of preserving modesty, Southeast Asian women tie a sheet around their bodies like a sarong during labor and express a preference to squat while giving birth. An Italian maternal grandmother may request permission to give her newborn grandson his first bath. After the bath, she dresses him in fine, white silk clothing that she stitched by hand for this momentous occasion. When women in Bali hear the first cries of a newborn, they lavish the new mother with gifts such as dolls, fruit, flowers, or incense to bless, honor, purify, and protect the new child.

The placenta is called *el compañero* in Spanish, translated to mean "the companion of the child." And there are a variety of cultural rituals associated with the disposal of the placenta, including having it dried, burned, or buried in a specific way. Although disposing of the placenta must meet with standard infection control precautions, individual family preferences should be honored as much as possible.

A variety of cultural practices influence postpartum and newborn care. Laotian women stay home the first postpartum month, near a fire or heater in an effort to "dry up the womb." The traditional postpartum diet for Korean women includes a soup made from beef broth and seaweed that is believed to cleanse the body of lochia and increase breast milk production. In Navajo tradition, a family banquet is prepared following the baby's first laugh because this touches the hearts of all those who surround the baby.

Care of the newborn's umbilical cord includes the use of a binder or belly band, the application of oil, or cord clamping, and then sterile excision. A Southeast Asian woman may fail to bring her newborn to the pediatrician during the first month after birth because this is considered to be a time for confinement and rest.

Postpartum cultural rituals are important for women of different cultures. Culturally diverse women may experience postpartum depression, with an increased risk related to the gender of the child, related to higher valuing of sons in some societies (Callister, Beckstrand, & Corbett, 2010).

GENDER ROLES

Many cultural groups show strong preference for a son. For example, according to Confucian tradition, only a son can perform the crucial rites of ancestor worship. A woman's status is closely tied to her ability to produce a son in many cultures including Asian Indian families (Goyal, 2016).

A Mexican immigrant woman may prefer that her mother or sister be present during her childbirth rather than the father of her child. In some cultures, fathers may prefer to remain in the waiting room until after the birth. Vietnamese fathers rarely participate in the birth of their children. Only after the newborn is bathed and dressed may the father see him or her. In cultures in which the husband's presence during birth is not thought to be appropriate, nurses should not assume this denotes lack of paternal involvement and support.

Modesty laws and the law of family purity found in the Torah prohibit the Orthodox Jewish husband from observing his wife when she is immodestly exposed and from touching her when there is vaginal bleeding. Depending on the specific religious sect, observance of the law varies from the onset of labor or bloody show to complete cervical dilation. Jewish husbands present at birth stand at the head of the birthing bed or behind a curtain in the room and do not observe the birth or touch their wives. Although cultural factors may limit a husband's ability to physically support or coach his wife during labor and birth, Jewish women still feel supported. Husbands praying, reading Psalms, and consulting with the rabbi represent significant and active support to these women.

For immigrant women living far from extended family support, there may be a shift to an emerging dominance of the nuclear family. For example, in Arab cultures, the extended family is primary, and with migration, fathers may assume more responsible very different than traditional roles. One mother, Fatima, said, "In my country I did not see my husband much . . . Here we are always with each other . . . When he is home he is with me and my son" (Bawadi & Ahmad, 2017, p. 104).

CHILDBIRTH PAIN AND CULTURE

A major pain experience unique to women is that associated with giving birth. Many cultural differences related to the perception of childbirth pain have been identified (Callister, 2011). Some women feel that pain is a natural part of childbirth and that the pain experience provides opportunity for important and powerful growth. Others see childbirth pain as no different from the pain of an illness or injury, that it is inhumane and unnecessary to suffer.

Words used to describe the pain associated with childbirth vary. Labor pain has been described as horrible to excruciating, episiotomy pain described as discomforting and distressing, and postpartum pain described as mild to very uncomfortable. Korean women described pain with words such as "felt like dying" or the "the sky was turning yellow," or the sense of "tearing apart." Mexican American women view pain as a physical experience, composed of personal, social, and spiritual dimensions. Scandinavian women demonstrate a high level of resilience and hardiness when giving birth, as do Australian women. One Australian woman viewed birth as symbolic of the challenges of life, "[Giving birth] makes you more resilient. You know you are able to handle things that you didn't think you could. I think it gives you strength because you know if you can through that, you can cope with a lot of other things" (Callister, Holt, & Kuhre, 2010, p. 133). Women's perceptions of personal control have been found to positively influence their satisfaction with pain management during childbirth.

DISPLAY 2–3
Culture and Pain Communication

- Assess pain and cultural pain behaviors and practices.
- Accept the choices of the woman about pain control after providing available information about pain management.
- Demonstrate a willingness to listen to the woman's description of her pain.
- Learn about culturally appropriate pain management strategies.

From Callister, L. C. (2011). The pain of childbirth: Management among culturally diverse women. In K. H. Todd & M. Incayawar (Eds.), *Culture, brain, & analgesia: Understanding and managing pain in diverse populations* (pp. 231–239). New York, NY: Oxford University Press.

Pain behaviors also are culturally bound. Some Hispanic laboring women may moan in a rhythmic way and rub their thighs or abdomen to manage the pain. During labor, Haitian women are reluctant to accept pain medication and instead use massage, movement, and position changes to increase comfort. Filipino women believe that noise and activity around them during labor increases labor pain. African American women may be more vocally expressive of pain. American Indian women are often stoic, using meditation, self-control, and traditional herbs to manage pain. Puerto Rican women are often emotive in labor, expressing their pain vocally. There is disparity between the estimation of labor pain by caregivers and the pain the women reported they were experiencing. The Coping with Labor Algorithm is proving helpful in assessing pain in laboring women rather than use of the traditional pain scale (Fairchild, Roberts, Zelman, Michelli, & Hastings-Tolsma, 2017). Suggestions for communication skills related to pain assessment and management are summarized in Display 2–3.

MAJOR CULTURAL GROUPS

The major cultural groups in the United States include African American/Black (AA/B), American Indian/Alaska Native (AI/AN), Asian American/Pacific Islander (AA/PI), Hispanic/Latino (H/L), and White/Caucasian (W/C). Designation in one of these five categories is not equated with within-group homogeneity. The U.S. population by race and ethnic origin is shown in Figure 2–6 (USCB, 2015). The names used to identify these major U.S. cultural groups are those used by the USCB. The following two modifications were made in the year 2000 census data. The AA/PI category was separated into two categories: AA or Native Hawaiian/PI, and Latino has been added to the Hispanic category (H/L).

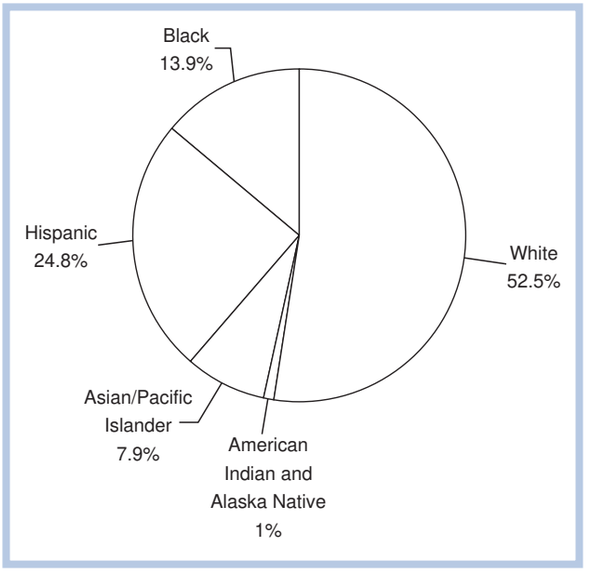


FIGURE 2–6. United States' predicted population by race and ethnic origin, 2050.

African American or Black

According to 2010 census data, this group constitutes 12.6% of the population in the United States. This heterogeneous group has origins in Black racial groups of Africa and the Caribbean Islands, including the West Indies, Dominican Republic, Haiti, and Jamaica. AA/B persons may speak French, Spanish, African dialects, and various forms of English. By 2050, the AA/B population is expected to nearly double its present size to 61 million. A disproportionate percentage of AA/Bs are disadvantaged because of poverty, racism, and low educational levels, and they are more likely to have only public insurance. AA/B women are less likely to use any contraceptive method and along with H/L are less likely to use a moderately or highly effective method (Dehlendorf et al., 2014). Comparative lifetime pregnancy rates for U.S. women between the ages of 15 and 44 years are 2.7 for W/Cs and 4.6 for AA/B and H/L women. Health disparities exist between W/C and AA/B women. There is a higher incidence of low-birth-weight and small-for-gestational-age infants in AA/B mothers, especially with advanced maternal age (Collins, Rankin, & Hibbs, 2015). Infant mortality rates for AA/Bs have consistently been twice those of the overall population (USDHHS, Office of Minority Health 2016). As a group, AA/Bs are at increased risk for diabetes, lupus, HIV/AIDS, sickle cell anemia, hypertension, and cancer of the esophagus and the stomach (Purnell & Paulanka, 2013; Spector, 2014).

