



Experiences of Certified Nurse Midwives in Providing Culturally Competent Care for Hispanic Women

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Abstract

Background: The Hispanic population in North Carolina has more than quadrupled since 1990. Several studies have shown an increasing number of health disparities in the area of women's health for this population, specifically HIV, cervical cancer, and late initiation of prenatal care. However, there is little research about the experiences health care providers have in providing care to Hispanic women.

Purpose: The purpose of this study was to explore Certified Nurse-Midwife (CNM) experiences with providing care to Hispanic women to identify any specific challenges and recommendations to address this health disparity.

Design: This qualitative research study consisted of semi-structured interviews with five CNMs. Flanagan's (1954) critical incident technique was used to describe the experiences of five CNMs caring for Hispanic women in Southeastern North Carolina.

Results: Data analysis indicates that CNMs face many barriers when providing care to Hispanic women, including language as the most commonly reported barrier by participants. Resources to overcome this barrier include the availability of Spanish-speaking care providers and the use of language lines.

Conclusion: Implications of this study highlight the increasing need for women's

health care providers to incorporate strategies to provide culturally competent care to women of Hispanic origin.

Keywords: nurse midwife, culturally competent care, barriers to care, health disparity

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Introduction

The Hispanic population in North Carolina is steadily growing, and it has more than quadrupled since 1990. In 2008, the NC Hispanic population was estimated to be 640,000 compared to only 76,726 in 1990.^{1,2} The United States Census Bureau estimated the 2004 Hispanic population of NC to be just over 6% of the total population.³ In 2006, North Carolina had the fifth highest Hispanic growth rate, with a near 55% increase between 2000 and 2006. Of the 4.3 million women residing in North Carolina, Hispanic women make up 4% of this total.⁴ Because there is an upward trend in the growth of the Hispanic population, particularly women, it is imperative that health care providers address the health care needs of these women.

Several studies have explored the health outcomes of Hispanic women residing in the United States. Specific to women's health, Hispanic women report lower levels of knowledge on prevention of the Human Papillomavirus (HPV)⁵ and AIDS,⁶ and have a higher infant mortality rate, compared to non-Hispanic white women.³ In 2001, the greatest proportion of US cases of perinatal HIV was reported for infants of Hispanic and African American descent.⁶ Hispanic women also suffer some of the highest cervical cancer incidence rates in the US, which is twice as high as non-Hispanic white women.⁵ Reasons for their lack of knowledge on prevention include communication barriers between themselves and their health care providers, financial instability, and the lack of culturally competent health care workers.⁷

Hispanic women are also less likely than non-Hispanic women to report initiating prenatal care within the first trimester of pregnancy. The North Carolina Report Card on racial and ethnic disparities found that 29.9% of Hispanic women received late or no prenatal care.³ Factors related to this disparity in receiving prenatal care include their view of pregnancy as a "natural and normal" process,⁸ lack of financial means, lack of transportation, embarrassment of having a physical examination, and long waiting times.⁹

Certified Nurse-Midwives (CNMs) work in the area of women's health by providing prenatal and postpartum care, as well as routine gynecologic services to a multitude of populations and cultures. According to an article in the Journal of Nurse-Midwifery, 99% of clinically active CNMs provide care to women from

vulnerable populations, including those who are poor, uninsured, or immigrant.¹⁰ Therefore, it is important that CNMs practice cultural awareness in the health care setting.

The American College of Nurse-Midwives identified cultural competency as one of the “Hallmarks of Midwifery,” meaning it is a desirable quality of all members of the profession.¹¹ Cultural competency means to understand an individual’s health behaviors that are influenced by cultural and social factors, while devising interventions that take these issues into account, to assure that quality health care is delivered to all members diverse populations.¹² One of North Carolina’s health goals for 2010 is to eliminate health disparities among different segments of the population, which includes racial and ethnic disparities.¹³ Because CNMs provide care to a number of diverse populations, cultural competency is necessary to achieve this goal. Evidence shows a trend in poor health outcomes among Hispanic women; however, there are limited studies on practices provided by CNMs to these women. The purpose of this study was to describe the experiences of CNMs in Southeastern North Carolina in providing care to Hispanic women during their childbearing years.

Research Questions

The research questions posed for this study are:

1. What are the experiences of CNMs in Southeastern North Carolina in providing care to Hispanic women?
2. What barriers do CNMs in Southeastern North Carolina face in providing culturally competent care to Hispanic women?
3. What resources are available to overcome these barriers?

