Immigrant Women's Experiences of Maternity-Care Services
In Canada: A Narrative Synthesis

A Research Briefing Report

G.M.A. Higginbottom[(1)], M. Morgan [(2)], Y. Chiu [(3)], M. Alexandre[(4)], D. Kocay[(5)], J. Forgeron[(6)]

Faculty of Nursing, University of Alberta[(1)]; King's College, London, UK[(2)]; Multicultural Health Brokers Co-operative, Edmonton [(3)];Citizenship and Immigration Canada[(4)]; Public Health Agency of Canada[(5)]; Alberta Health Services[(6)].

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Background:

Female immigrants constitute an increasing proportion of births in industrialized countries and may have greater fertility than women born in these countries [1]. In Canada, 52% of immigrants are women [2]. This creates specific challenges for female immigrants in their access and navigation of the healthcare system and more specifically maternity care services. The diverse and multicultural nature of Canadian society and Canada's statutory commitment to multiculturalism means that the synthesis of knowledge related to immigrant experiences of maternity care is an urgent imperative because of rapidly changing demography and the potential to realize health potential. Synthesized evidence is needed in order for knowledge users within multiple sectors to appropriately configure maternity services and programs. Partnering with key stakeholders, we conducted a narrative synthesis [3] of qualitative and quantitative studies to answer the research question:

(a) ***What are the experiences of immigrant women in accessing and navigating maternity services in Canada?,*** and **(b) the effects of the perceptions and experiences of these women on their birth and postnatal outcomes**?

In particular, focus was placed on accessibility and acceptability as an important dimension of access to maternity care services as perceived and experienced by immigrant women, and the impact/influence of this perception and experience on birth and postnatal outcomes. An additional aim of this narrative synthesis is to provide stakeholders with perspectives on maternity-care services as experienced by immigrant women in Canada.

Research Methods:

A systematic review using a narrative synthesis [3] approach was used to identify, appraise and synthesize reports on empirical research using qualitative, quantitative and mixed-method designs. Guidelines for systematic and grey literature review were followed to identify and select literature. The synthesis relied primarily on text to summarize and explain findings, using four elements: i) developing a theory of why and for whom, ii) developing a preliminary synthesis, iii) exploring relationships in the data, and iv) assessing the robustness of the synthesis. ATLAS.ti software was used for synthesizing findings.

Findings:

Literature search of electronic databases and grey literature resulted in the selection of 24 primary research papers for inclusion in this study [4 – 27]. This consisted of 14 quantitative/mixed methods, and 10 qualitative studies. Heterogeneity existed in clinical context (perinatal – 7; prenatal – 1; prenatal and delivery – 1; delivery – 1; and, postpartum – 14). Analysis of these 24 studies led to the development of four interrelated themes: perinatal access, acceptability and congruence of services; postnatal depression; social and spousal support; and uninsured women.

Utilization of prenatal care and classes - 8 quantitative [6, 7, 13, 15, 16, 20, 23, 26], and 3

qualitative [12, 21, 24] studies reported on this theme. Some studies reported little difference between immigrant and Canadian born women in seeking or utilizing prenatal care from physicians [7, 13, 15]. Other studies reported greater discrepancy in utilization of prenatal care from physicians [12, 16, 20, 24] presenting an equivocal picture. Several studies reported similar rates and timing of seeking prenatal care from physicians, but many found that immigrant women were far less likely to have knowledge about or attend prenatal classes. A survey of South Asian immigrants in Calgary showed that 53% of respondents were unaware of prenatal classes [6]; another study in same city with a diverse sample reported high awareness (75%) of prenatal classes but unknown utilization levels [26].

