Chapter 7
Immigrants, Refugees, and Undocumented Mothers

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7.1 Privilege of Place

Home, including family, community, and nation, is the place of belonging, privilege, safety, and personal control. Personal control is a culturally transmitted belief about the degree to which one can shape one's life, positively or negatively. Disruptions in place of belonging can occur for many reasons. Intimate partner violence is a common cause of disruption and loss of personal control within the immediate environment (Anderson et al., 2002). Community level violence, natural and man-made disasters, political persecution, genocide, and war can disrupt place of belonging and devastate any sense of personal control (Anderson & Anderson, 2020). These events can result in internal displacement within a nation, such as Hurricane Katrina, or it can result in migration beyond national borders. However, this is not necessarily related to untoward events.

Migration is movement to another nation of which one is not a citizen in order to achieve a specific goal, often with the intention of settlement as a permanent resident or naturalized citizen. It may occur in efforts to improve economic standards, to form family relationships across nations, to pursue career opportunities, or for safety. All persons seeking settlement within another country are *immigrants*. *Refugees* are a category of immigrants defined by the United Nations High Commission for Refugees (UNHCR) as "…people who have fled war, violence or persecution and have crossed an international border to find safety in another country" (UNHCR, n.d., para 1). These persons are eligible, upon the discretion and invitation of other nations, to settle in and seek citizenship in these nations. Examples

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are recent invitations by the USA to selected Afghan and Ukrainian refugees. Most immigrants have legal documentation of entrance into the USA. Immigrants who entered without legal immigration papers or continued residence beyond a specified time frame without renewing legal immigration papers are defined as *undocumented immigrants* (Department of Homeland Security, n.d.). As of 2018, 86.4 million people in the USA, about 27% of the population, were immigrants or their children, who were often citizens by birth in the country (Zong et al., 2018, Feb 8). Immigrants may or may not be warmly welcomed.

7.2 Motherhood and Place

Many immigrants face difficulties in accessing healthcare and navigating both cultural differences and legal requirements in the healthcare system (Lawrence et al., 2020). Having a sense of personal control is influenced by place and being an immigrant in an unfamiliar environment can be daunting. Difficulty accessing adequate maternal healthcare can increase their risk for poor maternal health outcomes (Aptekman et al., 2014; Banke-Thomas et al., 2017; Hasstedt et al., 2018; Kentoffio et al., 2016; United States Preventive Services Task Force, 2021).

An immigrant mother's sense of personal control is influenced by her lived experiences, cultural norms from both her country of origin and the USA, and perceived self-efficacy in controlling one's self and environment. Whether legal, refugee, or undocumented, she may feel may feel overwhelmed, at least temporarily, in a new country. Having left any or all of her former social, economic, cultural, and linguistic ties may create disruption to sense of place (Ogbuagu, 2021; Pangas et al., 2019). Perceived personal control and sense of place as the first hurdles in seeking care can potentially delay entrance to care (Jain et al., 2022).

Utilizing care includes gaining entry to a healthcare site and developing a patient–provider relationship (Gulliford et al., 2002; Millman, 1993). Finding a provider who can meet her physical needs, but who engenders trust and is culturally humble and respectful may not be so easy (Banke-Thomas et al., 2019). English or Spanish proficiency may or may not be an issue. Some immigrants have not had an opportunity to access such linguistic education in their home countries (Banke-Thomas et al., 2017; Deacon & Sullivan, 2009). Lack of insurance and/or economic or social resources are also considerable hurdles (Banke-Thomas et al., 2019; Deacon & Sullivan, 2009; Hacker et al., 2015; Hasstedt et al., 2018). Complex paperwork, bureaucracy, institutional policies about coverage, limited safety net services, discriminatory practices, negative provider and staff attitudes, high-intervention models of birthing, media charges of extortion, and fear of deportation and/or interruption of the immigration process can affect sense of personal control and impede access to care (Banke-Thomas et al., 2019; Cabral & Cuevas, 2020; Hacker et al., 2015; Hasstedt et al., 2018; Heckert, 2020; Jain et al., 2022; Ogbuagu,

2021; Pangas et al., 2019). Many fear being labeled as a "public charge" if they apply for public assistance (Lawrence et al., 2020). Many immigrant mothers fear and do experience disrespectful care or abusive treatment (Pangas et al., 2019; United Nations, 2019, July 11).