Literature Review

A review of recent literature provided knowledge on known barriers to prenatal care for Hispanic women, the health disparities that result, and the role of the CNM in providing culturally competent care to childbearing women.

Researchers have found consistency in Hispanic women’s reasons for seeking late or no prenatal care. Reasons include communication barriers between the patient and provider, financial instability, and lack of transportation or childcare services.¹ Shaffer (2002) interviewed 46 pregnant Hispanic women about factors influencing their access to prenatal care. Alarmingly, all 46 women said that having someone who speaks their language was a key decision-maker in accessing and continuing prenatal care. Some of the women reported that a Spanish speaking health care provider would better understand their culture. Another study revealed that Hispanic women who had an interpreter available to them during their visits were less satisfied than women who had a Spanish-speaking provider.⁹ Lack of health insurance was also found to be a barrier to

accessing care. Kalofonos and Palinkas (1999) further explored this barrier among Mexican-American women and found that women without any form of health insurance were almost six times as likely to have fewer than three prenatal care visits as women who did have health care coverage.

In 2006, 62.3 percent of non-Hispanic white women reported themselves to be in excellent or very good health, compared to only 53.4 percent of Hispanic women.⁴ Minority women are disproportionately affected by a number of diseases and health conditions, including HIV/AIDS and sexually transmitted infections. Non-Hispanic black women and Hispanic women accounted for more than three-fourths of women with HIV/AIDS in 2006.⁴ A survey on timely prenatal care initiation and perinatal HIV transmission indicated that Hispanic women may be at an elevated risk for missing perinatal HIV prevention opportunities due to higher rates of late prenatal care.⁶

Several studies have reported high incidences of cervical cancer in Hispanic women. A focus group on their knowledge of HPV showed that Hispanic women have some inconsistencies in their beliefs about HPV transmission,⁵ indicating a need for education from the health care provider. Additionally, because of their lack of culturally sensitive prenatal care, Hispanic women in one study were found to lack information about testing for birth defects.¹³ Accordingly, Hispanic women older than 35 years are three times more likely to have a child with Down Syndrome than white women.¹⁴ An exploratory analysis of Hispanic, white, and African American women receiving no prenatal care found that these women were more likely to have low birth weight and small for gestational age infants.¹⁵

The American College of Nurse-Midwives (ACNM) places great emphasis on its national certification examination in nurse-midwifery. In 2000, the ACNM conducted a task analysis on beginning midwives to determine their comprehension of knowledge and skills related to the profession. The ACNM labeled cultural competency as one of the core competencies of midwifery, meaning it is a professional responsibility of all CNMs to provide culturally sensitive care to their patients and families.¹¹ Tandon, Parillo, and Keefer (2005) conducted a study of 417 Hispanic and non-Hispanic women initiating prenatal care. Semi-structured interviews were conducted and Hispanic women were more likely to report that nurses and doctors treated them with disrespect during their prenatal care appointments than were non-Hispanic women. In addition, this lack of patient-centered care limited Hispanic women's ability to understand information given to them during prenatal visits. While we know there is evidence of health disparities among Hispanic women, there is little evidence to discuss the experiences of CNMs in providing cultural competent care to this population to improve health care outcomes.

Methodology

This qualitative research study used the critical incident technique developed by Flanagan (1954).¹⁷ During World War II, the critical incident technique was used to quickly train flight crews and to determine the success or failure of a mission. Flanagan developed this technique to more efficiently identify critical flight crew behaviors than more traditional research methods. His findings played a key role in identifying screening criteria for flight crews and the development of flight training programs. Today, the critical incident technique is used for emergency situations, educational methods, and professional certification and licensure. More specifically, this technique has been used in health care settings to identify patient's responses in studies of health care quality.¹⁸

The critical incident technique focuses on providing solutions to practical problems by obtaining information from real life experiences. In the case of this study, information about experiences of CNMs with Hispanic women was desired, and this information was easily obtained by listening to stories about these experiences. These interviews allowed participants to describe which interventions are more effective in overcoming barriers between the non-Hispanic provider and the Hispanic patient. This method pulls facts out of interviews and reduces personal opinions and biases. Additionally, the critical incident technique offers flexibility. Although the face-to-face interview is the most effective method for collecting data, questionnaires, telephone interviews, and workshops can be used as well. The intention of this method is to allow the participant to be as specific as possible in describing incidents from memory.¹⁷

Sample and Procedure

The sample in this IRB approved study included a convenience sample of five CNMs practicing in southeastern North Carolina. CNMs were contacted by email inviting them to participate in the study. Participants were asked to provide any names of colleagues who would be willing to be contacted for possible participation. These additional participants were contacted by email and directed to contact the researcher if they were interested in participating. After obtaining informed consent, each participant completed a demographic questionnaire, which included their age, ethnicity, years of practice, percent of Hispanic patients seen each month, and the number of deliveries each month. The demographic data were recorded and the semi-structured interviews followed. Subject recruitment and interviews continued over a five month period until saturation of the data was identified.