Core Values

AA/B families display resilience and adaptive coping strategies in their struggles with racism and poverty. They have a strong religious commitment, as observed in Southern Baptist, fundamentalist, and Black Muslim church communities, which helps to enhance their spiritual health and general well-being (Wehbe-Alamah, McFarland, Macklin, & Riggs, 2011). Fifty-one percent of AA/B families are headed by women, and more than 55% of all AA/B children younger than 3 years are born into single-parent families. AA/B families have extensive networks of extended families, friends, and neighbors who participate in child rearing with a high level of respect for elders. Children are highly valued, and as a result of extended family networks, the "mothering" a child receives comes from many sources. An example of this is the active role assumed by the maternal grandmother when an adolescent pregnancy occurs. Becoming a mother at a young age is acceptable. AA/Bs are demonstrative; comfortable with touch, physical contact, and emotional sharing; and have an orientation toward the present. AA/B women demonstrate great strength and matriarchal leadership, even in the face of devastating challenges such as being HIV-positive and mothering children who were also HIV-positive. Providing healthcare to this group may be complicated by folk practices, including the belief that all animate and inanimate objects have good or evil spirits. Healers may include family, a "Granny," or a spiritualist. Folk practices may also include pica (i.e., ingestion of nonfood items such as starch, clay, ashes, or plaster); use of herbal medicine; and wearing of garlic, amulets, and copper or silver bracelets (Spector, 2014).

Cultural Beliefs and Practices

Some AA/B may resent being called African Americans because this does not represent their origin. AA/B living in poverty may demonstrate a lack of respect or fear of public clinics and hospitals. They tend to seek prenatal care later than other women, usually after the first trimester. The incidence of breastfeeding is related to the level of maternal education and social support. AA/B women are more expressive of pain and are usually accompanied during labor and birth by female relatives. Most male newborns are circumcised.

Haitian women are less likely than other groups to seek prenatal care. During pregnancy, they believe they should not swallow their saliva and instead carry a spit cup with them. Fathers are less likely to be present during birth, believing it is an event only for women. Haitian women are encouraged by their community to breast-feed. However, some inaccurate beliefs, such as thick milk causing skin rashes and thin milk resulting in diarrhea, persist. During the postpartum period, women may believe that a series of three baths aids in their recovery. On the first 3 days, women bathe in a special water infused with herbs. For the next 3 days, women bathe in water in which leaves have been soaked and warmed by the sun. After 4 weeks,

a cold bath is taken that is believed to tighten muscles and bones loosened during the birth process. Women also believe that wearing a piece of linen or a belt tightly around the waist prevents the entry of gas into their body. Eating white foods such as milk, white lima beans, and lobster are avoided during the postpartum period because they are believed to increase vaginal discharge and hemorrhaging. Traditionally, Haitian women do not have their newborns circumcised because they believe circumcision decreases sexual satisfaction, but as acculturation occurs, this procedure is becoming more common. West Indian countries of origin are Trinidad, Jamaica, and Barbados. Traditionally, the father of the baby is not present during labor and birth.

Ghanian and other African childbearing women may believe in witchcraft and often access Western healthcare, ethnomedicine, and faith-based interventions simultaneously to ensure positive childbearing outcomes.

Ethiopian women are considered to be in a delicate state after birth. To be protected from disease and harm, they remain secluded for at least 40 days. A special diet that includes milk and warm foods such as gruel made of oats and honey is thought to increase breast milk production.

Somali refugee women are resistive to and fearful of cesarean births and most technologic perinatal interventions and are very afraid of dying in childbirth. As one woman said, "They get a C-section . . . they gonna die" (Brown, 2010, p. 220).

American Indian and Alaskan Native

Descendants of the original peoples of North America (including AI, Eskimo, and Aleut), this group constitutes 0.9% of the population. Alaska has one of the largest AI/AN population in the United States, with 14.8% reporting a sole racial heritage (Dillard & Olrun-Volkheimer, 2014). There are 500 federally recognized AI nations accessing healthcare from Indian Health Services and/or traditional healers.

AI/ANs have a higher unemployment and poverty rate than the general population. They average 9.6 years of formal education, the lowest rate of any major group in the United States. Urban AI/ANs have a much higher rate of low-birth-weight infants compared with urban W/Cs and rural AI/ANs and a higher rate of infant mortality than urban W/Cs (Raglan, Lannon, Jones, & Schulkin, 2015). Urban AI/ANs have a high incidence of risk factors associated with poor birth outcomes, including delayed prenatal care, single marital status, adolescent motherhood, and use of tobacco and alcohol. These risk factors resemble the prevalence among AA/ABs except for the higher incidence of alcohol use among AI/ANs. As a group, AI/ANs have an increased risk for alcoholism, heart disease, cirrhosis of the liver, and diabetes mellitus (Purmell & Paulanka, 2013; Spector, 2014).

Core Values

In general, AI/ANs have a strong spiritual foundation in their lives with a holistic focus on the circular wheel of life. It is important to live in complete harmony with nature. Values include oral traditions passed from generation to generation. Elders play a dominant role in decision making, and many AI/AN tribes are matrilineal (Palacios, Strickland, Chesla, Kennedy, & Portillo, 2014); involving maternal grandmothers in teaching young mothers is an important and culturally sensitive intervention. Because infant care may be multigenerational, Brooks, Holdtich-Davis, Docherty, and Theodorou (2016) note that visitation adjustment may be made when an AI/AN newborn is in the newborn intensive care unit.

AI/ANs are present-oriented, which may make it difficult to obtain an accurate health history because the past may be perceived as unrelated to current conditions. They believe in harmony. They may avoid eye contact and limit touch. Use of a formal interpreter increases the credibility of the healthcare provider because listening is highly valued.

Cultural Beliefs and Practices

During pregnancy, women avoid touching their hair. If an infant is born prematurely or expected to die, a family member may request to perform a ceremony that includes ritual washing of the hair. If hair is removed to initiate a scalp intravenous line on a newborn, some families want the hair returned to them.

The mother and newborn remain indoors resting for 20 days or until the umbilical cord falls off. The umbilical cord may be saved because some AI/ANs believe that it has spiritual significance. Patterns of infant care include group caregiving, living spiritually, merging the infant into Indian culture, using permissive discipline, and observing the child developing.

Asian American and Pacific Islander

AA/PIs are people with origins in the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. They constitute 3.6% of the population in the United States and are projected to make up 8.7% by 2050. There is great diversity in the 28 AA/PI groups designated in the census. Asians comprise 95% of this population and are divided into 17 groups, speaking 32 different primary languages, plus multiple dialects. Major groups of AAs include Chinese, Japanese, Koreans, Filipinos, Vietnamese, Cambodians, and Laotians. The major groups, Chinese and Japanese, are the most long-standing groups of Asian immigrants.

PIs comprise 5% of AA/PIs, with specific groups including Hawaiian, Samoan, Guamanian, Tongan,

Tahitian, North Marianas, and Fijian. There are more than 50 subgroups speaking at least 32 different languages. Approximately two thirds of Asians living in the United States are foreign-born. This group is culturally and linguistically heterogeneous. In the United States, AA/PIs are highly concentrated in the western states and in metropolitan areas.

There is a paucity of data on the health status of AA/PIs. Asian mothers have a 21% rate vaginal birth after cesarean (Cheng, Declercq, Belanooff, Iverson, & McCloskey, 2015). Because they are a small minority, AA/PIs are often overlooked in healthcare services planning and research. In relation to healthcare, AA/PIs comprise the most misunderstood, underrepresented, underreported, and understudied ethnic population. They are often mistakenly referred to as the healthy minority. Their educational attainment has a bimodal distribution, with 39% having college degrees and 5% assessed as functionally illiterate. They use primary and preventive care less often than non-Hispanic Whites. If they have limited English proficiency, barriers to healthcare include making an appointment, locating a health facility, communicating with healthcare providers, and acquiring health literacy. Post-traumatic stress syndrome is of concern in AA/PI refugee women, especially Hmong women, who may have suffered atrocities while living in their country of origin. Infant mortality rates are highest in Native Hawaiians (11.4/1,000 live births). As a group, AA/PIs are at increased risk of hypertension, liver cancer, stomach cancer, and lactose intolerance (Purnell & Paulanka, 2013; Spector, 2014).