Upon entrance to the USA, some immigrants have superior health indicators. This is termed the *immigrant paradox.* These excellent health indicators erode the longer the immigrants are in the USA. Some explanations for this are described as follows. First, there is a general expectation that all immigrants are in dire straits, certainly not the case. There may be selection bias in that healthier immigrants have the energy to go to another nation. The "salmon bias" is the description of sicker immigrants who return to their natal countries. Lastly, is the well-researched finding of dietary, social and family changes within one generation of immigration, often resulting in increased consumption of low-nutrient fast foods and alcohol use as well as decreased family involvement and support (Lawrence et al., 2020).

The immigrant paradox may or may not affect birth outcomes. The immigrant paradox seems to hold for Mexican-immigrant mothers who have better birth outcomes in the first generation. Conversely, birth outcomes among South Indian mothers are worsened by immigration. Immigrant mothers are very diverse, from those entering the USA in good health and with legal immigration status to those who are suffering from acute and chronic conditions, malnutrition, and the stigma of refugee or undocumented status (Lawrence et al., 2020). Overall, immigrant women are at increased risk for specific pregnancy and birth-related complications including postpartum depression, gestational diabetes, induction, and cesarean delivery (Hasstedt et al., 2018; Shellman et al., 2014). Nonetheless, mothers who immigrate to the USA often do so voluntarily (Volkan, 2018), indicating a propensity for adaptation and personal control. Programs such as the Oregon's expansion of Emergency Medicaid to cover undocumented immigrant women have shown a positive effect on maternal health outcomes as these mothers have been encouraged to exercise personal control in their healthcare (Swartz et al., 2019). While all immigrants face numerous unknowns in a new country, each faces challenges in adapting to the healthcare system.

7.3 Exemplars of the Lived Experience

We, BA and LR, have both worked for many years providing healthcare to immigrant, refugee, and undocumented mothers in the USA and in international settings. We offer a few composite exemplars of personal control among the many resilient and courageous women with whom we have worked.

7.3.1 Exemplar: An Immigrant Mother from South Asia

Mothers from South Asian countries may face limited autonomy in healthcare decision-making. In traditionally patriarchal societies, men often decide if and when a family member should be taken to a healthcare facility and what decisions should be made about care. After immigrating to the USA, these mothers may experience some confusion as healthcare providers ask them to make at least minor decisions at the point of care, and may be unprepared to do so without consulting family members. As a nurse practitioner, I (LR) have encountered mothers from South Asia with little autonomy and personal control who embraced personal control as empowering. Ruma, a 23-year-old mother from Bangladesh, was pregnant with her fourth child when I met her. She was distraught due to the difficult birth of her third child and stated she had barely recovered when she became pregnant again. She expressed fear regarding her impending delivery and caring for her other children, expecting during another prolonged recovery and even another pregnancy. Our rapport developed over several visits and as the time drew closer to her due date, Ruma and I discussed options for future birth control. She listened carefully and accepted the printed information I provided, saying she would try to discuss the matter with her husband. Ruma had never initiated any conversation pertaining to family planning with her husband. To consider doing so now was both exhilarating and intimidating, but a first step toward personal control in adapting to her new environment.