During the semi-structured interview, participants were asked to (1) describe their experiences with Hispanic women, (2) explain barriers in providing care to this population, (3) explain resources to overcome barriers, (4) explain preparation modalities in providing culturally competent care, and (5) describe what aspects are important in a practice to provide culturally competent care. Questions were derived from information found during the literature review. At the conclusion of

the interview, each participant was asked if there was any other information from their experiences that they thought would be helpful in this study.

Each interview was a one-time interview that took place in person at the CNM's place of practice. The length of the interview was anywhere between twenty to sixty minutes, depending on the information the CNM had to provide. The interviews were tape recorded and later transcribed for data-analysis. Only the primary investigator and faculty advisor had access to the data files and all data was stored in a locked, secure file. Each CNM was identified on tape as "CNM 1," "CNM 2," and so forth, so that their identity was kept confidential. Consistency in answers to the interview questions occurred early on in the interview process; it was at this time that the interviews stopped and data analysis began.

Major categories were identified based on the responses to each interview question. The student researcher and two doctorally prepared nurses independently sorted the interview responses to determine the major categories of critical incidents; the three independent reviews resulted in 95% agreement. Disagreements were used to refine and determine the final set of major categories for each interview question.

Results

Critical incidents were gathered from the semi-structured interviews and grouped in to the following categories: experiences with Hispanic women, barriers to care, resources to overcome barriers, midwifery coursework, and attributes important in a practice to provide culturally competent care.

Demographic Data

A convenience sample of five CNMs currently practicing in southeastern NC participated in the interview process. The age of the sample ranged from 34 years to 61 years, with a mean of 49.8 years. The average years of practice as a midwife were 7.25 years. Four of the five CNMs said that Hispanic women make up 5% or less of their patient population, while one CNM reported Hispanics as making up 75% of her patient population. The average number of deliveries that participants have each month is 14. All five participants reported that they were non-Hispanic and could not speak Spanish fluently.

Experiences with Hispanic Women

All five (100%) CNMs reported that they are currently practicing as midwives. Three (60%) of the participants currently work in a private practice, while two (40%) participants currently work in a health department. Two (40%) midwives reported previously practicing in a setting in which Hispanic women made up greater than 50% of their patient population. Currently, four of the five CNMs said that Hispanic women make up less than 5% of their patient- population.

Barriers to Providing Care

Table 1 describes barriers in providing care to Hispanic women as reported by the CNMs. A total of 22 critical incidents were reported for this category. The critical incidents in this category include: language barriers, lack of additional time needed for interpretation, lack of access to care, uncertainty of accuracy of translation by interpreter, male partner dominance during interactions, complication of language lines, lack of Spanish-speaking care providers, and lack of literacy by the patients.

Table 1: Barriers to Providing Care (n=22)

Major Category	Number of Incidents	Percent
Language Barrier	5	22.7%
Lack of Additional Time Needed for Interpretation	4	18.2%
Lack of Access to Care	3	13.6%
Uncertainty of Accuracy of Translation by Interpreters	3	13.6%
Male Partner Dominance During Interactions	2	9%
Complexity of Language Lines	2	9%
Lack of Spanish-speaking Care Providers	2	9%
Lack of Literacy by Patients	1	4.5%
Total	22	

The most commonly reported critical incident was a language barrier, which made up 22.7% (n=5) of the critical incidents. The second most commonly reported critical incident for this category was a lack of additional time needed for language interpretation, which accounted for 18.2% (n=4) of the incidents. One CNM said, “Time, you need more time when you don’t speak the language. Everything has to be doubled.”

Another commonly reported barrier was things that impede their access to care, such as transportation, lack of insurance, and undocumented citizenship. Access

to care was reported as a barrier in three (13.6%) incidents. A statement that relates to access barriers is, "Transportation was a barrier. I had to have a lot of flexibility in my schedule with patients. These were all patients who didn't have any insurance, so lots of them had no transportation."

Getting lost in translation while using an interpreter accounted for 13.6% (n=3) of the critical incidents for this category. For instance, one CNM reported, "I sometimes feel we lose something in the translation. I'm not always sure the information that I'm asking is getting interpreted to the patient correctly."