Adequacy of perinatal care – This theme was further sub-divided into the following categories: *prenatal care* (3 quantitative [6, 13, 26], and 4 qualitative [12, 19, 21, 24]); *delivery and in-hospital care* (8 quantitative [6, 7, 8, 11, 14, 15, 16, 26], and 4 qualitative [12, 21, 22, 27] studies); and, *postpartum* care (8 quantitative [10, 11, 14, 15, 16, 18, 20, 25], and 8 qualitative [4, 5, 9, 12, 17, 19, 21, 24] studies). With respect to the adequacy of *prenatal care*, South Asian immigrants in Calgary thought they received all the care they needed during pregnancy and birth [6]. The majority of uninsured women in Montreal were categorized as having inadequate prenatal care utilization [13]. Participants in Eastern Canada raised 3 issues of concern about prenatal classes and the tour of the hospital maternity unit [21]. Some women were not told about these classes or did not understand their purpose; did not attend the classes because the classes did not offer any care arrangements for their other children; and could not participate in these classes because they were not designed exclusively for women. Attending these classes with other men would have caused them great discomfort due to their religious beliefs [21]. Studies reporting on adequacy of delivery and in-hospital care showed that immigrant mothers were satisfied with care in hospital [6] especially as related to breastfeeding [16]. Most women (90%) in one study felt that hospital staff were sensitive to cultural/religious beliefs [26]. However, there were also reports of dissatisfaction in other studies. Women of Muslim faith (n=6) experienced remarks that were insulting, insensitive, based on stereotypes, and left them feeling embarrassed [21]. Somali women had several issues with care often related to female genital circumcision: (i) <1 % wanted caesarean but 50% received; (ii) "little discussion or say about procedures related to their birth and pain management"; (iii) 87.5% reported hurtful comments made by their caregivers related to their circumcision; (iv) many thought the nurses regarded them as "being lazy" (83.6%) or reluctant to "cooperate" (79.6%) [7]. Indo-Canadian immigrant women learned fewer baby care and self-care procedures [20]. Several Punjabi women reported experiencing difficulty during their hospital stay in being provided hot food by hospital staff (i.e., being given sandwiches, jello, and salads instead) [12]. To enable early discharge, nurses are compelled to encourage women to begin walking and washing as soon as possible following delivery, despite cultural prescriptions that require strict bed rest or avoidance of showers [22]. In exploring the adequacy of *postpartum care* reported by immigrant mothers, one study reported that fewer recent immigrants than Canadian-born were contacted by (84% vs 95%), or saw (70% vs 79%), a health care provider after discharge, except for routine visits [15]. Immigrant women in Ontario were more likely to visit an obstetrician or accept a public health nurse visit [25]. For 12 of 20 mother-infant pairs in one study, there was no evidence in charts of contact within 48 hours or of interventions to address maternal depression and social isolation [14]. New mothers' satisfaction with care from nurses and physicians correlated to the number of psychosocial issues discussed [18].

Barriers identified in the pre and postnatal periods – Five quantitative [6, 10, 13, 25, 26], and 9 qualitative [4, 9, 12, 17, 19, 21, 22, 24, 27] studies reported on this theme. Lack of knowledge amongst immigrant mothers, especially as related to breastfeeding and postpartum depression (PPD) was reported in two studies [4, 24]. Inhibitors to following through with (postpartum) referrals were: language barriers, transportation problems, difficulty making appointments, partner's absence, child care absence, cold weather, perceived inappropriate referral, and cultural practices differences [9]. Other barriers reported in the studies were: wait times for appointments [19], presence of men in prenatal

classes that contravened religious beliefs [21], lack of health insurance [13, 21], concerns about families' ability to manage potential complications [22], and time constraints [24]. According to one study, lack of money was not commonly identified as a barrier by immigrant mothers [6]. Other barriers included in the studies are cculturally inappropriate care during labor and delivery, lack of information about breast feeding techniques and Language and communication difficulties

Isolation and limited social support – This theme emerged from 3 quantitative [14, 15, 25], and 4 qualitative [4, 17, 21, 27] studies. This theme was described in a variety of ways. In one study, 9 of 20 immigrant women had psychosocial concerns (largely anxiety and social isolation) identified in hospital or community charts [14]. Peer support related to breastfeeding was very important to Vietnamese participants [24]. A large cross-sectional study in Ontario found that immigrant women were significantly more likely than Canadian-born women to have low social support at home [25]. Refugee claimant women, for example, felt isolated, "didn't know where to get services, had difficulty getting to services and overall felt they had 'no one to help'" [17]. For immigrant parents with babies in the neonatal intensive care unit {NICU), social supports were identified as family, friends, NICU staff, a spouse or partner, long-distant support via the telephone, other children, and church [27]. For new mothers of South Asian and Chinese origin with postpartum depression, when describing outside support as helpful, it was typically community health nurses who played a key role for women [19]. Lack of spousal support was also heighted in the few studies [27, 19, 14, 25].