Core Values

Values embody the philosophical traditions of Buddhism, Hinduism, and Christianity. They believe events are predestined and strive for a degree of spirituality in their lives. Core values include cohesive families, filial piety and respect for the elderly, respect for authority, interdependence and reciprocity (group orientation), interpersonal harmony, and avoidance of disagreement and conflict. Motherhood is often viewed in some AA/PI cultures as the central role for women. For example, a qualitative study of Indonesian women confirmed that being a mother was their ultimate destiny (Afiyanti & Solberg, 2015). One Hmong woman said that without children, "the whole family won't have joy . . . it looks [to others] like she isn't liked by her husband" (Corbett et al., 2017, p. 210). A Tongan mother explained, "Having children is a very important thing in our culture. That is how we grew up in the islands, you just keep going and having children" (Reed et al., 2017, p. 147).

Pride, fatalism, education/achievement orientation, respect for tradition, and a strong work ethic are also core values. Asians seldom express strong reactions to emotionally arousing events and are taught to suppress feelings to maintain harmonious relationships with others. They avoid public displays of affection, except among family and close friends, and have clearly defined gender roles.

Traditional therapies are often employed concurrently with Western medicine, including acupuncture, herbs, nutrition, and meditation (Callister, Eads, et al., 2011). Asian women may believe Western medicines are too strong and may halve the prescribed dosages. Chinese women avoid oral contraceptives because of a perception that hormones may be harmful. Screening exams such as cervical screening may be avoided because of modesty and discomfort with such intimate procedures.

Cultural Beliefs and Practices

Traditional Asian healthcare beliefs and practices are Chinese in origin, with the exception of Filipino beliefs and practices being based primarily on the Malaysian culture (Chin, Jaganathan, Hasmiza, & Wu, 2010). The yin/yang polarity is a major life force and focuses on the importance of balance for the maintenance of health. Yin represents cold, darkness, and wetness; yang represents heat, brightness, and dryness. For those who subscribe to the hot/cold theory (including Asians and Hispanics), health requires harmony between heat and cold. Balance should be maintained for women to be in harmony with the environment. During pregnancy, women eat "cold" foods such as poultry, fish, fruits, and vegetables. Eating "hot" foods, such as red peppers, spicy soups, red meat, garlic, ginger, onion, coffee, and sweets, at this time is believed to cause abortion or premature labor. A designation of "hot" or "cold" does not necessarily refer to physical temperature but the specific effects the food is believed to have on the body (Li, Hsu, Chen, & Shu, 2017).

Because pregnancy is a "hot" condition, some expectant mothers may be reluctant to take prenatal vitamins, which are considered a "hot" medication. Encouraging the woman to take her prenatal vitamins with fruit juice may resolve the problem. Some pregnant Asian women believe that iron hardens bones and makes birth more difficult, and these women resist taking vitamin preparations containing iron. Many Southeast Asian women believe that exposure of the genital area is inappropriate because this is considered a sacred part of the body. They may be reluctant to have Pap smears, wait to seek prenatal care, and communicate poorly about physical changes of pregnancy. Sexual intercourse is avoided during the third trimester because it is thought to thicken amniotic fluid, causing respiratory distress in the newborn.

Vaginal exams and an open hospital gown may be deeply humiliating and unnerving to Southeast Asian women who value humility and modesty. Giving birth is believed to deplete a woman's body of the "hot" element

(blood) and inner energy. This places her in a "cold" state for about 40 days after birth, which is assumed to be the period for the womb to heal. Rice, eggs, beef, tea, and chicken soup with garlic and black pepper are foods high in "hotness" and are eaten by postpartum women. During postpartum, pericare and hygiene are considered important, but women are discouraged from showering for several days to 2 to 4 weeks. They believe that exposure to water cools the body and interrupts balance, which may cause premature aging. Differences between cultural traditions and the Western healthcare delivery system may cause cultural tension. One woman said, "American hospital workers don't really understand Chinese traditional customs and what may be important to a Chinese mother" (Callister, Eads, et al., 2011). Another Chinese woman noted,

> [The nurses] don't really know or understand. They just aren't aware. Right after birth, I told them I wanted to keep myself warm and I wanted more blankets but they said I didn't need blankets. As Chinese we are more afraid of the cold but the [nurses] didn't seem to think so. (Callister, Eads, et al., 2011, p. 390)

Most AA/PI women breast-feed for several years. Women in the Hmong community (originally from Laos) may choose to formula feed, inaccurately believing American women do not breast-feed because they do not see this practice in public like they did in their homelands (Wambach & Riordan, 2016).

Korean mothers may believe that newborns need sleep and little stimulation. They are discouraged from touching the baby. Thus, they may not understand the amazing capabilities of the newborn to see, hear, and interact. Child rearing often occurs within the extended family. A newborn's head is considered sacred, the essence of his or her being. Touching the newborn's head is distressing to parents and should be avoided. Traditionally, newborns have not been circumcised, but as acculturation occurs, some AA/PIs have adopted this practice.

Cambodian women may avoid certain activities during pregnancy, such as standing in doorways, because they believe this will cause the baby to become stuck in the birth canal. Sexual intercourse is not permitted during the third trimester. It is thought that avoidance of sexual intercourse during pregnancy will produce a more attractive baby. Vernix caseosa is believed to be sperm. Cambodian woman will not be seen cuddling their newborns; instead, the newborn is held down and away from their body. Herbal medications are prepared during the third trimester to be eaten three to four times per day during the postpartum period to restore body heat. Along with eating special foods that are thought to restore lost heat, mothers wear heavy clothing during the postpartum period. Breastfeeding is delayed for several days because colostrum is thought to be harmful for the newborn.

Filipino women are discouraged from remaining in a dependent position late in pregnancy because sitting or standing may cause retention of fluid. Sexual intercourse is discouraged for the last 2 months. The women eat eggs, believing that slippery foods help the baby move through the birth canal more easily. Filipino women are accompanied during labor by a woman who has experienced birth herself.

Korean women avoid certain animal foods during pregnancy because they believe these foods can harm the newborn's character or appearance. It is believed that eating duck can cause the newborn to be born with webs between the fingers and that eating eggs causes the child to be born without a spine. Dairy products are not traditionally part of the Korean diet, so care should be taken to ensure women are receiving adequate amounts of calcium during pregnancy. In the Korean culture, the new mother is perceived as being sick and needing care. Postpartum Korean women do not easily participate in self-care activities or care for their newborn. The husband's mother is responsible for caring for the newborn and the recovery of her daughter-in-law. The need to return the hot element to the body postpartum is accomplished by eating seaweed soup made with beef broth and avoiding anything cold, such as ice. The soup is thought to increase breast milk production and rid the body of lochia. Korean women may refuse an ice pack for control of perineal edema because of the belief that coldness in any form may cause chronic illness such as arthritis. Women who breast-feed are reluctant to supplement with formula. Immigrant Korean mothers develop a distinct birth culture (Seo, Kim, & Dickerson, 2014).

Samoan women do not eat octopus or raw fish during pregnancy. Women supporting the laboring woman often gently massage her abdomen to relieve discomfort and determine the position of the baby. Postpartum, the abdomen may be bound and massaged by the midwife. Women do not carry the newborn after dark or stand in front of windows with the newborn at night. Most women choose to breast-feed, and it is customary to abstain from sexual intercourse while breast-feeding. Generally, male infants are circumcised.

Vietnamese women avoid sexual intercourse and keep warm during their pregnancy. Special hygiene practices include using salt water to wash their teeth and gums.

Chinese women focus on "doing the month" (*zuo yue zi*), with elaborate and specific restrictions for the first month following giving birth designed to promote the health and well-being of both mother and newborn (Saito & Lyndon, 2017). Sometimes, nurses assume that with acculturation and education, childbearing women will be less likely to practice traditional beliefs,

but many educated Chinese childbearing women do indeed "do the month" and value other cultural practices (Callister, Eads, et al., 2011). Comprehensive lists of Asian Indian perinatal cultural practices and traditions have been generated (Goyal, 2016; Wells & Dietsch, 2014).

Hispanic and Latino

H/L women have ethnic origins from countries where Spanish is the primary language, including Mexico, Puerto Rico, Cuba, Spain, and South or Central America. They constitute 1 out of 6 of the population in the United States and are the largest and fastest growing ethnic group (Centers for Disease Control and Prevention [CDC], 2015). Immigration is estimated at 1 million people per year, and census data does not include the significant number of undocumented H/Ls living and working in the United States. Spanish is the most common second language spoken in the United States. Sixty-seven percent of Hispanics are of Mexican origin. Assimilation is minimal, with strongly held cultural beliefs and behaviors. Traditional beliefs, values, and customs govern decision-making behaviors.