Many of the participants reported that the male partners of the patients would often times help to translate the conversation. However, this was seen as a barrier, as opposed to being beneficial, 13.6% (n=3) of the time. In regards to male partner dominance during interactions, one CNM said, "...sometimes I find that Hispanic males are very controlling in the interaction between the provider and their wife. Sometimes, they are the ones [that will take over], even if you are directing a question at the patient."

Other statements that pertain to barriers in providing care to Hispanic women as stated by the CNMs in the interviews are as follows:

The complication with using a language line was reported by one CNM as,

"At the hospital, they have a language line, it's kind of like the last result. It can be helpful, but it's kind of stilted and artificial."

Lack of Spanish-speaking care providers was reported by one CNM as,

"Well it would be helpful if we could all speak the language. That's the biggest thing. Or, to at least have an interpreter present."

Lack of literacy by the patients was reported by one CNM as,

"Another barrier was literacy. They couldn't write in English or Spanish. So we had learning brochures and teaching things that I translated into Spanish, [but] we still had to teach it to them."

Resources to Overcome Barriers to Providing Care

Resources that the CNMs used to overcome barriers to providing care are demonstrated in Table 2. A total of ten critical incidents were reported for this category. The available resources mentioned during interviews included: Spanish-speaking providers, language lines, use of family members, health departments, and use of a 'frequently used phrases' list.

Table 2: Resources to Overcome Barriers (n=10)

Major Category	Number of Incidents	Percent
Spanish-speaking Providers	3	30%
Language Lines	3	30%
Use of Family Members	2	20%
Health Departments	1	10%
List of “Frequently Used Phrases”	1	10%
Total	10	

The most commonly used resources reported for overcoming barriers were Spanish-speaking providers and language lines. In both cases, three (30%) critical incidents were reported. In regards to having Spanish-speaking providers, one CNM said, “I think the ideal would be to have providers that do speak Spanish fluently. We have one midwife that does speak Spanish fluently.” A statement that pertains to the use of a language line as a resource is, “There is an 800 number at the hospital that we use. You can get an interpreter over the phone.”

The second most commonly reported resource to overcome barriers was the use of family members for translation and interpretation, which accounted for 20% (n=2) of the critical incidents. A statement made by a CNM in regards to use of family members is, “We can use their husbands as a means of communication. They tend to know the language better.”

Other statements that pertain to resources to overcome barriers are as follows:

A statement that pertains to the use of health departments as a resource was reported by one CNM as,

“The health department is very qualified. They are receiving good care there. They have a WIC program; they have social workers there, and transportation.”

A statement that pertains to the use of a “frequently used phrases list was reported as,

“Someone always makes up some kind of cheat sheet, or frequently used phrases to try and help you get through.”

Course Work in Midwifery Program

There were two critical incidents reported pertaining to the coursework that prepared the CNMs to provide culturally competent care. Four (80%) CNMs reported they had one course in their midwifery program that covered a broad range of cultures. A statement that pertains to this type of course is, “We had to take a course that made us culturally aware of the diverse cultures we were working with.”

One (20%) CNM reported that culturally competent care was incorporated throughout all of her classes, rather than having one class reserved for this. She said, “There wasn’t like one course on cultural competency, it was pretty much a part of everything.”

Attributes Important to Providing Culturally Competent Care

The attributes reported as important to providing culturally competent care are reported in Table 3. A total of 11 critical incidents were reported for this category. Attributes that were reported include: having an interpreter present, understanding the culture, asking the male partner to step out, trying to make the patient feel less isolated, reading body language, taking time, understanding the language, and recognizing that there are access issues. The most commonly reported attribute was to have access to an interpreter, which accounted for 36.4% (n=4) of the critical incidents. In regards to having an interpreter present, one CNM reported, “We have three or four interpreters. They are available if I need them.”

Table 3: Attributes Important to Providing Culturally Competent Care (n=11)

Major Category	Number of Incidents	Percent
Having an Interpreter Present	4	36.4%
Understanding the Culture	2	18.2%
Asking Male Partner to Step	1	9.1%
Making Patient Feel Less Isolated	1	9.1%
Reading Body Language	1	9.1%
Taking Time	1	9.1%
Understanding the Language	1	9.1%
Total	11	

Other statements pertaining to attributes important to providing culturally competent care are as follows:

A statement in regards to understanding the culture was reported by one CNM as,

“Certainly an understanding of the culture [is important]. Recognizing that they’re going to eat rice and beans everyday and you have to work around that. Family is very important to them, so knowing that.”