7.3.2 Exemplar: An Immigrant Mother from the Middle East

Mothers from the Middle East may demonstrate personal control by requesting a female provider and maintaining both physical and cultural modesty at all times. However, as a social expectation often demanded by male partners, this may not always be a matter of personal control for the mother. Salma came to me (LR) at three weeks postpartum with significant weight loss following the birth of her first child, a beautiful baby girl. Her husband expressed concern and frustration. He said “She does not eat, then she is weak and cannot care for our child properly.” Initially, he was reluctant to leave the room, stating he would interpret for her, although Salma spoke English. The baby was fussy and he left the room with her. Salma then tearfully explained that she did not feel she was a good mother. She had anticipated being overjoyed with motherhood, but instead said she felt miserable with little interest in doing anything. Salma screened positive for postpartum depression. She was referred for care, but her husband insisted upon a female provider and refused the referral when they learned that a female psychologists or psychiatrist was not immediately available. Salma would not broach the subject of referral with her husband and continued to be depressed and unresponsive to her child, husband, and environment. The necessity of a female psychologist, psychiatrist or psychiatric nurse practitioner in this situation was essential.

7.3.3 Exemplar: A Refugee Mother from Southeast Asia

Refugees face unique challenges in seeking and accessing healthcare (Banke-Thomas et al., 2019) and in feeling safe in their new environment. The dictates of the culture, however, may provide significant strengths. I (BA) spent five years doing ethnographic research with Cambodian refugees in the refugee camps and border camps in Thailand and the third country resettlement areas of Southern California. I conducted doctoral and postdoctoral research on the health-seeking behaviors and practices of Cambodian refugee mothers. Like other southeast Asian populations, the role of women in the family is strong. Women are the designated healthcare guardians for family members including infants, children, adolescents, their male partners, the elderly who need assistance, and themselves. They have autonomy in their care. The women, especially the senior females, have a strong voice in determining who is considered sick (or not), what traditional treatments should be prescribed, and whether allopathic medicine is acceptable. These women have significant control over what happens. They have definite opinions on how to manage the 40-day lying-in period after childbirth including the treatment of *mother roasting* (charcoal burners or space heaters under the bed to warm the body even in 100 F degree heat in Southern California), the avoidance of any dietary *cold* foods (ice water, fruits and vegetables), and the importance of *hot* foods (meat, meat broths, and rice wine). After her baby was born, Radina was very upset when the nurse encouraged her to drink the ice water provided at her bedside, telling me the nurse was trying to murder her. The strengths in the culture gave her voice to express her concern and the personal control to explain why this was so upsetting (Anderson & Frye, 1989; Anderson & Frye, 1995).

7.3.4 Exemplar: A Second-Generation Mother from Central America

I (BA) checked my list of patients at the Southern California inner-city clinic not far from the Mexican–US border where I was a nurse-midwife provider. Thirty patients on the list, a wide diversity of both English- and Spanish-speaking mothers. Many were long-established as citizens, others were immigrants in process of obtaining citizenship or green cards, and some were undocumented. California had made the decision to offer maternity care to all women regardless of immigration status. This clinic was not far from the canyon described in the book *The Tortilla Curtain* (Boyle, 1996), a thinly-veiled novel that riveted the nation with narratives of devastating outcomes for undocumented persons, including pregnant women.

On the list, Rosa was identified as a 16-year-old primigravida, a confirmed first pregnancy. When I went into the exam room to meet Rosa, another woman in her mid-30 s sat beside her, nursing a toddler. Rosa introduced me to her mother, Navidad, and her little brother, Enrique. Navidad was a first-generation immigrant,

originally entering the country with undocumented status, and eventually becoming a citizen. Rosa was a citizen, having been born in the USA, along with seven of her nine siblings. She had just completed her sophomore year in high school when she became pregnant. The baby's father was a high-school dropout who worked as a mechanic but economics were tight. Gang membership offered financial opportunities and community status. Francisco, nicknamed Paco, sometimes came with Rosa to her prenatal visits and was very proud of becoming a father. Rosa planned to breastfeed her baby, as her mother had with all her children, and she was honored within the family for her healthy pregnancy. She wore her maternity clothes as tightly as possible to shown off the developing curvature of her pregnancy.