Significant increases in the H/L population are related to a natural increase (births over deaths) of 1.8%, high fertility rates, and immigration. It is estimated that by 2020, more than 13.8 million H/L women of childbearing age living in the United States (March of Dimes, 2014). Latino women are younger than non-H/L women at the age of first pregnancy. The fertility rate of H/L women is 84% higher than White women and 31% higher than Black women. Although H/Ls are the most likely group of women to have children, they are the least likely to initiate early prenatal care. In a phenomenologic study of H/L childbearing women, emerging themes demonstrated that these women experienced anguish (*la angustia*) related to uncertainty and lack of knowledge, which leads to a yearning (*el anhelo*) to be educated without losing their native identity (*identidad*) (Fitzgerald, Cronin, & Bocella, 2016). Another study identified the importance of the development of trust so that H/L mothers feel comfortable and confident (*confianza*) (Jones, 2015).

Forty-three percent of H/L births were to unmarried mothers, with adolescents accounting for a large percentage of those births. Two thirds of H/L births are to Mexican American mothers. Unintended pregnancies are more common among H/Ls compared with other ethnic groups, especially among women of low socioeconomic status.

Compared with women born in the United States, foreign-born H/L women are more likely to be economically disadvantaged and uninsured, factors usually associated with poor outcomes, and adjustments are made for maternal and healthcare factors (Ramos, Jurkowski, Gonzalez, & Lawrence, 2010). H/Ls make up over 21% of the uninsured population. With larger families and inadequate sources of income, more than 30% of H/L live below the poverty level.

Despite these factors, first-generation, or less acculturated, Mexican American women seem to have a perinatal advantage despite low levels of maternal education, low socioeconomic status, and less than adequate prenatal care. The infant mortality rate is lower in foreign-born Mexican-origin Latina women than those born to U.S.-born women (DeCamp, Choi, Fuentes-Afflick, & Sastry, 2015; Hessol & Fuentes-Afflick, 2014). Aspects of their culture that seem to protect them include nutritional intake, lower prevalence of smoking and alcohol consumption, extended family support, and spirituality and/or a religious lifestyle.

Immigrants usually favor Depo-Provera or Norplant rather than oral contraceptives for family planning, and there is a shift toward less patriarchal control of family planning. Use of the term *well woman visit* is more appropriate than *family planning visit* when scheduling an appointment. Because there may be much distress and embarrassment about touching and inserting fingers into the vagina, diaphragms are not a good choice as a family planning method. H/Ls may not perceive the need for routine checkups such as Pap smears.

Cesarean birth rates in the border region have increased to 31.6% among U.S. Hispanics and to 27.9% among Hispanics living in the United States border region (McDonald, Mojarro Davilla, Sutton, & Ventura, 2015). H/Ls are at higher risk for diabetes (twice that in W/Cs—9.8% vs. 5%) (National Diabetes Information Clearinghouse, 2015), obesity, parasitic disease, and lactose intolerance (Spector, 2014). H/Ls are not a homogenous group, with significant variations between Puerto Rican, Mexican, Peruvian, Chilean, and other H/Ls.

Core Values

In the H/L community, there are strong family ties, large and cohesive kin groups, and a family decision-making process. It is believed that the family has a meditating effect on stress and depression. Family values include pride and self-reliance, dignity, trust, intimacy, and respect for older family members and authority figures. H/L women usually consult their husbands, significant others, or other important family members such as godparents about major health decisions. *Curanderismo* or folk medicine is frequently used. Mexican Americans may seek the services of folk healers such as herbalists, bone and muscle therapists,

and midwives. These practitioners are more prevalent in border towns and may be used there as an adjunct to the established healthcare systems. An emerging group of healthcare providers are bilingual nurse-*curanderas*. Culturally appropriate interventions such as the Hispanic Labor Friends Initiative and *Familias Sanas* are proving helpful for disadvantaged Hispanic childbearing women.

Cultural Beliefs and Practices

Pregnancy is an important family event engendering extensive physical and emotional support from family members. Motherhood is viewed as the most important role a woman can achieve. Most H/L babies are wanted, cherished, and pampered, thought to be untouched by sin and evil.

H/Ls have a present orientation. This orientation affects how prenatal care is accessed. Women are frequently late for or miss prenatal appointments and may not understand how high-risk behaviors affect maternal and fetal/neonatal well-being. H/Ls have a sense of fatalism, believing that their destiny is controlled by fate or by the will of God. Hispanic women may seek early prenatal care as unnecessary because pregnancy outcomes are beyond personal control. This sense of fatalism can also promote a sense of vulnerability and lack of control. They expect *personalism* and *respecto* from healthcare providers. During pregnancy, women maintain healthy diets and exercise, and they may take herbs and drink teas recommended by herbalists. Certain folk traditions are thought to prevent birth defects. A safety pin attached to an undergarment helps protect the fetus from a cleft lip or palate. If a pregnant Guatemalan woman sees an eclipse (or a "bite" taken out of the moon), her unborn child may have a bite taken out of the mouth, resulting in a cleft lip or palate.

Some H/L women believe that unsatisfied cravings cause defects or injury to the fetus. For example, a strawberry nevus is believed to occur because the pregnant woman had an unsatisfied craving for strawberries during her pregnancy. Vitamins and iron are avoided by some women during pregnancy because they are thought to be harmful. Women believe that walking during labor makes birth occur more quickly and that inactivity decreases the amount of amniotic fluid and causes the fetus to stick to the uterus, delaying the birth. Many Hispanic women prefer not to have epidural analgesia/anesthesia. Cesarean birth may be feared and viewed as life-threatening for the mother. Immigrant Hispanic women giving birth may exhibit "cultural passivity," demonstrating stoicism during labor and birth and deferring to healthcare providers for any decision making.

During postpartum, women are discouraged from taking a shower for several days. Belief in the "evil eye" means that a fixed stare from a person believed to be envious may result in illness. *La manita de azabache*, a black onyx hand, may be placed on or near the newborn to ward off the envious evil eye. An H/L mother may assume that a nurse who overly praises her newborn or is perceived as staring at the child can cause the child to cry excessively and be very restless. H/L women view colostrum as bad or old milk and may delay breastfeeding until several days after the birth (Wambach & Riordan, 2016). Avoiding foods such as chilies and beans is thought to protect the newborn from illness. In the early postpartum period, the maternal–newborn dyad is considered *muy delicados* (vulnerable or delicate) and stays at home for 7 to 15 days, and for some, up to 40 days postpartum (Spector, 2014). H/L women experiencing symptoms of postpartum depression may not seek mental health services because of the stigma attached to doing so (Callister, Beckstrand, et al., 2010). Traditionally, circumcision has not been practiced, but as acculturation occurs, this practice is becoming more acceptable. Some H/L families may want to keep and bury the placenta. Guidelines for providing culturally competent care for H/L families have been developed (Sobel & Metzler Sawin, 2016; USDHHS, Health Resources and Services Administration, 2016).

White or Caucasian

W/Cs have origins in Europe, North Africa, or the Middle East and constitute 83% of the population of the United States. There are 53 ethnic groups classified as W/C living in the United States. In many ways, W/Cs are perceived as being privileged. For example, there are substantial differences in sources of prenatal care, with 78% of W/C women receiving private care W/C childbearing women had the lowest rate of vaginal births after cesarean than other racial/ethnic groups (Cheng et al., 2015). However, it should be noted that despite this perception, the median income of non-Hispanic White households declined by 1.7% between 2013 and 2014 with no significant changes in other racial or ethnic groups (USCB, 2015).

W/C is generally acknowledged to be the dominant culture. This cultural group seems intent on achieving accomplishments quickly, contributing to a high-energy, high-stress lifestyle, compared with other cultural groups that have more peaceful ways of life. Predominant belief systems accept the Western biotechnologic model of healthcare, including elective inductions, elective cesarean births, and assisted reproductive technology. Women in this group are more likely to embrace such practices, but paradoxically, like women in other cultural groups, most childbearing women want nurturing, supportive, and meaningful care (Callister & Khalaf, 2010).

Core Values

Core values include individualism, self-reliance, personal achievement and independence, democratic ideals and egalitarianism, work and productivity, materialism, punctuality, and future time orientation as well as openness, assertiveness, and directness in communication.

Immigrant and Refugee Women

Increasingly, the United States is becoming a global village. Immigrant women are coping with tremendous cultural differences and issues related to making transitions that may be extremely stressful (Missal, Clark, & Kovaleva, 2016). In addition to multiple challenges such as fear and isolation among childbearing women (Benza & Liamputtong, 2014), many demonstrate great resiliency and strength (deChesnay et al., 2016). Immigrant and refugee women may embrace distinct culture practices such as Somali and Pakistani mothers (Hill, Hunt, & Hyrkäs, 2012; Qureshi & Pacquiao, 2013). Immigrant and refugee women are very heterogeneous.