A statement in regards to asking the male partner to step out of the room was reported by one CNM as,

“I think a lot of times, what I see, is that women don’t speak English, but the men do. And there is a power differential. So, recognizing, not letting the husband always translate, asking him to step out.”

Another comment that relates to this topic is,

“It depends on the woman, but I don’t think [Hispanic women] are necessarily as open when their husband is in the room.”

A statement that pertains to making Hispanic women feel less isolated was reported by one CNM as,

“I think, first and foremost, [it’s important to] recognize these women as people. Recognizing that just because there is a language barrier, doesn’t mean there is a difference in intelligence.”

Discussion

Five CNMs practicing in southeastern North Carolina participated in this qualitative research study to determine their experiences with Hispanic women. The major categories included in this study were (1) experiences with Hispanic women, (2) barriers to providing care, (3) resources to overcome barriers, (4) coursework regarding culturally competent care, and (5) attributes important in providing culturally competent care. It was commonly reported that Hispanic women made up less than 5% of the patient population for the CNMs in this study. The greatest barriers to providing care were language barriers and lack of additional time needed for the use of an interpreter, which coincides with information found in the study by Schaffer (2002). The most often reported resource to overcome barriers to providing care was Spanish-speaking care providers. All CNMs said their midwifery included coursework on providing culturally competent care. The most common type of coursework was a single class that incorporated information from several different cultures. The greatest attributes to providing culturally competent care included having an interpreter available and having an understanding for the Hispanic culture.

Limitations

Limitations to this study include the size of the sample, the experiences of the sample, and the data analysis procedures which limit the generalizability of the findings. The small sample size of five CNMs and the somewhat surprising finding that four of the five CNMs reported that Hispanic women comprised 5% or less of their patient population are limitations to the study. Interviews with Hispanic or Spanish-speaking midwives would have strengthened the methodology, however this study was conducted in a rural area of NC, where there were few, if any, Spanish-speaking midwives available for interviews. The setting of this study also made it difficult to generalize the data to larger segments of the population. An additional limitation includes the methodology chosen. Although ideal for this particular study, the Critical Incident Technique is not commonly used in nursing research, likely making it a questionable phenomenon to the reader.

Implications for Nursing Practice

Barriers to language between the patient and caregiver were the most commonly reported barrier to providing Hispanic women the proper care they deserve. Although it would be ideal for Hispanic patients to have a provider that speaks their language, this is not practical. This implicates the need for CNMs to be aware of the communication barriers and to initiate the use of an interpreter when needed. It was also reported that male partners can often take over the conversation between the caregiver and their wife. In this case, it is important for health care providers to remember who the patient is in certain situations, and to direct their care toward the patient, not their surroundings.

CNMs should also be aware of the financial and transportation barriers that may limit Hispanic women's access to care. These patients need to be educated on resources available to overcome such issues. There is a need for nurses to have an understanding of the cultural differences of Hispanic women, such as food preferences and the importance of family to them. CNMs should find ways to incorporate such issues into their plan of care. CNMs need to recognize that even though these women may be of a different cultural background, Hispanic women still need the same care that a non-Hispanic woman would receive.

Hispanic women represented less than or equal to five percent of the patient population for four of the five CNMs interviewed. This information coincides with information found in the review of the literature regarding late initiation of prenatal care by Hispanic women. This implicates a need for CNMs to recognize that this population needs education about the risks of not seeking early prenatal care.

This study also proves the need for additional cultural competency courses in midwifery programs. It would be helpful for midwifery programs to offer Spanish, as well as other foreign languages, as an elective course of study.

Implications for Future Research

Inclusion of a larger sample would be ideal for future research, as well as incorporation of CNMs from regions other than southeastern NC. Interviews with Hispanic patients and providers to determine their views on cultural competency in this setting may also provide relevant information in future research.

Conclusion

The number of Hispanic women in southeastern North Carolina is continuing to rise. Additionally, evidence from the literature review shows poor gynecologic health care trends for this segment of the population. Most barriers mentioned in this study can relate to the issue of having a lack of understanding of the Spanish language. Such barriers make it difficult for CNMs to provide Hispanic women the care they deserve. Also illuminated in this study, is the importance of understanding the different cultural beliefs among Hispanic women and how these beliefs may influence their care. While every provider may not know the language of their patient, it is important that every provider understand something about their patient's culture and where they come from. For it is this understanding that will change the way they perceive the care they have received.

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