I cared for Rosa during childbirth, a short and gentle labor with minimal intervention and the birth of a well-developed baby boy ready for his first meal. While Rosa labored during the wee hours of the night, Paco was caught in the crossfire of gang violence and killed in a shoot-out on the mean streets of the night. Rosa was devastated but held her little son close to her bosom, nursing him with the skills she has learned from her own mother. She assumed control of her life, enfolded within the safe arms of family-her *madre, padre, tios, tias, sobrinos,* and all the rest of the extended family.

7.4 Undocumented: The Shadow World of the 70-Mile Rio Grande Valley

The Rio Grande River of southern Texas and the vast deserts of the southwest are legendary in American history. The border between Mexico and the USA, stretching across Texas to California, is a place that is a culture unto itself. There are pockets of violence, as described in the graphic novel *No Country for Old Men* (Cormac McCarthy, 2006). Undocumented immigrants usually enter the USA at one of these points. The Rio Grande Valley (RGV) has a fluctuating population as it is a frequent wintering site for agricultural migrant workers who fan across the vast agricultural lands in the USA during planting and harvesting times.

Annually, migrant field workers from Mexico and Central America come to the rural Midwestern farmlands and to the Central Valley of California in the USA to harvest the crops. Their arrival to pick tomatoes was part of my rural Midwestern childhood. As a child, I (BA) played with their children in the migrant camps, fascinated by the sound of their melodic Spanish as we traded English and Spanish words. There were many pregnant women in the migrant camps. They worked in the fields even as labor started. When one mother went into labor, I ran home to tell my mother. By the time we arrived, the baby was born. My mother took the young woman and her baby to the local doctor who proclaimed both to be in good health. It was not until far ahead in the future that I learned the harsh realities that faced these migrant mothers.

Later, as a university professor, I learned about a project located in the Rio Grande Valley (RGV) in southern Texas near the US–Mexico border. They offered maternity care for all mothers, legally documented or otherwise. Holy Family Services, founded in 1983 by four Roman Catholic nuns, is a licensed free-standing birth center operated by Certified Nurse Midwives (CNMs). It has been licensed longer than any other birth center in Texas (see https://www.holyfamilybirthcenter.com/about-us). Some of my students went there for clinical rotation and one of my former doctoral students, Dr. Heather Swanson, became the director. While in Texas, I asked her if I could visit Holy Family in the Rio Grande Valley. She invited me to stay on site and learn about the holistic approach to maternity care that included full-scope care as well as lodging and food for birthing families as needed, gardening projects promoting home gardening, assistance with immigration paperwork, and opportunities for volunteers. Holy Family definitely understands that adverse social determinants of health (SDoH) can drive maternal health outcomes and structures to program to help families have healthy outcomes in an environment of respectful maternity care.

In this chapter, we (BA & LR) examined personal control as an American value that affects mothers on the southern border. We interviewed Dr. Ann Millard, PhD, professor of anthropology and public health in the RGV and former editor of the *Medical Anthropology Quarterly* and Dr. Heather Swanson, DNP, CNM, professor of nursing and former director of Holy Family Services. They both generously shared the rich tapestry of their experiences in this unique American landscape.

7.4.1 The Path to Personal Control

The sense of personal control may be eroded by immigration, especially if under the intense stress of crossing the border undocumented. Many undocumented immigrants have walked across the Rio Grande river, but at times it becomes turbulent and deep, resulting in drowning deaths. Others have crossed through the deserts of the Southwest. Undocumented immigrants may take high risks as they flee incredibly dangerous situations. That characterization does not apply to all immigrants, but a common thread among immigrants is seeking options, choices, and control in their lives.