Currently, there are unprecedented challenges in immigration policies and there a global refugee crisis exists, with the vulnerable fleeing violence or persecution (https://www.refinery29.com/2015/09/93814/refugee-crisis-ways-to-help). Under the United States Resettlement Programs admits refugees from 79 countries, with over 70% coming from the Democratic Republic of the Congo, Syria, Burma, Iraq, and Somalia. Nearly 60,000 refugees come to the United States annually (CDC, 2014). Over 72% of refugees are women and children (United States Department of State Bureau of Population, Refugees, and Migration, 2017). Strategies have been identified to assist vulnerable refugee childbearing families (Callister, 2016).

Cultural Beliefs and Practices

As first-generation, less acculturated Americans, these women have stronger ties to cultural traditions and customs than second- or third-generation Americans. For instance, they may have given birth previously in their home attended by a traditional midwife and their mother or mother-in-law. In a phenomenologic study of Arab migrant women giving birth in the United Kingdom, the overriding theme was "displacement and reformation of self" (Bawadi & Ahmad, 2017, p. 101).

The biomedical and highly technologic environment of birthing units in the United States may be foreign and frightening (Winn, Hetherington, & Tough, 2017). There may be a deep sadness for these mothers as they give birth without the assistance of their own mothers. One Mexican immigrant mother explained her feelings, "When I had my baby I felt like crying. I called for my mother but she could not come to help. My mother was here in my heart because she could not come" (Callister, Beckstrand, & Corbett, 2011). Some immigrants and refugees are migrant farm workers, living in unsanitary, unsafe, and crowded conditions. Language, illiteracy, and cultural barriers have a negative impact on access to healthcare.

Cultural beliefs, such as the belief among some African immigrants that condoms may lodge in the abdominal cavity and result in obstruction, infection, or cancer, also represent a significant challenge. Another cultural challenge is the resistance of Cambodian refugees to utilize contraception. Beliefs about gender inequalities and intimate partner violence compromise the health of immigrant childbearing women. Some may be at risk for perinatal depression (Callister, Beckstrand, et al., 2011), and immigrant status may be a deterrent to seeking mental health services (Shellman, Beckstrand, Callister, Luthy, & Freeborn, 2014).

There are multiple barriers to Pap screening use among immigrant women. Among African immigrant women, these barriers include lack of knowledge about screening, cost, cultural beliefs such as modesty and privacy, fear, and communication issues (Adegboyega & Hatcher, 2017). For example, one woman felt her religious beliefs were protecting her, "Before I heard about all these cancers, who was taking care of me? It was God and He is still living. I believe God is still taking care of me" (Adegboyega & Hatcher, 2017, p. 482). Provider sensitivity, family support, and education may help to improve Pap screening use among immigrant women.

It is estimated that by 2025, there will be at least 15 million American Muslims, many of whom will be immigrants or refugees. Their beliefs include *shadadah* (monotheism), *salat* (prayer five times daily), *zakat* (purification), *sawm* (fasting during Ramadan), and *hajj* (a pilgrimage to Mecca). Islamic concepts include these five teachings, along with modesty, visiting the ill, and dietary and gender restrictions. The bride's status in the family is uncertain until she has proven fertility with the birth of her first child, and sons are highly valued. Seeking prenatal care is not considered important unless there are complications. Predictors of delayed healthcare seeking in Muslim women have been identified (Vu, Azmat, Radejko, & Padela, 2016). Childbirth education classes may be considered by H/L childbearing women to be excessive planning that may negatively affect the outcomes of pregnancy.

As conservators of family health, the role of immigrant women in health promotion is critical. Refugees are eligible for special refugee medical assistance during their first 18 months in the United States. After this initial coverage, those who cannot afford private health insurance and are ineligible for Medicaid benefits may become medically indigent. Limitations in literacy and language make it difficult to enter the healthcare system. Feelings of fear and paranoia create

circumstances where these women are unwilling to access care. Like other childbearing women, immigrant women appreciate supportive and respectful care (Sheng, Le, & Perry, 2010).

It is interesting to note that foreign-born Chinese women have more positive perinatal outcomes, including fewer low-birth-weight or small-for-gestational-age newborns, or preterm birth. Immigrant women may be more susceptible to helminthic diseases, including tapeworm, roundworm, and hookworm, because these are endemic in Asia. Eighty percent of the 5 million women of childbearing age who are HIV-positive are from sub-Saharan Africa, with 90% of HIV cases in this area transmitted through heterosexual contact.

Ritually Circumcised Women

It is estimated that at least 130 million women throughout the world have been ritually circumcised. Immigrants and refugee women from developing countries in Asia (including Malaysia, India, Yemen, and Oman) and 28 African countries may have experienced female genital mutilation. Among Somali women, more than 98% of the women have experienced female circumcision/female genital mutilation. Egypt has the highest incidence worldwide (Little, 2015). Genital mutilation may occur at any point between the newborn period and the time a woman gives birth to her first child. These women experience severe pain and complications during childbirth because the inadequate vaginal opening and scarring may prevent cervical dilatation and fetal passage. After giving birth in their native countries, some women experience reinfibulation (i.e., suturing together of the labia). Because female circumcision is a culturally bound rite of passage, women may resent Western attitudes about this practice, which has strong social and cultural support but is illegal in the United States. Perinatal nurses need to create an environment of trust, establish rapport with male family members, ensure privacy, and be sensitive to the stoicism demonstrated toward childbirth pain. Cultural repatterning may occur with the acceptance of alternatives such as flattening of the clitoris and symbolic cutting of the pubic hair.

Deeply Religious Women

Many religious and spiritual beliefs and practices influence childbearing (Callister & Khalaf, 2010). Orthodox Jews have a rich body of traditions associated with childbearing and great reverence for childbearing and child rearing. Some Jewish women feel a moral responsibility to bring at least two children into the world because of the destruction of their progenitors during the Holocaust. Circumcision is a Jewish ritual based on a Hebrew covenant in the Old Testament of the Bible (Genesis 7:10–14) performed on all male children by a mohel on the eighth day of life.

For Islamic women, creating an environment that honors traditional practices according to the precepts of Islam is important. Islamic women practice a cleansing process at the end of each menstrual period, and modesty is very important, which has an influence on cervical cancer prevention (Guimond & Salman, 2013). Palestinian refugee women feel a strong obligation to bear a significant number of children, especially sons, to continue the generations of the Arabic bloodline. A woman espousing the beliefs of the Church of Jesus Christ of Latter-day Saints (Mormon) may request her husband to lay his hands on her head and give her a blessing for strength, comfort, and well-being as she labors and gives birth. Mexican American women often speak in terms of a person's soul or spirit (*alma* or *espiritu*) when referring to one's inner qualities. Among Canadian aboriginal women, an elder provides one-on-one education about spiritual beliefs, including the role of the creator in conception, the valuing of life, and the blessings of motherhood (Di Lallo, 2014).

The sacred day of worship varies. Sunday is the Sabbath for most Christians. The Muslim's holy day is sunset Thursday to sunset Friday. Jews and Seventh Day Adventists celebrate the Sabbath from sunset on Friday to sunset on Saturday. For an Orthodox Jewish woman, honoring the Sabbath may mean not raising the head of the bed to breast-feed and not turning on the call light to request assistance because in the Orthodox culture, these acts would constitute work. Table 2–1 provides common religious dietary prohibitions.

TABLE 2–1. Religious Dietary Prohibitions

Religion	Dietary prohibitions
Hinduism	All meats are prohibited.
Islam	Pork and alcoholic beverages are prohibited.
Judaism	Pork, predatory fowl, shellfish, and blood by ingestion (e.g., blood sausage, raw meat) are prohibited. Foods should be kosher (i.e., properly prepared). All animals should be ritually slaughtered to be kosher. Mixing dairy and meat dishes at the same meal is prohibited.
Mormonism (Church of Jesus Christ of Latter-day Saints)	Alcohol, tobacco, coffee, and tea are prohibited.
Seventh-day Adventists	Pork, certain seafood (including shellfish), and fermented beverages are prohibited. A vegetarian diet is encouraged.

There is a strong relationship between health status and spiritual well-being. Religiosity and a spiritual lifestyle have been found to be the source of powerful strength during childbearing, especially when complications such as fetal or neonatal demise occur. For example, in a study of the lived experience of Jordanian Muslim women having a critically ill neonate, such experiences are considered a test of faith, qualified by the phrase *inshallah* or "as God wills" (Obeidat & Callister, 2011). Spiritual beliefs and religious affiliations may represent effective coping mechanisms and act as sources of support.