Access to appropriate information – A total of 12 papers were reviewed that contributed to this theme; this consisted of 6 quantitative [6, 14, 15, 16, 25, 26], and 6 qualitative [4, 5, 17, 19, 21, 24] studies. One study reported that newcomers were less likely to take folic acid before and during pregnancy and to place their infants on their backs (both due to lack of information) [15]. In a large cross-sectional Ontario survey, learning needs (primarily for information) for immigrant women were more often unmet in hospital [25]. For refugee claimant women in Quebec, interpreters were not available and women could not easily express their concerns or understand information provided [17]. Mothers with PPD who accessed psychological support had received the information from their friends and advertisements [4]. Immigrant mothers in Montreal (speaking English or French) agreed more strongly that hospital staff helped them feel confident in breastfeeding, while Canadian-born mothers felt they had received contradictory information from hospital staff [16].

Outcomes Related to Access to and Use of Services – This theme consists of the following sub-themes: *birth outcomes* (1 quantitative [13] study), *postpartum mental health* (6 quantitative [10, 14, 15, 18, 23, 25], and 3 qualitative [4,17, 19] studies), and *breastfeeding and childcare issues* 5 quantitative [8, 11, 14,15,16], and 1 qualitative [24] studies). A study related to *birth outcomes* indicated that despite inadequate prenatal care for uninsured women, they had similar outcomes with respect to gestational age, birth weight, number of vaginal deliveries, number of inductions, use of epidural analgesia, and attendance at the postpartum visit [13]. Immigrant mothers' access to and use of *postpartum mental health* services were explored in several studies. One study showed that newcomer women with less prenatal care (later or limited) were two times more likely to have an Edinburgh Postnatal Depression Scale (EPDS) of ≥10 (P=0.03) [23]. In another study, involving 50 refugee participants in Montreal who received a 4 month home visit, 26 had symptoms of PPD and 16 reported not eating meals due to lack of resources [17]. Almost none of the women with PPD sought out referrals to psychological support services via nurses; instead they were given the information through friends or advertisements[4]. Women in one study had all come into contact with health care practitioners, but only a few described these encounters as critically important. Support for women must move beyond the medical management of depression and include a range of supports that take into account social, cultural, and other contextual factors [19]. With respect to *breastfeeding and childcare issues*, one study reported that after hospital and community chart review, 8 of 20 immigrant women had breastfeeding difficulties identified, with resolution recorded in 2, referral documented in 1, 6

issues unresolved in hospital, 5 still had issues on follow up by community nurse, and 1 already switched to bottle [14]. Nevertheless, breastfeeding initiation was reported to be similar for both groups, with immigrant mothers being 1.7 times more likely to breastfeed at three months [15].

Key Messages

- Health care professionals should be aware of not only the basic postpartum health needs of immigrant women but also to their income, learning, and support needs (especially community resources) by ensuring effective interventions and referral mechanisms, particularly for income and social support. Direct or better organized referral pathways to cultural or faith-based health and social programs" are required
  Early information transfer could be enhanced by providing solid healthcare information at the border, upon arrival, for migrants [9].
- Fewer immigrant women than Canadian-born women were reported to have accessed prenatal classes on breastfeeding and childcare (15)
- Provision of culturally safe and appropriate care is essential to enable care providers to understand the cultural manifestations and context of PPD and the provision of training on culturally safe care. [25].
- Greater communication between nurses and physicians may allow for knowledge transfer and collaborative care about issues (particularly psychosocial) [18].
- Although generally given the opportunity to obtain necessary services, immigrant women in Canada face many barriers related to utilization of and access to services, including language challenges, potential 'cultural clash', availability and awareness of appropriate information and supports as well as discordant expectations on the parts of the women and service providers.
- Enhancements to maternity care for immigrant women will ultimately benefit not only these women but also the health of future generations of Canadians
- Carefully interpreted findings will allow for knowledge users within multiple sectors to strategically enhance maternity care services and professional development, in order to ensure timely and appropriate provision of culturally congruent maternity care.

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For further information concerning this study please contact: gina.higginbottom@ualberta.ca also see:
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