Dr. Ann Millard (AM) observed that the undocumented women initially seem to lose their sense of autonomy in their lives. She described young mothers, sheltered initially by Catholic Charities USA Center on the border, as being very subdued and fearful of what would happen next as they witnessed local retaliation against the center. In providing sanctuary, Catholic Charities USA has experienced a significant number of hate messages and personal threats directed toward the Catholic Sisters (Clarke, 2022, Feb 16). As immigrants establish a new life initiating the documentation processes, spreading out into the community to create a living environment, and coming together as communities (*colonias*), they begin to grow in a sense of personal control. She described this process of establishing a new life as fraught with

difficulty—finding a place to live, obtaining the necessities for survival, and reestablishing traditional spheres of influence and responsibility. They struggle with significant SDoH: economic instability with transient employment, language barriers, lack of health literacy, lack of adequate family support and sometimes violent neighborhood conditions. They fear calling the police as they negotiate the legal documentation process. Dr. Millard stated, “It’s enough to drive anybody crazy, the amount of pressure to be in a society when you don’t have documents and it’s just gotten worse over the years” (AM, personal communication, August 9, 2022).

She also described a thoughtful process in which careful resource management and acceptance of less-than-ideal living conditions is accepted as a path to personal control. Often, a family rents or informally buys a piece of unimproved land lacking sewage, water, trash removal, and electricity. Family composition fluctuates as those in agricultural migrant work come in and out. They accept low-paying transient jobs as a path to increased job security and personal control. Mothers may be left behind to manage the properties while others seek agricultural work. Gradually they improve the property although any financial setback can destroy all gains. In general, nutrition erodes with time, tending toward junk food. Most families do not plant a home garden for food security as gardening is perceived as a marker of poverty (AM, personal communication, August 9, 2022).

Pregnancy and childbirth at the Southern Border is influenced by the mother’s legal status, border politics, a healthcare system at times besieged by danger in the streets, and the deeply rooted culture of honoring motherhood. Dr. Heather Swanson (HS) described maternity care in the RGV. Some families choose to obtain maternity care at low-cost unlicensed clinics providing birth services. The licensed healthcare workforce is comprised primarily of physicians, many of whom are Hispanic-Americans as well as a significant number from the Indian subcontinent who have immigrated to the USA, certified nurse-midwives, and professional nurses, many of Hispanic-American heritage. It is essential for these healthcare providers to be fluent in Spanish. Maternity care is offered in clinics and hospitals and there is high-turnover among healthcare providers due to burnout and the large volume of care provided. Some mothers have private or public insurances but for undocumented persons, much of the financial transactions are cash or barter. Families in the process of negotiating legal status must provide ongoing financial records to case workers and they fear disclosure of any unpaid bills that could impede the movement toward legal status. Holy Family Services is a licensed freestanding birth center offering full-scope maternity care for nonsurgical deliveries provided by nurse-midwives. Families are offered additional services such as assistance with the necessary immigration paperwork, the option of a safe environment and food for families on site during childbirth, and cash payment and sometimes barter (HS, personal communication, August 10, 2022).

There are many reasons for undocumented mothers and their families to be fearful. There is mistrust and the sense that the healthcare system is cold and detached, yet they generally will not confront nor question medical decisions. Instead, they may ignore directions or spread the word about specific untrustworthy healthcare providers. Fearing ridicule, they may not be forthcoming about the *botanicas* and

other traditional remedies that are commonly used nor will they discuss *susto,* a culture-bound syndrome describing fear and withdrawal behavior when one cannot cope (AM, personal communication, August 9, 2022; HS personal communication, August 10, 2022). In working with a comparable population in California, I (BA) found I needed to be very careful to ask about traditional practices and beliefs in a nuanced and nonjudgmental manner.