HEALTH DIFFERENCES IN POPULATIONS OF CHILDBEARING WOMEN

There is a paucity of research identifying health differences among minority groups and the prevalence of illness among specific populations of childbearing women. As far as body structure is concerned, AA/PIs typically have small-for-gestational-age neonates. Birth weight is lower in AA/B newborns, but size for size, they are more mature for gestational age. AA/B newborns have a mean 9 days' shorter gestation period than other ethnic groups, and there is a slowing of intrauterine growth in Black infants after 35 weeks' gestation. Infants born to AA/B women are 1.5 to 3 times more likely to die than other infants (CDC, 2013). Mongolian spots are commonly found in AA/B, AA/PI, AI/AN, and H/L infants.

In addition to physical differences, cultural practices may be misinterpreted during an initial examination. Dermal practices among Southeast Asian refugees may be noticed and assumed to be a sign of physical abuse. An example of a cultural practice that may be misinterpreted is "cupping." In this practice, a cup is heated and placed on the skin, leaving a circular ecchymotic area. Pinching and rubbing may produce bruises or welts. Rubbing the skin with a spoon or coin produces dermal changes. Touching a burning cigarette to the skin may also represent cultural self-care (Spector, 2014).

Chemical substances, including pharmaceuticals, are metabolized differently among groups. Ethnopharmacologic research is a growing and important specialty. It is essential that as part of a cultural assessment, specific questions are asked about the presence or absence of potentially adverse effects of medication. It may be possible in some instances to reduce dosages in culturally diverse women.

There is an increasing incidence of alcoholism among H/Ls and AA/Bs, whereas Asians have the lowest rates of alcoholism. Most Asians and AI/ANs experience a rapid onset but slow decrease in blood acetaldehyde levels, leaving long periods of exposure to substances that cause alcohol intoxication. Fetal alcohol syndrome, or its effect, is highest among AI/ANs. Caffeine is metabolized and excreted faster by W/Cs than Asians. The incidence of lactose intolerance is 94% in AA/PIs, 90% in AA/Bs, 79% in AI/ANs, 50% in H/Ls, and 17% in W/Cs. This can have a negative effect on breastfeeding because infants may be lactose intolerant as well.

The Rh negative factor, common in Caucasians, is rare in other groups (especially Asians) and essentially absent in Eskimos. There is a high incidence of diabetes in AI tribes, whereas the disease is rare in Alaskan Eskimos. The prevalence of insulin-dependent diabetes mellitus is highest among AA/Bs. Gestational diabetes mellitus occurs in 20% of pregnant women and is not attributed specifically to race or culture.

Communicable diseases that threaten foreign-born and new immigrants, particularly those from China, Korea, the Philippines, Southeast Asia, and the Pacific, are tuberculosis (TB) and hepatitis B. Half of the women who give birth to hepatitis B–carrier infants in the United States are foreign-born Asian women. There is a significantly higher incidence of TB in AI/ANs and foreign-born AA/PIs, and the incidence of TB is 4 times higher among Asians than the overall population. AA/PI and AI/AN women diagnosed with TB tend to be of childbearing age (CDC, 2013).

There is a higher incidence of hypertension in AA/Bs and H/Ls. The incidence of lupus is 4 times higher in AA/B women and is twice as prevalent in H/L women when compared to W/C women. Native Hawaiian and Samoan women are reported to have the highest obesity rates in the world, although maternal obesity is increasing at an alarming rate in the developed world in many populations including low-income women (Chang et al., 2015).

Sickle cell anemia occurs predominately in AA/Bs. Tay-Sachs disease is predominately found in Hasidic Jews of Eastern European descent, particularly Ashkenazi and Sephardi women. Recent advancements in genetic screening among this population are promising (Ferreira et al., 2014). Thalassemia is a genetic blood disorder found in women from the Mediterranean region, the Middle East, and Southeast Asia.

Researchers have also documented racial disparities in complications of pregnancy and childbirth. AA/B women were more likely to have 10 of 11 maternal perinatal complications than W/C women, including preterm labor and premature rupture of membranes (PROM), hypertensive disorders, diabetes, placenta previa (PP) and abruption, infection of the amniotic cavity (IAC), and cesarean birth. H/L women were at a higher risk than White women for diabetes, PP, PROM, IAC, and postpartum hemorrhage. In a recent study of the relationship between race, inflammation, and psychosocial factors in childbearing women, results

suggest that chronic anxiety among AA/B women may contribute to preterm birth because of an impaired inflammatory response (Catov, Flint, Lee, Roberts, & Abatemarco, 2015).

BARRIERS TO CULTURALLY COMPETENT CARE

Culturally competent care is more than a nicety: It is essential in the delivery of quality and safe care to childbearing women and their families. The new nursing scope and standards of clinical practice, specifically Standard 8, focuses on the importance of culturally competent nursing care, practicing "in a manner that is congruent with cultural diversity and inclusion principles" (American Nurses Association, 2016). Barriers to culturally competent care include values, beliefs, and customs; communication challenges; and the biomedical healthcare environment.

Differences in Values, Beliefs, and Customs

Ethnocentrism is the belief that one's ways are the only way. *Cultural imposition* is the tendency to thrust one's beliefs, values, and patterns of behaviors on another culture. Characteristics of caregivers that influence their ability to be culturally competent include educational level, multicultural exposure, personal attitudes and values, and professional experiences. Identifying and understanding the childbearing woman's attitudes, behaviors, values, and needs assists the perinatal nurse in identifying interventions that are culturally appropriate; are acceptable to healthcare providers, the women, and their families; have the potential to increase adherence to therapeutic regimens; and will over time result in constructive changes in perinatal healthcare delivery.

Cross, Brazon, Dennis, and Isaacs (1989) originally developed the cultural competence continuum, which moves incrementally across six stages: destructiveness, incapacity, blindness, precompetence, competence, and proficiency. Nurses demonstrate various levels of commitment when caring for culturally diverse women on a continuum from resistant care to generalist care to impassioned care. Nurses who are resistant judge behaviors, ignore client needs, and complain. Resistant nurses may ignore or resent culturally diverse women and their families. They may see culture as an inconvenience or problem. Nurses who provide generalist care are respectful and competent but do not differentiate cultural diversities. Culture, to them, is a nonissue. They may empathize with client experiences but don't feel empowered to bring about substantial change. Racist attitudes of colleagues are tolerated. Nurses who provide impassioned care have a high degree of personal commitment to provide culturally sensitive care. These nurses go beyond accommodation to an appreciation of cultural diversity. They are aware of the complexities of cultural competence and the variability of expressions within cultural groups. Creativity and flexibility are the hallmarks of the care they provide to culturally diverse clients. They feel empowered to make a difference through their clinical practice. Display 2–4 provides the characteristics of the culturally competent nurse. It is important for nurses to become culturally aware as the nurse becomes increasingly sensitive to multiple cultures in order to minimize health inequities (Horvat, Horey, Romios, & Kis-Rigo, 2014). Cultural knowledge involves gaining knowledge of the worldviews of others. Development of assessment skills to understand the values, beliefs, and practices of others means engaging in cross-cultural interactions rather than avoiding them.

It is essential that the nurse examines his or her own cultural beliefs, biases, attitudes, stereotypes, and prejudice and asks, "Whose birth is it anyway?"

DISPLAY 2–4

Characteristics of the Culturally Competent Nurse

- Moves from cultural unawareness to an awareness and sensitivity to his or her own cultural heritage
- Recognizes his or her own values and biases and are aware of how they may affect clients from other cultures
- Demonstrates comfort with cultural differences that exist between himself or herself and clients
- Knows specifics about the particular cultural groups he or she works with
- Understands the significance of historic events and sociocultural context for specific cultural groups
- Respects and is aware of the unique needs of specific women
- Understands the diversity that exists within and between cultures
- Endeavors to learn more about cultural communities through interactions with diverse women, participation in cultural diversity workshops and community events, readings on cultural dynamics, and consultations with community experts
- Makes a continuous effort to understand others' points of view
- Demonstrates flexibility and tolerance of ambiguity and is nonjudgmental
- Maintains a sense of humor
- Demonstrates willingness to relinquish control in clinical encounters, to risk failure, and to look within for sources of frustration, anger, and resistance
- Promotes cultural practices that are potentially helpful, tolerates cultural practices that are harmless or neutral, and works to educate women to avoid cultural practices that may be potentially harmful

The following story is told by Khazoyan and Anderson (1994, p. 226):

> Señor Rojas sat at the bedside of his laboring wife, held her hand, and spoke soft, encouraging words to her. This was the kind of support that she desired during her labor: his presence, his attention, and his affection. Following the birth of their child, Señora Rojas expressed contentment and proudly described the support that her husband had provided. He had met her expectations. The nurses, however, expected more. They had wanted Señor Rojas to participate more actively in his wife's labor by massaging her back and assisting her with breathing techniques.