Providing and obtaining care during birth can be problematic for both healthcare providers and their clients. While data is somewhat limited, the cesarean rate is very high, up to 60% in some hospitals and fluctuating according to local conditions. In some areas, healthcare providers fear violence and abduction by violent gangs if they come into or leave the hospitals in some areas during hours of darkness. Clients in labor at night fear going into the streets to get to the hospitals. They will make huge efforts to reach a hospital early in the day to avoid street violence. Some doctors will do a quick cesarean section before leaving the hospital at sunset in order to get the baby born, similar to the dynamics in Bagdad, Iraq, during the height of the war there. Hospitals usually do not allow family, especially children, to stay with the laboring mother, particularly during the COVID-19 pandemic. Feeling "like a number in the system," restrained by finances or lack of emergency government Medicaid funding, isolated in labor, and concerned about safety after dark, many mothers and their families embrace the Holy Family model of care. If they are not a good fit for a low-risk birth in a free-standing birth center or they experience a complication during labor requiring transfer to a hospital, they frequently object. A typical comment in this situation is: "No, No, No—I can't pay the bill. I need to stay here because my immigration process is almost done and I can't show I owe any money and where will my family go?" In an emergency situation, and if no night ambulance is available or affordable (a frequent occurrence), a staff from the Holy Family may need to accompany the mother to the hospital. (HS, August 10, 2022). Enhancing the mother's sense of personal control is critical to helping her to embrace her role, to prevent psychological birth trauma, and avoid posttraumatic stress disorder, a common occurrence among mothers in the RGV (Heckert, 2020; Pangas et al., 2019; Shellman et al., 2014; Trainor et al., 2020; Volkan, 2018).

7.4.2 The Pathway to Inclusion

Personal control involves feeling included. The pathway to inclusion in the American culture may be strewn with experiences of exclusion, development of skills necessary for participation, overcoming adverse SDoH, and finding a balance between cultures. The experience of inclusion in the 70-mile checkpoint zone of the RGV may be quite different from other parts of the nation. Many undocumented and fully documented immigrants state that life in the 70-mile checkpoint zone buffers the social exclusion sometimes experienced in other parts of the nation (HS, personal communication, August 10, 2022). In the RGV, the Mexican-American culture is normative. There are robust indicators of cultural influence from the Mexican

open-markets and small grocery stores, music, food trucks serving traditional cuisine, and large outdoor family gatherings with closely spaced children. Young women proudly display their pregnant bellies with tight and colorful clothing. It is customary to have photographs taken in late pregnancy to memorialize a serene, Madonna-like young mother with her enlarged pregnant abdomen (AM, personal communication, August 9, 2022; HS, personal communication, August 10, 2022). In California, I (BA) have been included in baptisms as an adult guardian (*comadre*), weddings, and celebration of *quinceañera*, the rite of passage acknowledging a young woman's coming of age at age 15. In the RGV and in much of the Southwest, these are normative events that promote a sense of inclusion and celebrate motherhood, but this inclusion is not necessarily experienced in all parts of the nation. As Dr. Swanson notes, "In most places along the 70 mile range, it is not really Texas or America. It's a different world that is a cultural merging" (HS, personal communication, August 10, 2022).

Feeling included and a sense of personal control in the 70-mile range is different from feeling inclusion in the larger American society. It may take significant time, especially for those who begin their journey in more difficult circumstances. One pathway to inclusion is education, highly respected among the Latinx immigrants of the RGV and elsewhere in the nation, even as they struggle with English language fluency and accessing educational opportunities for their children. Skills are valued and young men are encouraged to complete high school and then learn a skill, often manual, that will provide economic security, thus ameliorating the adverse SDoH, economic insecurity. Young women, often childbearing at a young age and with children in tow, are encouraged to complete high school and then pursue a tangible skill, such as bookkeeping or medical assistant. If a young woman becomes a medical assistant, donning the scrubs she wears to the clinic, the family expresses pride (AM, personal communication, August 9, 2022; HS, personal communication, August 10, 2022).

The Deferred Action for Childhood Arrivals (DACA) is a program initiated under the Obama Administration in 2012 to protect undocumented immigrants brought to the USA as children under the age of 16. Called the Dreamers Act, DACA has sought to provide a pathway for educational support and inclusion in American society for around 800,000 undocumented children as they emerged into adulthood (see https://www.uscis.gov/DACA). There have been many legal challenges to DACA, deepening political divisions in the nation.

Two powerful dramas are exemplars of the struggles of Latinx youth as they approach adulthood and parenting in America. The 2002 film, *Real Women have Curves*, captures the intergenerational conflict between an 18-year-old woman who wants to go to college and her traditional mother who wants her to marry and start childbearing. It is particularly poignant in depicting the issues of social inclusion and role expectations for young immigrant women. The 1988 documentary *Stand and Deliver* speaks to the issues around DACA, highlighting the struggles for sense of inclusion among undocumented immigrants. Based upon the true story of Jaime Escalante, a math teacher at an inner city high school in Los Angeles, it tracks his preparation of poorly prepared students from families in poverty to success in the

national Advanced Placement Calculus exam. This story is exemplar of the pathway to inclusion facing undocumented immigrants—a pathway strewn with exclusion, development of skills necessary for participation, overcoming adverse SDoH, and finding the balance between cultures. Later, I (BA) was privileged to have taught two of Jaime Escalante's former students at the university graduate level. It was clear that these young Latinx students had overcome formidable SDoH and incorporated a sense of personal control. Likewise, undocumented immigrant mothers face challenges to personal control on their pathway to inclusion and healthy motherhood.

7.5 Summary

Having a sense of personal control is influenced by place. Being in an unfamiliar environment can be daunting and immigrant, refugee, or undocumented mothers may struggle with a sense of personal control in their journey toward inclusion in American society.

Many immigrants demonstrate the immigrant paradox, arriving in the USA with better health habits than second and subsequent generations. Adverse SDoH such as difficulty accessing adequate healthcare, health literacy, and a sense of safety and inclusion within the community all factor into the immigrant struggle, increasing the risk for poor maternal health outcomes. The challenge is to support those immigrants who become part of our society to maintain healthy behaviors and minimize risks for poor maternal health outcomes.

References

Anderson, E. N., & Anderson, B. (2020). *Complying with genocide: The wolf you feed*. Rowman & Littlefield Publishing Group.

Anderson, B. (Frye, B.) (1989). Health care decision making among Khmer immigrants Unpublished doctoral dissertation, Loma Linda University School of Public Health.

Anderson, B., & Frye, B. (1995). Use of cultural themes in promoting health among southeast Asian refugees. *American Journal of Health Promotion, 9*, 4.

Anderson, B., Hopp Marshak, H., & Hebbeler, D. (2002). Identifying intimate partner violence at entry to prenatal care: Clustering routine clinical information. *Journal of Midwifery and Women's Health, 47*, 5.

Aptekman, M., Rashid, M., Wright, V., & Dunn, S. (2014). Unmet contraceptive needs among refugees: Rossroads clinic experience. *Canadian Family Physician, 60*(12), e613–e619.

Banke-Thomas, A., Gieszl, S., Nizigiyimana, J., & Johnson-Agbakwu, C. (2017). Experiences of refugee women in accessing and utilizing a refugee-focused prenatal clinic in the United States: A mixed methods study. *Global Women's Health, 1*(1), 14–20.

Banke-Thomas, A., Agbemenu, K., & Johnson-Agbakwu, C. (2019). Factors associated with access to maternal and reproductive health care among Somali refugee women resettled in Ohio, United States: A cross-sectional survey. *Journal of Immigrant and Minority Health, 21*(5), 946–953.