Communication

Communication barriers include lack of knowledge, fear and distrust, racism, bias and ethnocentrism, stereotyping, nursing rituals, and language barriers (Ebanks et al., 2010). Communication (or lack of communication) between cultures occurs whenever a message produced in one culture must be processed into another culture. A study of African American expectant mothers concluded that high-quality patient–provider communication improved their experience with prenatal care (Dahlem, Villarruel, & Ronis, 2015).

A significant barrier to culturally competent care is language and the lack of bilingual personnel and staff with culturally diverse backgrounds (Koh, Gracia, & Alvarez, 2014). Hospitals frequently enlist nonprofessional employees of the client's ethnic background to act as interpreters. These individuals are often unfamiliar with English medical terminology and may not be able to translate accurately. Interpreters who are members of the client's cultural group may be of a different social class than the client or may be more acculturated and anxious to appear part of the dominant culture. In some cases, interpreters may be disdainful or dismissive of the client's belief system. Using children or other family members to interpret may also lead to problems. Interpretation may be based on the perceptions of the interpreter as to what is best to communicate, and they often may omit important information. According to the USDHHS, Office of Minority Health's (2016) *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, interpreters should be provided by the healthcare facility (Display 2–5). The standards for culturally and linguistically appropriate services are described in Display 2–6. Interpreters may need the help of the nursing staff to feel comfortable and effectively provide services to the non–English-speaking patient. Guidelines for perinatal nursing staff as they work with a medical interpreter are reviewed in Display 2–7.

Healthcare Environment

This barrier includes bureaucracy (such as the inability of the dietary department to provide culturally appropriate foods), nonsupportive administration, lack of educational opportunities to promote cultural diversity, lack of translators, and rigid policies and protocols that do not support cultural diversity. Maternal child healthcare may be the first encounter immigrant women have with healthcare delivery systems in the United States. Consider how difficult it is for the woman who may be living in the United States without the support of extended family (especially female family members), speaking little or no English, having a limited understanding of the dominant culture, having little education, and working in a low-skills-level job without benefits. When this woman arrives at the birthing unit, the unfamiliar environment and procedures serve only to increase her stress. Being hospitalized means entering a new and foreign culture with a high level of technology, the necessity of conforming to unit policies and procedures and unfamiliar schedules, having one's privacy invaded, and behaving as a "patient." This may be very challenging for women.

Another issue is our birth language, which may not reflect how women feel about having a baby. For example, use of the term *delivery* versus *birth* diminishes what the woman's role really is, devaluing her accomplishment as a mother and de-emphasizing the important cultural and spiritual context of giving birth. The woman is not passively "delivered" by the omnipotent caregiver; she should be the central figure actively giving birth. Similarly, rather than "cesarean section," the focus should be on the woman giving birth rather than focusing on a surgical procedure, using the language "cesarean birth." These small but significant linguistic differences are important in the demonstration of respect.

DISPLAY 2–5
Standards for Medical Interpreters

- Confidentiality
- Accuracy: conveying the content and spirit of what is said
- Completeness: conveying everything that is said
- Conveying cultural frameworks
- Nonjudgmental attitude about the content to be interpreted
- Client self-determination
- Attitude toward clients
- Acceptance of assignments
- Compensation
- Self-evaluation
- Ethical violations
- Professionalism

From Commonwealth Fund. (2005). *National standards for medical interpreters.*

DISPLAY 2–6

Standards for Culturally and Linguistically Appropriate Services (CLAS)

Standard 1. Healthcare organizations should ensure that the patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Healthcare organizations should ensure that staff at all levels and across all disciplines provide culturally competent care.

Standard 4. Healthcare organizations must offer and provide language assistance services, at no cost, to each patient/consumer with limited English proficiency at all points of contact in a timely manner during all hours of operation.

Standard 5. Healthcare organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Healthcare organizations must ensure the competence of language assistance provided to limited English-proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except at the request of the patient/consumer).

Standard 7. Healthcare organizations must make available easily understood patient-related materials and post signage in the language of the commonly encountered group or groups represented in the service area.

Standard 8. Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, and operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Healthcare organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcome-based evaluations.

Standard 10. Healthcare organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Healthcare organizations should maintain a current demographic, cultural, and epidemiologic profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Healthcare should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, presenting, and resolving cross-cultural conflict or complaints by patients/consumers.

Standard 14. Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

From U.S. Department of Health and Human Services, Office of Minority Health. (2017). *Cultural competency.* Retrieved from https://www.minorityhealth.hhs.gov/

TECHNIQUES TO INTEGRATE CULTURE INTO NURSING CARE

Understanding the cultural context in which patients live is important to fully appreciate their response to illness and is necessary for planning appropriate nursing and medical interventions. It is essential that culturally competent care be integrated into all standards of practice (Betancourt, Corbett, & Bondaryk, 2014; Douglas et al., 2014). Becoming culturally competent is a developmental process. In a recent study of cultural competence in obstetric and neonatal nurses, diversity training, the following variables were positively correlated with cultural competence: perceptions of cultural competence and years of practice in the specialty area (Heitzler, 2017). Neonatal intensive care nurses spoke of sometimes "fragile interactions" with cultural diverse families of vulnerable newborns. The importance of honoring diversity is essential in such settings (Hendson, Reis, & Nicholas, 2015).

Nurses who shared their experiences of caring for non–English-speaking patients identified the importance of an increased awareness of patient needs, professional development including more knowledge about other cultures, and more time and resources (Ian, Nakamura-Florez, & Lee, 2016). As nurses become more sensitive to the issues surrounding healthcare and the traditional health beliefs of the women they care for, more culturally competent healthcare will be provided. Examples of ways that perinatal nursing units might become more culturally competent are described in Display 2–8. Cooper, Grywalski, Lamp, Newhouse,

DISPLAY 2–7
Guidelines for Working with a Medical Interpreter

- Orient the interpreter.
- Request a female interpreter the approximate age of the woman.
- Be prepared prior to the interpreter coming and try to communicate with the woman prior to the interpreter arriving.
- Ask the interpreter the best way to approach sensitive issues such as sexuality or perinatal loss.
- Face the woman and direct your questions to the woman rather than the interpreter.
- Ask about one problem at a time, using concise questions and phrases.
- Look for nonverbal cues.
- After the interaction, review the woman's answers with the interpreter.

From Ebanks, R. L., McFarland, M. R., Mixer, S. J., Munoz, C., Pacquiao, D. F., & Wenger, A. F. Z. (2010). Cross cultural communication. *Journal of Transcultural Nursing, 21*(4 Suppl.), 137S–150S. doi:10.1177/104365961037432

and Studlien (2007) have described a program in their hospital to increase the cultural competence of nurses.

When the cultural expectations of the nurse and the woman conflict, both are left feeling frustrated and misunderstood. The woman's adherence to traditional practices may be seen as strange and backward to the nurse, who responds by trying to "fit" the woman into the biotechnologic Western system. For example, an AI/AN mother may avoid eye contact and fail to ask questions or breast-feed in the presence of the mother–baby nurse. For many women, including Southeast Asian women, there is "loss of face" because they feel

DISPLAY 2–8
Changing Institutional Forces to Facilitate Culturally Competent Care

- Changing birthing room policies and unit protocols to promote individualized and family-centered care
- Lobbying for increased resources such as translation services and cultural mediators
- Designing continuing education opportunities to increase cultural competence
- Hiring a nursing staff reflecting the culture of the community
- Generating a pool of volunteer translators who meet women prenatally and follow them through their births and the postpartum period
- Increasing the availability of language line services
- Developing innovative programs addressing the unique needs of culturally diverse populations and integrating community and acute care services for childbearing women and their families

DISPLAY 2–9
Cultural Assessment of the Childbearing Woman

- How is childbearing valued?
- Is childbearing viewed as a normal physiologic process, a wellness experience, a time of vulnerability and risk, or a state of illness?
- Are there dietary, nutritional, pharmacologic, and activity prescribed practices?
- Is birth a private intimate experience or a societal event?
- How is childbirth pain managed, and what maternal and paternal behaviors are appropriate?
- What support is given during pregnancy, childbirth, and beyond, and who appropriately gives that support?
- How is the newborn viewed, what are the patterns regarding care of the infant, and what are the relationships within the nuclear and extended families?
- What maternal precautions or restrictions are necessary during childbearing?
- What does the childbearing experience mean to the woman?

From Callister, L. C. (1995). Cultural meanings of childbirth. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 24*(4), 327–331. doi:10.1111/j.1552-6909.1995.tb02484.x

responsible for any confusion or cultural conflict with the nurse, who is perceived as a social superior. This experience may discourage them from future contact with healthcare professionals. Assessment information should be accessed, including place of birth, how long the woman has lived in the United States, ethnic affiliation and the strength of that affiliation including ethnic communities, personal support systems, language and literacy, style of communication, religious practices, dietary practices, and socioeconomic status. Display 2–9 provides the components of a cultural assessment of the childbearing woman.