Boyle, T. (1996). *The tortilla curtain*. Penguin Random House.
Cabral, J., & Cuevas, A. G. (2020). Health inequities among latinos/hispanics: Documentation status as a determinant of health. *Journal of Racial and Ethnic Health Disparities, 7*(5), 874–879.
Clarke, K. (2022). Two nuns have a message for Catholics angry about their ministry to immigrants: 'We don't have any intention of stopping. *America: The Jesuit Review*. https://www.americamagazine.org/politics-society/2022/02/16/catholic-charities-catholic-vote-migrants-242408
Cormac McCarthy, C. (2006). *No country for old men*. Vintage International.
Deacon, Z., & Sullivan, C. (2009). Responding to the complex and gendered needs of refugee women. *Affilia, 24*(3), 272–284.
Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does' access to health care'mean? *Journal of Health Services Research & Policy, 7*(3), 186–188.
Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: A literature review. *Risk Management and Healthcare Policy, 8*, 175.
Hasstedt, K., Desai, S., & Ansari-Thomas, Z. (2018). Immigrant women's access to sexual and reproductive health coverage and care in the United States. *Issue Brief (Commonwealth Fund), 2018*, 1–10.
Heckert, C. (2020). The bureaucratic violence of the health care system for pregnant immigrants on the United States-Mexico border. *Human Organization, 79*(1), 33–42. https://doi.org/10.17730/0018-7259.79.1.33
Jain, T., LaHote, J., Samari, G., & Garbers, S. (2022). Publicly-funded services providing sexual, reproductive, and maternal healthcare to immigrant women in the United States: A systematic review. *Journal of Immigrant and Minority Health, 24*(3), 759–778. https://doi.org/10.1007/s10903-021-01289-2
Kentoffio, K., Berkowitz, S. A., Atlas, S. J., Oo, S. A., & Percac-Lima, S. (2016). Use of maternal health services: Comparing refugee, immigrant and US-born populations. *Maternal and Child Health Journal, 20*(12), 2494–2501.
Lawrence, D., Ramakrishman, K., & Yun, K. (2020). Achieving health equity for immigrants and their children. In A. Plough (Ed.), *Culture of health in practice: Innovations in research, community engagement, and action* (pp. 137–153). Oxford University Press.
Millman, M. (Ed.). (1993). *Access to health care in America*. National Academies Press. https://pubmed.ncbi.nlm.nih.gov/25144064/
Ogbuagu, B. C. (2021). Reimagining the convoluted plights of refugee, immigrant and undocumented immigrant women: Implications for the reauthorizations of the violence against Women's act of 1994 in the United States. *Social Education Research*, 75–102.
Pangas, J., Ogunsiji, O., Elmir, R., Raman, S., Liamputtong, P., Burns, E., Dahlen, H. G., & Schmied, V. (2019). Refugee women's experiences negotiating motherhood and maternity care in a new country: A meta-ethnographic review. *International Journal of Nursing Studies, 90*, 31–45.
Shellman, L., Beckstrand, R. L., Callister, L. C., Luthy, K. E., & Freeborn, D. (2014). Postpartum depression in immigrant Hispanic women: A comparative community sample. *Journal of the American Association of Nurse Practitioners, 26*(9), 488–497.
Swartz, J., Hainmueller, J., Lawrence, D., & Rodriguez, M. (2019). Oregon's expansion of prenatal care improved utilization among immigrant women. *Maternal and Child Health Journal, 23*(2), 173–182.
Trainor, L., Frickberg-Middleton, E., McLemore, M., & Franck, L. (2020). Mexican-born women's experiences of perinatal care in the United States. *Journal of Patient Experience, 7*(6), 941–945. https://doi.org/10.1177/2374373520966818
United High Commission for Refugees. (n.d.). *What is a refugee?* https://www.unhcr.org/en-us/what-is-a-refugee.html
United Nations. (2019). *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence,* United

Nations General Assembly 74th session: Advancement of women. https://digitallibrary.un.org/record/3823698

United States Department of Homeland Security. (n.d.). Reporting Terminology and Definitions. https://www.dhs.gov/data

United States Preventive Services Task Force. (2021). *A & B Recommendations*. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

Volkan, V. D. (2018). *Immigrants and refugees: Trauma, perennial mourning, prejudice, and border psychology*. Routledge.

Zong, J., Batalova, J., & Hallock, J. (2018). Frequently requested statistics on immigrants and immigration in the United States. *Migration Information Source Spotlight*. www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states