Enhancing Communication Skills

Display 2–10 contains suggestions for communicating effectively with childbearing women and their families. It is important to remember that effective communication requires a sincere desire to understand the other person's way of behaving and seeing the world. This allows for cultural reciprocity, when a woman feels that she has permission to share her cultural needs, concerns, and feelings. Respect and sensitivity characterize this kind of relationship. A perinatal nurse described the following experience:

> I cared for a Mexican-American woman in maternal/fetal testing. I was able to help her out by being her translator. Modesty was a big issue with her, and she was extremely uncomfortable with undoing her pants and showing her abdomen for the procedure. I felt that there was a unique

DISPLAY 2–10

Culturally Competent Communication

- Enhance communication skills (greet respectfully, establish rapport, demonstrate empathy, listen actively, provide appropriate feedback, demonstrate interest).
- Develop linguistic skills.
- Determine who the family decision makers are.
- Understand that agreement does not indicate comprehension.
- Use nonverbal communication.
- Use appropriate names and titles.
- Use culturally appropriate teaching techniques.
- Provide for sufficient time.

From Callister, L. C. (2016). *Developing and assessing culturally appropriate health education for childbearing women.* White Plains, NY: March of Dimes Foundation; Ebanks, R. L., McFarland, M. R., Mixer, S. J., Munoz, C., Pacquiao, D. F., & Wenger, A. F. Z. (2010). Cross cultural communication. *Journal of Transcultural Nursing, 21*(4 Suppl.), 137S–150S. doi:10.1177/104365961037432

> bond and friendship that was created because of my understanding and sensitivity to her cultural values. It makes all the difference to the woman if she is able to communicate with you and you can convey that you really care.

Be considerate, be polite, and speak softly. Caring behaviors and personal attention from healthcare providers are important to individuals of all cultures. Spend a few minutes talking to the woman and her family as she is admitted to the birthing unit to build rapport. Just a greeting and knowing a few of the social words in the woman's language and use of culturally specific etiquette helps to establish rapport. It is essential to understand cultural communication patterns. For example, Native Americans may maintain silence and not interrupt others. Hispanics appreciate interactions that begin with personal conversation or small talk, which serves to promote trust. Informed consent should be obtained within the framework of culturally congruent care (Marrone, 2016).

Developing Linguistic Skills

Learning a second language is an excellent way to lower cultural barriers. A labor and delivery nurse described her experience caring for a Mexican immigrant woman:

> When I stepped into the room and began to speak in my high-school-level Spanish, her face brightened and she quickly responded in a rapid flow of unintelligible (to me) foreign syllables. Soon, we were able to communicate quite well, and I became comfortable with her. I translated the physician's words and vice versa. I rubbed her leg and stroked her hair when she cried out or moaned. I'd then ask her about the pain and reassured her as much as I could.

Pay attention to changing trends in language and incorporate them into your spoken and written language. Avoid using complex words, medical terms, and jargon that are difficult to understand in any language. Keep instructions simple and repeat as necessary. Saying "I understand" may be patronizing. Speak slowly, speak distinctly, and try to appear unhurried. State your message slowly, sentence by sentence. Find creative ways to convey information. One mother–baby nurse described caring for a woman who spoke no English:

> I was left with hand gestures and body language for communication. It was very difficult for her to understand my actions. Her assessment was especially hard because I was unable to assess her pain, bleeding, and nipple tenderness adequately. I finally found an English to Spanish dictionary, but this was of limited help to me because I was so bad at pronouncing the words that she still had a very difficult time understanding me. Finally, I just let her read the words from the dictionary. This was the most effective way of communicating that I could come up with. I know that she felt somewhat isolated because she had a difficult time communicating her needs to me also.

Determining Who Makes Family Decisions

Ask women whom they wish to include in their birth experience and make sure those persons are present for all discussions and participate in decision making. Families fulfill several roles for women, including providers of security and support, caregivers, advocates, and liaisons. Families should be treated respectfully with the goal of establishing trust. For some cultural groups, conversation should be directed toward a specific family member. It is important to identify a spokesperson in the family, often the family member most proficient in English. Ask about family roles and respect the preferences of the woman and her family. When a Mexican immigrant woman was asked whether she wanted an epidural, the father of the baby answered, saying it was better for the baby to have an unmedicated labor and birth. The wife complied with this suggestion, and the nurse modeled support for the laboring woman and demonstrated respect for their decision as a couple. Many Mexican women may prefer not to have epidural analgesia/anesthesia. Understanding the role of different family members in the Korean family system is important because a woman's mother-in-law traditionally cares for her and the newborn during the postpartum period. The nurse needs to recognize that any teaching she does must include the mother-in-law.

Understanding That Agreement May Not Indicate Comprehension or the Ability to Adhere to Healthcare Recommendations

Maternal health literacy is an important consideration because it has an effect on the health of the childbearing woman and her child. Screening tools that may be useful

include Rapid Estimate of Adult Literacy in Medicine (REALM), Test of Functional Health Literacy in Adults (TOFHLA), and the Newest Vital Sign (NVS) (Callister, 2016). The woman may pretend to understand in an effort to please the nurse and gain acceptance. The woman's smile may mask confusion, and her nod of assent or "uh-huh" may mean only that she hears, not that she understands or agrees. For example, a new mother who did not speak English was admitted to the mother–baby unit during the night shift. When asked if she was voiding sufficient amounts, she responded, "Yes." In the early morning hours, the mother began to complain of intense abdominal pain. She was catheterized and drained of more than 1,200 mL of urine. The nurse had incorrectly assumed the woman's understood.

The story is told of a 14-year-old AN new mother who was instructed to return to the hospital lab within 24 hours to have her newborn's bilirubin level drawn. When the nurse inquired further, she learned that this young mother had only been in the city for 2 weeks and had never used public transportation and had no money. The nurse was able to assist with community resources to help this young mother rather than judging her as neglectful for not following discharge instructions (Ebanks et al., 2010).

Using Nonverbal Communication

Use eye contact, friendly facial expressions, and face-to-face positions. Do not assume the woman dislikes you, does not trust you, or is not listening to you because she avoids eye contact. Koreans, Filipinos, and many other Asian groups, as well as AI/ANs, consider direct eye contact rude and confrontational. Islamic women are taught to lower their gaze with members of the opposite sex. Use touch to express caring and comfort. Nonverbal communication makes an important difference. A birthing nurse said,

> I cared for a Korean first-time mother who came to the hospital fully dilated and gave birth to her son un-medicated. She did not speak any English, and her young husband was obviously uncomfortable and had little understanding about what was going on. As she gave birth, I could see the pain in her face, but she was stoic. I felt powerless because of her language and [other] cultural barriers, but I stayed with her and held her hand and encouraged her. Even though she could not understand my words, I hope she understood that I really cared.

Use universally understood language, such as charades (acting out), drawings, and gestures, and repeat the message several times using different common words. Use of simple words that are easily translated serves to improve communication.

Using Names and Titles

Determine how the childbearing woman and her family wish to be addressed. Names and appropriate titles are often complex and confusing. Mexican American clients appreciate being addressed by their last name. In the Korean culture, family members are addressed in terms of their relationship to the youngest child in the family (such as "Sung's grandmother"). It is important to learn how the woman wants to be addressed and to record it in the patient record so she won't have to answer the question over and over again.

DISPLAY 2–11

Developing Culturally Appropriate Educational Material

- Be aware of your own assumptions and biases.
- Develop an understanding of the target culture, including core values.
- Work with a multicultural team.
- Develop materials in the native language rather than having materials translated.
- Have materials reviewed by members of the target cultural group.

Teaching Techniques

Use visual aids and demonstrations and assist with return demonstrations. Do not assume that the woman can read or write. Ensure that teaching or educational materials can be understood by the client and are appropriate for the woman's cultural group and educational level. Display 2–11 contains suggestions for beginning the process of developing culturally appropriate patient education material. Appendix 2–A contains a sampling of culturally specific educational resources.

Accommodating Cultural Practices

Stereotypical generalization involves two dynamics: stereotyping and generalizing. Stereotyping, or believing that something is the same for everyone in a group, should be avoided. Generalizing, however, must be done to understand *potential* cultural beliefs and practices. The goal of individualizing care is to achieve a balance between what is indigenous to the culture and what may be specific to an individual woman. An experience that made one nurse sensitive to differences among women within the same culture was when she assumed that birth in H/L culture was exclusively a woman's experience, with little involvement by the father of the baby. She said,

> When I helped a Hispanic couple having their first baby, much to my surprise the father was right in there coaching his wife. So I supported his efforts and tried to make the birth experience what they wanted it to be.